KINETIC CHIROPRACTIC
CONSENT FOR USE OR DISCOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health car information.

- We may have to disclose your health information to another health car provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance companies have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

Printed Name	Authorized Provider Representative
Signature	Date
Date	

Lisa L. Koenig
Doctor of Chiropractic
Board Certified
Applied Kinesiologist

**IN AN EFFORT TO MAKE THIS OFFICE
MORE EFFICIENT AND PLEASANT,
IT WOULD BE GREATLY APPRECIATED IF…**

YOU REMEMBER THAT **YOUR PAYMENT AND THE COST OF ALL SUPPLEMANTS AND SUPPLIES YOU RECEIVE ARE DUE ON THE DAY OF YOUR APPOINTMENT.** AS A COURTESY, WE WILL SUPPLY YOU WITH A SUPERBILL FOR YOUR INSURANCE COMPANY.

YOU UNDERSTAND THAT THER IS A **48-HOUR CANCELLATION POLICY** IN THIS OFFICE. IF YOU DO NOT GIVE US AT LEAST 48 HOURS NOTICE THAT YOU CANNOT MAKE YOUR APPOINTMENT, YOU WILL BE CHARGED THE **$100.00 CANCELLATION FEE.** THIS FEE APPLIES TO BOTH MASSAGE AND CHIROPRACTIC APPOINTMENTS.

YOU HAVE HAD ANY NEW ACCIDENTS OR INJURIES SINCE YOUR LAST VISIT; PLEASE INFORM THE RECEPTIONIST PRIOR TO SEEING THE DOCTOR AT THE BEGINNING OF YOUR TREATMENT. IF YOU HAVE MOVED SINCE YOUR LAST VISIT, PLEASE INFORM THE RECEPTIONIST OF YOUR NEW ADDRESS AND TELEPHONE NUMBER.

YOU REMEMBER ON THE DAY OF YOUR APPOINTMENT **NOT TO WEAR COLOGNES OR PERFUMES.** THERE ARE MANY OF US, BOTH STAFF AND OTHER PATIENTS, WHO ARE ALLERGIC TO THESE SUBSTANCES AND MAY SUFFER CONSIDERABLY.

YOU REMEMBER THAT WE, UNFORTUNATLEY, **DO NOT HAVE ANY PATIENT PARKING AVAILABLE.**

_____

Signature

_____

Date

Lisa L. Koenig
Doctor of Chiropractic
Board Certified
Applied Kinesiologist

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: The state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxation or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination if we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. Our only practice is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.

Oakland, CA 94611 * 510.909.4190

KINETIC CHIROPRACTIC
Lisa L. Koenig
4168 Piedmont Avenue, STE E
Oakland, CA 94611

Pediatric History Form

Patient Name_____ SS#_____
Name of Parents / Guardians_____
Address _____City _____State _____Zip_____
Home Phone_____ Work Phone_____ Email Address_____
Birth Date _____ Sex_____ Weight_____ Height_____ Number of siblings_____
Who referred you to us? _____
Reason for seeking chiropractic care**:**_____
Other Doctors seen for this condition Y/N Specialty: _____
Prior treatment and outcome: _____
Other Health Problems: _____

Symptoms: Please check any current or past problems your child has on the list below:

_Dizziness	_Allergies	_Diarrhea	_Broken bones
_ADHD	_Runny Nose	_Poor Appetite	_Sprains/Strains
_Backaches	_Itchy Eyes	_Hyperactivity	_Hernias
_Heart Condition	_Rashes	_Behavioral	_Neck Pain
_Chronic Earaches	_Unusual Moles	_Poor Memory	_Arm/Elbow Pain
_Diabetes	_Neuritis	_Insomnia	_Leg/Hip Pain
_Tuberculosis	_Digestive	_Nightmares	_Knee/Foot Pain
_Hypertension	_Sinus Trouble	_Bed Wetting	_Growing pains
_Fever/Chills	_Cough/Wheeze	_Pain Urinating	_Joint Pain
_Frequent Colds	_Chest Pain	_Convulsions	_Scoliosis
_Arthritis	_Constipation	_Paralysis	_Blood disorders
_Headaches	_Anemia	_Muscle Pain	_Stomach Aches
_Asthma	_Rheumatic Fever	_Fainting	_Other

Health History:
Name of Pediatrician: _____ Date of last visit _____
Reason for visit: _____
Medications and conditions being treated: _____
Has your child ever taken antibiotics? Y/N Condition treated: _____
Has your child been injured participating in contact sports (Soccer, Football, Martial Arts…) Y/N
If yes, describe (Sprain, Broken Bone, Head Trauma…) _____
Has your child ever been involved in a car accident? Y/N Date & Injuries _____
Has your child ever fallen head first from (Changing Table, Bed, Stairs…) Y/N _____
Other traumas not described above? Y/N Type & Date: _____
Prior surgery: Y/N Type and Date:_____ Menarche: Y/N Age:_____

Prenatal History
Location of Birth: O Home O Birthing Center O Hospital O Stepchild O Adopted
Complications during pregnancy: Y/N List: _____
Ultrasounds during pregnancy: N Y Number: _____
Medications during pregnancy/delivery: Y/N List: _____
Cigarette / Alcohol use during pregnancy: Y/N
Birth intervention: O Forceps O Vacuum O Caesarian,
Why?_____
Complications during delivery: Y/N List: _____
Genetic disorders or disabilities: Y/N List: _____
Birth weight_____ Birth length_____ APGAR scores: 1 min _____ 5 min _____

Feeding history
Breast Fed: Y/N How long'?_____ Formula fed: Y/N How long'?_____
Type:_____ Introduced to solids at _____ months. Cow's milk at _____ months
Food / juice allergies or intolerances Y/N List: _____

Developmental History
Sleep (Hrs per night) _____ Naps (number & lengths) _____ Problems sleeping _____
At hat age was your child able to: Crawl __ Sit alone __ Stand alone __ Walk alone __ Say words __

Childhood Diseases
O Chicken Pox - Age ___ O Mumps - Age ___ O Rubella - Age ___ O Whooping cough - Age ___
O Measles - Age ___ O Meningitis - Age ___ O Tuberculosis - Age ___ O Other - Age _____

Vaccination History:
O HBV / Hep B (Hepatitis B) – Age __ O MMR (Measles, Mumps, Rubella) – Age __
O DTP or O DTaP (Diphtheria, Tetanus, Pertussis) – Age __ O Varicella (Chicken Pox) – Age __
O HbCV / Hib (H. influenzae type b conjugate) – Age __ O PCV (Pneumoccocal) – Age __
O OPV (Oral Polio Vaccine) or O IPV (Inactivated Poliovirus) – Age __
Adverse Reactions to Any Vaccine? Y/N List: _____

Insurance
Do you have medical insurance? Y/N Insurance Company Name _____
Policy Number _____Insurance Company Phone number _____
Insured's Name _____Relationship to patient _____
Insured's DOB _____Insured's SS# _____
Insured's Employer _____ Insured's Employee Address_____

CONSENT TO CHIROPRACTIC CARE

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.
I, _____, being the parent or legal guardian of _____ hereby grant permission for my child to receive chiropractic care.

Signed _____Witnessed _____

Date _____