ACTIVE CARE ATLANTA
6290 Abbotts Bridge Rd, Suite 204
Johns Creek, GA 30097
T: 770.559.4236 F: 770.559.4795
www.ActiveCareAtlanta.com

Welcome to Active Care Atlanta (Child Form)

Name _____ Birth Date _____ Age _____ ☐ Male ☐ Female

Guardian's Name _____ Relationship _____

Guardian's Cell # _____ Home # _____

Address _____ City, State & Zip _____

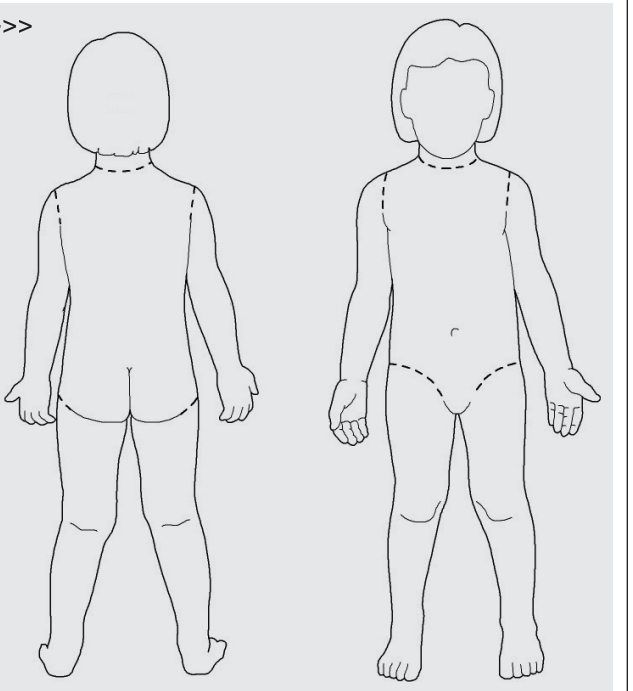
Guardian's Email _____

How did you hear about us? ☐ Friend/Family _____ ☐ Online ☐ Insurance Website

☐ Attorney _____ ☐ Event _____ ☐ Sign

☐ Physician's Referral _____ ☐ Other _____

1. Reason for today's visit _____
2. How long has the child had the problem? _____ ☐ Ongoing ☐ On & Off
3. Indicate the area(s) where the child is having discomfort. >>>>>>>



4. Has the child had the problem before? ☐ Yes ☐ No
5. What was the specific cause for this problem?

   _____
6. Is this related to an auto accident? ☐ Yes ☐ No
7. Has the child been to other doctors for the condition? ☐ No

   Doctor's name _____

   When _____

   Treatment _____
8. What makes it ***better*** or ***worse?***

   better _____

   worse _____
9. How long was the actual labor and delivery time?

   _____
10. Difficult and long birth can cause spinal misalignments.

    Was the child born by ☐ Natural Birth ☐ C section ☐ Forceps ☐ Suction Cup or Others? _____
11. Has the child had previous chiropractic care before?

    ☐ More than 30 times ☐ 10 to 30 times ☐ Less than 10 times ☐ Never
12. Poor posture leads to poor health and often indicate spinal problems. How would you rate the child's posture?

    Poor 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Excellent
13. Have you ever been told that the child has a spinal curvature or spinal arthritis? ☐ Yes ☐ No
14. Does the child play any sports? ☐ No ☐ Yes What Kind _____

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Medical History

1. Falls, sports impacts and auto accident can cause serious spinal problems. Has the child had any of those before?
   ☐ Never ☐ Yes *When* _____
2. Please mark the box next to each medical condition which applies to your child:
   ☐ ADD/ADHD ☐ Allergy _____ ☐ Asthma ☐ Bed Wetting ☐ Car Accident ☐ Chronic Cold
   ☐ Colic ☐ Digestion Problem ☐ Ear Infection ☐ Growing/Back Pain ☐ Headaches ☐ Recurring Fever ☐ Seizures
   ☐ Scoliosis ☐ Temper Tantrums ☐ Others _____
   Has the child been to any doctors for the condition above that you marked? ☐ *No*
   Doctor's name _____ *When* _____
   Treatment _____
3. Any other conditions/concerns we should know about the child's health:
   _____
4. List all medications the child is currently taking (OTC, Prescriptions, Vitamins, Herbs...) ☐ None
   _____
5. Family History: Tell us about any conditions the child's immediate family members are being treated for
   _____
6. ***GIRLS ONLY>>*** Has the child's menstruation begun? ☐ No ☐ Yes Age _____

AUTHORIZATION FOR CARE OF MINOR:

I hereby authorize the office and doctors they designate to administer care as they deem necessary to the child.

The above information is true and accurate to the best of my knowledge.

Guardian's Name _____ Signature _____ Date _____

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Payment Policies

(Please initial below)

_____ (initial) Our policy requires payment for all services at the time of visit. I understand that I am fully responsible for all charges.

_____ (initial) Our cancellation fee is $25.00 for a missed appointment without letting us know (via phone/voicemail/email) ***4 hrs before appointment time***. Appointment reminder service is complimentary but we urge you NOT to rely on it as technical issues can occur.

_____ (initial) As a courtesy, we verify insurance coverage for you. The verification we receive from your insurance plan is not a guarantee of benefits. In the event that my insurance company does not cover/pay the service, I acknowledge that I am responsible to pay the service.

_____ (initial) Patient balances 90 days old will be forwarded to a collection agency and a 23% fee will be applied.

_____ (initial) If payment is mailed directly to me from an insurance company, I will bring in the check within 2 weeks of receipt.

_____ (initial) There will be a $25.00 service charge on all returned checks.

Assignment of Benefit

---------- ***This section applies to patients wanting us to bill to insurance*** ----------

I direct and authorize **my insurance company to make payments *DIRECTLY* to ACTIVE CARE ATLANTA** for any and all benefits due as a result of the treatment.

I become fully financially responsible for any and all charges incurred in the course of treatment, including services not covered or paid by my insurance.

I hereby authorize **ACTIVE CARE ATLANTA** to: **(1)** release any information necessary to my insurance carriers and attorney to secure payment of benefits; **(2)** process insurance claims generated in the course of treatment; **(3)** issue a complaint to my insurance carriers or the Insurance Commissioner on my behalf if necessary.

A photocopy of this assignment is to be considered as valid as an original.

Guardian's Name _____ Signature _____ Date _____

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CONSENT TO TREATMENT

I give permission to all providers working for Active Care Atlanta to initiate care and provide treatment to my child. This authorization does not expire and is effective as long as my child is a patient.

Though rare, there are risks of complications associated with all health care procedures and treatments. These complications include but are not limited to: bruising, burns, muscle spasm, fractures, disc injuries and dislocations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Strokes have been the subject of tremendous disagreement. The occurrence of a stroke is exceedingly rare and is estimated to occur approximately once per 1 million to 5 million neck adjustments.

The Doctor will make every reasonable effort during the exam to screen for contraindications to care; however it's your responsibility to inform the Doctor if your child has a condition that would otherwise not come to the Doctor's attention.

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your **protected health information** (PHI). Our **Notice of Privacy Practices** details how we may use and disclose your PHI. You have the right to review our complete Notice which is located in the waiting room, front desk and our website.

By signing below you authorize our **use and disclosure of your PHI to third parties** for purposes related to treatment, payment, health care operations and those required by law. You also acknowledge that:

- **Active Care Atlanta** has a Notice of Privacy Practices you have had an opportunity to review.
- **Active Care Atlanta** may modify this Notice as needed at any time. If changes are made, they will be posted at our office.
- Certain situations may require the disclosure of patient PHI without patient authorization.
- Patient PHI may be used to contact patient as needed.
- Patient has the right to restrict the uses of his/her information.

The Patient may revoke this authorization at any time by submitting a written request to **Active Care Atlanta.** The request must include name, SS#, date of birth, address, a clear statement of intent to revoke this authorization and signature. This request is not effective until received and reviewed by **Active Care Atlanta**.

*By signing below, I've completely read the content above and I hereby give **my consent to the treatment** and acknowledge Active Care Atlanta's **Notice of Privacy Practices**.*

Patient / Guardian's Name _____ Signature _____ Date _____