keppyfamily chiropractic
Reconnect·Restore·Relight

Please fill out this form as completely as possible. It will help us use our first session; more productively, and may help you clarify what your goals for chiropractic care are. If you are unsure about any of the questions, please feel free to discuss this. (You can fill this out on your computer, if you like, and then print it. ***Please do not email the forms, for privacy reasons.****)*

Today's Date _____

Child's Name _____Date of Birth _____ Age_____

Address _____City_____State_____Zip_____

Parent/Guardian Name(s):_____

Siblings: (name/ages) _____

Phone (H) _____ (Cell) _____

Parent Email Address_____

Has your child been to a chiropractor before? ☐ Yes ☐ No

My child's birth was: (Check here if unknown ❑)

☐ Natural vaginal (no medications/interventions)

☐ Vaginal with interventions

☐ Induction ☐ Pain Medication ☐ Epidural ☐ Episiotomy

☐ Vacuum Extraction ☐ Forceps ☐ Other_____

☐ Caesarean Section

☐ Emergency ☐ Scheduled

Hours of labor (approximate, if known): _____

Gestational Age at birth (full term is 40 weeks): _____

Is/was your child breastfed? ☐ Yes ☐ No ☐ Unknown ☐ Currently Breastfeeding

If yes, for how long?_____

Has your child been vaccinated? ☐ Yes, fully ☐ Yes, on reduced schedule ☐ No Vaccinations

If yes, any reactions to vaccinations? _____

Eating Habits: (skip if child is not eating solid foods)

Age foods introduced:_____ First foods: _____

Would you consider your child a picky eater? ☐ Yes ☐ No

If yes, please explain: _____

Has your child had any surgeries or hospitalizations? ☐ Yes ☐ No

Type:_____ Approximate Date:_____

Type:_____ Approximate Date:_____

Has your child had any significant **illness** or **traumas**? ☐ Yes ☐ No

Type:_____ Approximate Date:_____

Type:_____ Approximate Date:_____

Has your child ever been diagnosed with any condition(s)? (include allergies) If yes, please explain.

_____

_____

_____

Please list any **medications** (prescription and/or over-the-counter), supplements, herbal, homeopathic, and/or natural remedies that your child is currently taking:

_____

_____

_____

What is the main reason for your child's visit today?

_____

_____

_____

Any other concerns?

_____

_____

_____

Whom may we thank for referring you to our office? _____

Would you like reminders of your child's appointments? If yes, ☐ email ☐ text

OFFICE & FINANCIAL POLICIES

1. **Fees are due and payable at the time services are rendered.**
   We accept cash, checks, and major credit cards.
2. Missed appointments and appointments cancelled without 24 hours' notice will be charged $25. These fees will be billed to you or collected on your next visit.
3. Checks returned for any reason will incur a $30 fee.
4. This office **does not** bill insurance but will provide you a superbill should you wish to bill your own insurance. Please be aware that insurance companies DO NOT cover homeopathic treatment or the cost of remedies.
5. Healthcare Savings Accounts and Flexible Spending Account dollars may be used to pay for services.
6. Homeopathic Product Information: All sales on homeopathic products are FINAL. Returns will NOT be accepted.
7. Please refrain from using strong fragrances (perfumes, lotions, oils, etc.) before your appointment. Some practice members are sensitive to such smells.

I understand the OFFICE & FINANCIAL POLICIES outlined above and agree to abide by them.

_____ _____

(signature) (date)

DISCLOSURE AND INFORMED CONSENT FOR TREATMENT:

I understand that I will be receiving treatment from a licensed Doctor of Chiropractic. Treatment may include chiropractic adjustments, physiological interventions (such as homeopathic remedies), and case specific interventions. The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. A vertebral subluxation is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause pain, dis-ease and/or loss of proper body function.

I understand that homeopathy is a complementary form of healing and is not a replacement for standard medical care. This form of treatment is not intended to supplant or replace treatment given by other licensed practitioners. Dr. Keppy will prescribe remedies for your self care to be self administered, as needed.

I understand that, due to the nature of disease, individual motivation for compliance with the doctor's recommendations, and because people are biologically and genetically unique, that no claims or guarantees are or can be made as to the outcome of this form of treatment. No cure, improvement, or outcome is or can be guaranteed for any condition. Compliance with any recommendations are undertaken by, and the responsibility of myself as client or parent/guardian of the client.

We do not offer to medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, you always need a body free from subluxations. If, during the course of our chiropractic examination, we encounter unusual findings that are out of the scope of chiropractic practice, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them regarding your healthcare goals.

I,_____ being the parent or legal guardian of

_____ have read and fully understand the

above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____

(signature) (date)

Privacy Policy

Health Insurance Portability and Accountability Act (HIPAA)
Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Keppy Family Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Keppy Family Chiropractic. I understand that analysis, diagnosis or treatment of me by Keppy Family Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Keppy Family Chiropractic is not required to agree to the restrictions that I may request. However, if Keppy Family Chiropractic agrees to a restriction that I request, the restriction is binding on Keppy Family Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Keppy Family Chiropractic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Keppy Family Chiropractic and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Keppy Family Chiropractic. This Notice of Privacy Practices also describes my rights and duties of Keppy Family Chiropractic with respect to my protected health information.

Keppy Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Keppy Family Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Parent or Guardian Signature **Date**

Please Print Parent or Guardian Name