CONFIDENTIAL PERSONAL HEALTH HISTORY

Patient's Name: _____ Parent/ Legal Guardian's Name: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip:_____ Work Phone: _____

Minor's DOB: _____ Age: _____ Sex: M F Height: _____ Weight: _____

SSN: _____ Email Address: _____

How did you hear about us? (Name of person or Company) _____

Please list your chief health complaints, symptoms, or concerns in the order of their severity below:

1. _____ For how long: _____
2. _____ For how long: _____
3. _____ For how long: _____

Are the symptoms: ☐ Improving ☐ Getting worse ☐ About the same ☐ Irregular

Check off the activities that aggravate their condition:

☐ Standing ☐ Walking ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting ☐ Coughing

Have you seen another doctor for this condition? ☐ Yes ☐ No

If yes, Dr. name: _____ Date Consulted:_____ Diagnosis: _____

Has the minor ever had an MRI of their spine? ☐ Yes ☐ No

If yes, name of facility: _____ Date of MRI: _____

Medications the minor is currently taking: _____

Is the condition due to a(n): ☐ Auto Accident ☐ Sport Injury ☐ Unknown ☐ Other _____

Date of Accident or Injury: _____ Where did it occur? ☐ Auto Accident ☐ Home ☐ Business ☐ Other _____

Please list all major accidents, injuries or falls you have had in your lifetime **(or write none)**:

_____

_____

Date:

Minor's Name: _____ Date: _____

Below is a list of diseases, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully, as these problems can affect your overall course of Your Care.

Please check any of the following diseases or conditions you have had:

__Pneumonia	__Mumps	__Influenza	__Anemia	__Eczema
__Rheumatic fever	__Smallpox	__Pleurisy	__Auto immune disease	__Measles
__Polio	__Chicken pox	__Arthritis	__Heart disease	__Lumbago
__Tuberculosis	__Diabetes	__Epilepsy	__Thyroid	__Asthma
__Whooping cough	__Cancer	__Mental disorder	__HIV positive	__Kidney Stones

Please check ✓ the line of symptoms you have or had in the last 6 months.

MUSCULO-SKELETAL SYSTEM
__Head Pain/ Problems
__Neck Pain/Problems
__Shoulder Pain/Problems
__Arm Pain/Problems
__Hand Pain/Problems
__Mid Back Pain/Problems
__Chest Pain/Problems
__Stomach Pain/Problems
__Low Back Pain/Problems
__Hip Pain/Problems
__Leg Pain/Problems
__Foot Pain/Problems
__Walking Pain/Problems
__Chewing/ Jaw Pain
__General Stiffness

NERVOUS SYSTEM
__Nervousness
__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion / Depression
__Fainting
__Convulsions
__Cold/Tingling Extremities
__Muscle Cramping
__Stress

GENERAL SYSTEM
__Fatigue
__Allergies
__Fever
__Headaches
__Migraine Headaches
__Tension Headaches
__Sinus Headaches
__Loss of Sleep

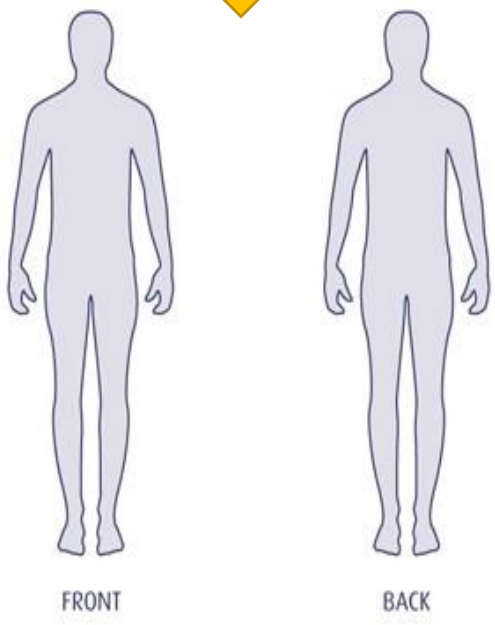
GENETO-URINARY SYSTEM
__Bladder Trouble
__Painful/Excessive Urination
__Discolored Urine
__Bed-Wetting

GASTRO-ENTESTINAL SYSTEM
__Poor/Excessive Appetite
__Excessive Thirst
__Frequent Nausea
__Vomiting
__Diarrhea
__Constipation
__Hemorrhoids
__Liver Problems
__Gall Bladder Problems
__Heartburn/ Indigestion
__Black/ Bloody Stool
__Colitis

EARS, EYES, NOSE & THROAT
__Sinus Problems
__Vision Problems
__Dental Problems
__Sore Throat
__Earaches
__Ringing in Ears
__Hearing difficulty
__Stuffed Nose

CARDIO-VASCULAR RESPIRATORY
__Chest Pain
__Shortness of Breath
__Blood Pressure Problems
__Irregular Heartbeat
__Heart Problems
__Lung Problems/congestion
__Ankle swelling
__Stroke

DARKEN IN THE AREA OF YOUR PAIN OR DISCOMFORT ON THE DIAGRAM BELOW



Major Surgery or Operations the minor has had and dates **(or write none)**:

_____

Reasons for hospitalizations (other than above): _____

Minor's Name: _____ Date: _____

Daily Lifestyle and Habits: (Circle all that applies)

Exercise	Daily	Weekly	Monthly	None
Sleep	>10 hrs.	7-10 hrs.	1-7 hrs.	<4 hrs.
Appetite	Heavy	Moderate	Light	None

Do you wear:

☐ Heal Lift ☐ Foot Pads ☐ Innersoles ☐ Arch Supports

Insurance Information:

Do you want us to file with your insurance? ☐ Yes ☐ No

☐ Health insurance ☐ Medicare ☐ Attorney

FEMALES ONLY:

First day of last cycle: _____

Currently Pregnant? ☐ Yes ☐ No ☐ Maybe

If pregnant, how many weeks?_____

Due Date: _____/_____/_____ ☐ Girl or ☐ Boy

Who is your OBGYN/Midwife/Doula?

_____

Please Sign: _____

***In case of an emergency, please give the name of a relative or close friend who lives in Louisiana:**

_____	_____	_____
Name	Relationship to patient	Contact Phone Number

*Do you authorize the release of the following health information to your emergency contact listed above?

Check each box that applies below:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. ☐ Yes ☐ No
- Able to make, reschedule, or cancel appointments for me ☐ Yes ☐ No
- Billing and statement information ☐ Yes ☐ No

PLEASE READ: Redisclosure: I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation, or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the USC Office of Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of revocation.

I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this clinic 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 the payment of these services in full. I also understand that if I suspend or terminate my care in this office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I also agree to pay any collection or legal fees that may occur if I do not pay my bill in a timely fashion, and it is placed in collections.

I understand if I have an unpaid balance to Enhanced Life Chiropractic and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so, incurred during collection efforts.

In order for Enhanced Life Chiropractic or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Enhanced Life Chiropractic and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (*ii)* contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (*iii*) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device as applicable.

_____	_____	_____
Signature of Parent or Legal Guardian	**Print** Parent or Legal Guardian's Name	Date

Enhanced Life Chiropractic

HIPAA FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Enhanced Life Chiropractic Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Enhanced Life Chiropractic, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Enhanced Life Chiropractic, LLC. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Enhanced Life Chiropractic, LLC. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Jeffrey Franco DC.

With this consent, Enhanced Life Chiropractic, LLC. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Enhanced Life Chiropractic LLC. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Enhanced Life Chiropractic LLC. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Enhanced Life Chiropractic LLC . restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Enhanced Life Chiropractic LLC. to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Enhanced Life Chiropractic LLC. may decline to provide treatment to me.

_____	_____	_____
Signature of Parent or Legal Guardian	**Print** Parent or Legal Guardian's Name	Date

Enhanced Life Chiropractic

To the patient: Every type of health care is associated with some risk of a potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of the treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please read this form carefully. Ask about anything you do not understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These include:

1. Stroke: Stroke is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulation have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). This problem occurs so rarely that there is no conclusive data to quantify probability.
2. Disc herniations: Disc herniations that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature. Residuals may last for a few days but seldom for longer periods of time.
3. Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle or ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.
4. Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indication of osteoporosis on their x-rays.

I hereby authorize and direct Enhanced Life Chiropractic, together with associates and assistants of her choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, various modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternative methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

I understand that if the minor's health insurance denies treatment or states not medically necessary, I will be responsible for charges out of pocket.

_____	_____	_____
Signature of Parent or Legal Guardian	**Print** Parent or Legal Guardian's Name	Date

Enhanced Life Chiropractic

Patient Financial Responsibility Disclosure Form

Insurance Disclaimer: “A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service.” We will provide an estimate of your benefits to the best of our ability, however, this estimate is not a guarantee of coverage. Any denials or additional fees from your insurance will be the patient’s responsibility.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be “reasonable and necessary.” Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

_____	_____	_____
Signature of Patient or Legal Guardian	**Print** Patient’s Name or Legal Guardian	Date