Child Health Form

To be filled out by parent or guardian

Please Print Clearly and fill in completely.

Child's Name ______________________ Date of Birth __________

Street Address ________________________________ Apt. # ____

City ______________ State ______ Zip ______ Phone ________

Please check Sex: Male __ Female ___ Right handed ___ Left handed ____

Health History:

Give reason for seeking chiropractic care: ________________________

Describe any health problems, including how long child has had them: ________

Is child under the care of any other doctor? Yes __ No __

If Yes, please list the doctors your child is seeing, the conditions being treated for, and any progress. ______________________________

List any current Medications: ______________________________

List any past surgeries & dates: ______________________________

List any past accidents & dates: ______________________________

List any x-rays child has had in the past 2 years: ____________________

Chiropractic History:

Has child been to a Chiropractor before? Yes ___ No ___ Doctor's Name ________

Date of last chiropractic visit __________ Reason for care ______________

Date of last chiropractic X-rays ________ How long was child under care? _____

Are other family members under chiropractic care? Yes __ No __ Who?________

Please describe any other information you feel would assist us in the care of your child? ______________________________

Print Parent's Name __________________ Phone: ____________

Parent's Signature: ___________________ Date: __________

Dr. Shayla Coomer, LLC
1150 Hungryneck Blvd.
Suite C-320
Mt. Pleasant, SC 29464
drshaylacoomer@gmail.com

Consent For Chiropractic Care

I hereby request that Dr. Shayla Coomer provide chiropractic services for me (or my minor child). I have read and understand the following:

1. The purpose of chiropractic care is the location, analysis and correction of vertebral subluxations for the restoration of normal nerve functioning.
2. Chiropractic is a separate and distinct profession, and is not the practice of medicine; therefore, diagnosis of medical conditions is not a primary goal.
3. The D.C.'s do not give, nor do they discourage me from receiving medical advice. If they deem it is advisable, they will refer me for medical advice.
4. Our D.C.'s use only chiropractic methods that are taught in accredited colleges and they will select appropriate techniques for my spine and the subluxations they find.
5. Chiropractic adjustments are exceedingly safe when applied properly; however, all actions in life come with some risk, including chiropractic adjustments.
6. Although the risks are minimal, there have been rare reports of vertebral artery damage, fractures and aggravation of disc conditions associated with chiropractic procedures.
7. That because a small force is introduced into the spine during an adjustment, there may be temporary minor musculoskeletal discomfort.
8. That I am invited to ask any questions or express any concerns that I may have.
9. That I am free to present a written withdrawal of my consent and discontinue care at any time.

Print Patient Name ______________________________ Date ____________

Patient Signature: ______________________________ Date ____________

Parent/Guardian Signature: ______________________________ Date ____________

Witness: ______________________________ Date ____________

Dr. Shayla Coomer, LLC
1150 Hungryneck Blvd.
Suite C-320
Mt. Pleasant, SC 29464
drshaylacoomer@gmail.com

Health Insurance Portability and Accountability Act (HIPPA)

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

Your Health Information Rights:

Although your health is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to;

Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522

d. **Obtain a paper copy of the notice of information practices upon request**
e. **Inspect and copy your health record as provided for in provided by 45 CFR 164.524**
f. **your health record as provided in disclosures of your information as provided in 45 CFR 164.528**
g. **Obtain an accounting of disclosures of your information as provided in 45 CFR 164.528**
h. **Request communication of your health information by alternative means or at alternative locations**
i. **Revoke your authorization to use or disclose health information except to the extent that action has already been taken**

Our Responsibilities: This Organization is required to:

a. **Maintain the privacy of your health information**
b. **Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you**
c. **Abide by the terms of this notice**
d. **Notify you if we are unable to agree to a requested restriction**
e. **Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.**

We reserver the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

My signature below indicates that I have been provided with the above information; the notice of privacy practices.

Patient Name (please print): **Signature:**

____

Date: _______/_______/_______

Patient Office Policy

To Our Patients:

The following information is provided to familiarize you with the policies and procedures of Dr. Shayla Coomer, LLC and to allow us to serve you more completely.

Please initial after you have read each of the following:

______**New Patients**
Initial visits are comprehensive information gathering sessions. Complete evaluation and review of your medical history are essential. In order to provide you with the most effective treatment, it is important that you complete the new patient documentation forms in as much detail and as accurately as possible.

______**Insurance**
In an effort to keep costs down and still provide the best service for our patients, we have opted out of filing insurance claims. We feel that our fees are reasonable and fair. On the whole, deductibles, allowables, and copayments are higher than our fees. In this era of rising health costs, etc., we are doing our utmost to provide service at a fair cost.

______**New Injuries**
In the event you sustain a new injury, please let the us know when you schedule your appointment. There may be additional paperwork to be filed, or Dr. Coomer may need to refer you for x-rays of the injured area and perform an exam of the injured area before being able to treat.

______**Text Message Alerts / Phone calls**
We will either send a text message or call for appointment reminders to you on your provided cell phone number.

______**Missed Appointments**
If you find it necessary to change your scheduled appointment, we ask that you do so on or before your confirmation text/call. If visit is canceled late or a "no show", you must pay for the missed appointment prior to being allowed to schedule a new appointment.

______**Payment of Bills**
Payment is due at the time services are rendered. Our policy is that patients maintain a zero balance.

______**Upsets**
We are here to serve you. Please speak with the staff or Dr. Coomer about anything that could be upsetting you (i.e. long waits, staff insensitivity, treatment confusion). We value your comments as helping us to help you and others.

______**Photos/Testimonials**
You give us permission to use your testimonial and/or uploaded image on our website and for other marketing purposes.

I have read and understand the above policies and agree to abide by the above policies

______________________________ ____________________
Signature Date