



PEDIATRIC HISTORY FORM

Dear Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please complete the following information. We look forward to working with you to build better health for your family.

Patient Information

Name: _____ S.S. #: _____
Address: _____ City: _____
State: _____ Zip: _____ Home Ph: _____
Birth Date: _____ Sex: M F Weight: _____ Height: _____
Referred By: _____

Parent/Guardian Information

Name(s): _____
Cell Ph: _____ Work Ph: _____
Birth Date: _____ S.S. #: _____

Purpose for Contacting Us? _____

Have you seen others doctors for this condition?: _____ N _____ Y

Other Health Problems? _____

Check any of the Following Conditions Your Child has Suffered from during the Past Six Month:

____ Ear Infections ____ Scoliosis ____ Seizures ____ Colds
____ Headaches ____ Asthma/Allergies ____ Digestive Problems ____ ADHD
____ Recurring Fevers ____ Growing/Back Pain ____ Colic ____ Bed Wetting
____ Car Accident ____ Temper Tantrums ____ Other: _____

Family History/Health Problems? _____

Previous Chiropractor: _____ Date of Last Visit: _____

Number of Doses of Antibiotics Your Child has Taken:
During the Past 6 Months: _____, During Last Year: _____

Number of Doses of Other Prescription Medications Your Child has Taken:
During the Past 6 Months: _____, During Last Year: _____

Number of Doses of Over-the-Counter Medications Your Child has Taken:
During the Past 6 Months: _____, During Last Year: _____

Prenatal History

Complications During Pregnancy? _____ N _____ Y, List: _____

Medications During Pregnancy/Delivery? _____ N _____ Y, List: _____

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section

Complications During Delivery? _____ N _____ Y, List: _____

Genetic Disorders or Disabilities? _____ N _____ Y, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Feeding History

Breast Fed? _____ N _____ Y, How Long: _____

Formula Fed? _____ N _____ Y

Developmental History

Please list any falls your child has had in the past (i.e. from changing tables, stairs, bed, bike, tub, etc.).

1. _____
2. _____
3. _____

Is/has your child been involved in any impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)? _____ N _____ Y, List: _____

Has Your Child Ever Been Involved in a Car Accident Over 3mph? _____ N _____ Y, When: _____
List Details: _____

Has Your Child Been Seen on an Emergency Basis? _____ N _____ Y, List: _____

Other Traumas Not Described Above? _____ N _____ Y, List: _____

Prior Surgery? _____ N _____ Y, List: _____

Childhood Diseases

Chicken Pox	N	Y, Age _____	Mumps	N	Y, Age _____
Rubella	N	Y, Age _____	Whooping Cough	N	Y, Age _____
Rubeola	N	Y, Age _____	Other	N	Y, Age _____

Please list all others: _____

Other Information

What percentage (%) of the day does your child...

_____ play outside or exercise?

_____ play videos games/watch TV/play on computer?

_____ engage in activities? (church, sports, school, etc.) Please List: _____

Rate your child's food intake: 1 2 3 4 5 6 7 8 9 10
(Poor – Processed Foods/TakeOut/Fast Food) to (Organic, Fresh, Healthy)

Rate your child's school performance: 1 2 3 4 5 6 7 8 9 10
(Poor) (Average) (Outstanding)

What could improve? _____

How many days per year does your child miss school due to illness? 0 1-2 3-6 7 or more

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office at time that services are rendered.

Name of Insurance Company: _____ Policy #: _____

Print Name: _____ Signature: _____ Date: _____



LIFESOURCE
HEALTH & WELLNESS

OFFICE POLICIES

1. It is our office policy that any patient and /or insurance company that pays up-front or in advance is entitled to an administrative discount.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are taken, they cannot be released, but may be copied. There may be a fee for copying of the x-rays.
3. If you have any out of pocket responsibility what will be your method of payment?

Cash Check Credit Card/Debit Card Attorney /Letter of Protection.

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and my self. Furthermore, I understand LifeSource Health & Wellness will prepare any necessary reports, and forms to assist in making collections from my insurance company and that any amount authorized to be paid directly to LifeSource Health & Wellness will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered to me, are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this amount.

Print Patient Name: _____ Date: _____

Patient Signature (or Guardian authorizing care): _____ Date: _____

In case of emergency notify: _____ Relationship: _____

Address: _____ City: _____

State: _____ Phone Number: _____



Jonathan Berns, D.C.
Justin Scott, D.C.

LIFESOURCE
HEALTH & WELLNESS

Erica Berns, D.C.
Melissa Kolenda, D.C.

“New Tampa’s Source for Maximizing Living”

TERMS OF ACCEPTANCE AND CONSENT FOR CARE
THIS DOCUMENT CONSTITUTES INFORMED CONSENT FOR
CHIROPRACTIC CARE

Our office has one goal, to aid the patient in achieving optimal health as quickly and safely as possible, through the removal of interference in their body. We do this through safe and gentle chiropractic care.

We will attempt to identify and diagnose any ailments you may have that may be corrected through chiropractic care, massage therapy and/or active/passive rehabilitation. If any condition or disease appears to be present out of our scope of practice, we will refer you to an appropriate physician to diagnose and/or treat that condition.

Our primary focus is the detection and correction of vertebral subluxation. This is the misalignment of one spinal bone or multiple bones with interference to the nervous system. Any interference to the nervous system may or may not cause various different symptoms. Again, our focus is to correct the cause, not the symptom.

Vertebral subluxations come on from physical, chemical, and/or emotional stress or trauma. Through specific chiropractic adjustments, we reduce and/or correct these subluxations. It is also important to note that the sooner we are able to treat your subluxations and the degenerative processes that are involved the faster and more completely your body will heal. It may be necessary to examine an individual each time a new injury occurs and often x-rays are necessary to maintain the utmost safety when dealing with your body. The risks of chiropractic care or massage therapy are minimal when dealing with a licensed professional; however, if you have concerns about these risks, please discuss them with the doctor prior to the examination.

I have read and I accept the terms above and understand them fully. I hereby give consent to the LIFESOURCE HEALTH & WELLNESS to evaluate me to determine my condition and treat me for such conditions. I also understand that I may at anytime discontinue with the exam and/or x-rays or any treatment if I so choose.

I, _____ have read and fully understand the above statements.
(PRINT NAME)

(SIGNATURE)

(DATE)

Complete if patient is a minor child. _____
(PRINT CHILD’S NAME)

I, _____ being the parent or legal guardian of the aforementioned child, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive treatment.

(SIGNATURE)

(DATE)



Privacy Notice

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at LifeSource Health & Wellness, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another healthcare provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and healthcare records may be used to contact you regarding appointment reminders, information about alternative to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing healthcare to you based on the orders of another healthcare provider.
- If we provide healthcare services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain our consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive

chiropractic care from us. We may also mail information to you regarding your healthcare or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend our health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply to all of your information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Erica Berns or Dr. Jonathan Berns.

If you would like further information about our privacy policies and practices please contact: Dr. Erica Berns or Dr. Jonathan Berns.

This notice is effective as of January 1st, 2007. This notice, and any alterations or amendments made hereto will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (Print)	Signature	Date

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Representative Name (Print)	Representative Signature	Date

Description of the authority to act on behalf of the patient.