CONFIDENTIAL PATIENT INFORMATION

Date _____

Child's Name_____ What would you like to be called? _____

Address:_____ City:_____ State: ___ Zip: _____

Home Phone:_____ Cell Phone: _____

Sex: ☐ M ☐ F Age:_____ Date of Birth:_____ Social Security No:_____

School Name: _____ Grade Level: _____

Name of Parent #1: _____ Name of Parent #1's Spouse:_____

Address: ☐ Same as Child _____ City: _____ State: ___ Zip: _____

Sex: ☐ M ☐ F Age:_____ Date of Birth:_____ Social Security No:_____

Home Phone:_____ Cell Phone: _____ Parent's Work Phone:_____

E-mail Address:_____

Parent's Occupation:_____ Parent's Employer:_____

Name of Parent #2: _____ Name of Parent #2's Spouse:_____

Address: ☐ Same as Child _____ City: _____ State: ___ Zip: _____

Sex: ☐ M ☐ F Age:_____ Date of Birth:_____ Social Security No:_____

Home Phone:_____ Cell Phone: _____ Parent's Work Phone:_____

E-mail Address:_____

Parent's Occupation:_____ Parent's Employer:_____

Major complaints and symptoms - Briefly describe your symptoms in order of severity, with worse symptom(s) first. You will be given the opportunity to include more detail on following pages.

_____

_____

_____

_____

How did you hear about our office? ☐ Referral - Who? _____ ☐ Google ☐ Advertisement - _____

☐ Other: _____

Have you ever had chiropractic care before? ☐ No ☐ Yes Where? _____

Has the child ever had chiropractic care before? ☐ No ☐ Yes Where? _____

How long ago was their last adjustment? _____ Reason for not returning: _____

Were the results satisfactory? ☐ No ☐ Yes ☐ N/A

Does the child have night sweats? ☐ No ☐ Yes	Do the child have pain that wakes them out of a sound sleep? ☐ No ☐ Yes
Have the child had any recent infections? ☐ No ☐ Yes	Has the child lost or gained weight in the past year? ☐ No ☐ Yes

Pediatrician's Name: _____

Location: _____

Would you allow us to send a report to your child's pediatrician? ☐ No ☐ Yes

What other wellness professionals are currently part of your child's health care team?

☐ Massage Therapist ☐ Personal Trainer ☐ Nutritionist ☐ Acupuncturist ☐ Naturopath ☐ Other: _____

Harmony Chiropractic Center, Inc.
5800 Monroe St. A11; Sylvania, OH 43560
419-517-5055

Name _____ Date _____

Main Complaint - Please fill out the following page as accurately as you can. Please **ONLY** describe the **MOST** important complaint on this page, like ADHD **OR** anxiety **OR** headaches.

USE THE FOLLOWING PAGES TO DESCRIBE ANY OTHER PROBLEMS THAT YOU MIGHT HAVE.

1. What is the presenting problem/chief complaint? Only list **ONE** problem here. _____

3. Have they experienced this condition before or a similar condition? _____

4. When did the problem begin? _____

5. How do you believe their problem began? _____

7. Did it begin: ☐ Gradually ☐ Suddenly

8. Has their problem improved, gotten worse or stayed the same? _____

9. How often do they experience this problem? ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5-6x/wk ☐ Daily ☐ other: _____

10. How often do they experience these symptoms throughout the day?
☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%) ☐ Only with activity

11. Is the problem worse or better at any time of the day? If so, when? _____

12. Please grade the intensity of this problem. Circle the number. (0 = No Problem and 10 = Problem is incapacitating):
Right Now: 0--1--2--3--4--5--6--7--8--9--10 Best Pain: 0--1--2--3--4--5--6--7--8--9--10 Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything worsen the problem? List any activities below that cause an increase in their symptoms for this one condition.

14. Does anything relieve the problem? List any activities below that cause a decrease in their symptoms for this one condition.

15. Do they have any pain or numbness that radiates into their arms or legs? No Yes Where? _____

16. Does their complaint interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain. _____

PLEASE PRINT OUT THEIR HISTORY OF TREATMENTS AND MEDICATIONS IF YOU HAVE A COMPLICATED HISTORY THAT DOES NOT FIT IN THE SPACE PROVIDED BELOW. PLEASE DO IT IN A TIMELINE FASHION. LIST THE DATES OF ALL MEDICAL PROVIDERS SEEN, MEDICATIONS GIVEN AND SURGERIES PERFORMED FOR YOUR PROBLEM

17. Have they seen any other doctors or therapists for this problem? No Yes If yes, who? _____
What treatment was given? _____
How effective was the care? _____

18. Have they had any imaging for this problem (X-ray, MRI, CT, etc.)? _____

DOCTOR'S NOTES: _____

Harmony Chiropractic Center, Inc.
5800 Monroe St. A11
Sylvania, OH 43560
419-517-5055

Name _____ Date _____

Secondary Complaint - Please fill out the following page as accurately as you can. Please **ONLY** describe the **MOST** important complaint on this page, like ADHD **OR** anxiety **OR** headaches.

1. What is the next problem/complaint? Only list **ONE** problem here. _____

3. Have they experienced this condition before or a similar condition? _____

4. When did the problem begin? _____

5. How do you believe their problem began? _____

7. Did it begin: ☐ Gradually ☐ Suddenly

8. Has their problem improved, gotten worse or stayed the same? _____

9. How often do they experience this problem? ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5-6x/wk ☐ Daily ☐ other: _____

10. How often do they experience these symptoms throughout the day?
☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%) ☐ Only with activity

11. Is the problem worse or better at any time of the day? If so, when? _____

12. Please grade the intensity of this problem. Circle the number. (0 = No Problem and 10 = Problem is incapacitating):
Right Now: 0--1--2--3--4--5--6--7--8--9--10 Best Pain: 0--1--2--3--4--5--6--7--8--9--10 Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything worsen the problem? List any activities below that cause an increase in their symptoms for this one condition.

14. Does anything relieve the problem? List any activities below that cause a decrease in their symptoms for this one condition.

15. Do they have any pain or numbness that radiates into their arms or legs? No Yes Where? _____

16. Does theircomplaint interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain. _____

PLEASE PRINT OUT THEIR HISTORY OF TREATMENTS AND MEDICATIONS IF YOU HAVE A COMPLICATED HISTORY THAT DOES NOT FIT IN THE SPACE PROVIDED BELOW. PLEASE DO IT IN A TIMELINE FASHION. LIST THE DATES OF ALL MEDICAL PROVIDERS SEEN, MEDICATIONS GIVEN AND SURGERIES PERFORMED FOR YOUR PROBLEM

17. Have they seen any other doctors or therapists for this problem? No Yes If yes, who? _____

What treatment was given? _____

How effective was the care? _____

18. Have they had any imaging for this problem (X-ray, MRI, CT, etc.)? _____

DOCTOR'S NOTES: _____

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Name _____ Date _____

Tertiary Complaint(s) - Please fill out the following page as accurately as you can. Please **ONLY** describe the **MOST** important complaint on this page, like ADHD **OR** anxiety **OR** headaches.

PLEASE REPRINT THIS PAGE TO DETAIL ANY ADDITIONAL COMPLAINTS.

1. What is the next problem/complaint? Only list **ONE** problem here. _____

3. Have they experienced this condition before or a similar condition? _____

4. When did the problem begin? _____

5. How do they believe your problem began? _____

7. Did it begin: ☐ Gradually ☐ Suddenly

8. Has their problem improved, gotten worse or stayed the same? _____

9. How often do they experience this problem? ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5-6x/wk ☐ Daily ☐ other: _____

10. How often do they experience these symptoms throughout the day?
☐ Constantly (76-100%) ☐ Frequently (51-75%) ☐ Occasionally (26-50%) ☐ Intermittently (0-25%) ☐ Only with activity

11. Is the problem worse or better at any time of the day? If so, when? _____

12. Please grade the intensity of this problem. Circle the number. (0 = No Problem and 10 = Problem is incapacitating):
Right Now: 0--1--2--3--4--5--6--7--8--9--10 Best Pain: 0--1--2--3--4--5--6--7--8--9--10 Worst Pain 0--1--2--3--4--5--6--7--8--9--10

13. Does anything worsen the problem? List any activities below that cause an increase in their symptoms for this one condition.

14. Does anything relieve the problem? List any activities below that cause a decrease in their symptoms for this one condition.

15. Do they have any pain or numbness that radiates into their arms or legs? No Yes Where? _____

16. Does your complaint interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Daily Routine Explain. _____

PLEASE PRINT OUT THEIR HISTORY OF TREATMENTS AND MEDICATIONS IF YOU HAVE A COMPLICATED HISTORY THAT DOES NOT FIT IN THE SPACE PROVIDED BELOW. PLEASE DO IT IN A TIMELINE FASHION. LIST THE DATES OF ALL MEDICAL PROVIDERS SEEN, MEDICATIONS GIVEN AND SURGERIES PERFORMED FOR YOUR PROBLEM

17. Have they seen any other doctors or therapists for this problem? No Yes If yes, who? _____

What treatment was given? _____

How effective was the care? _____

18. Have they had any imaging for this problem (X-ray, MRI, CT, etc.)? _____

DOCTOR'S NOTES: _____

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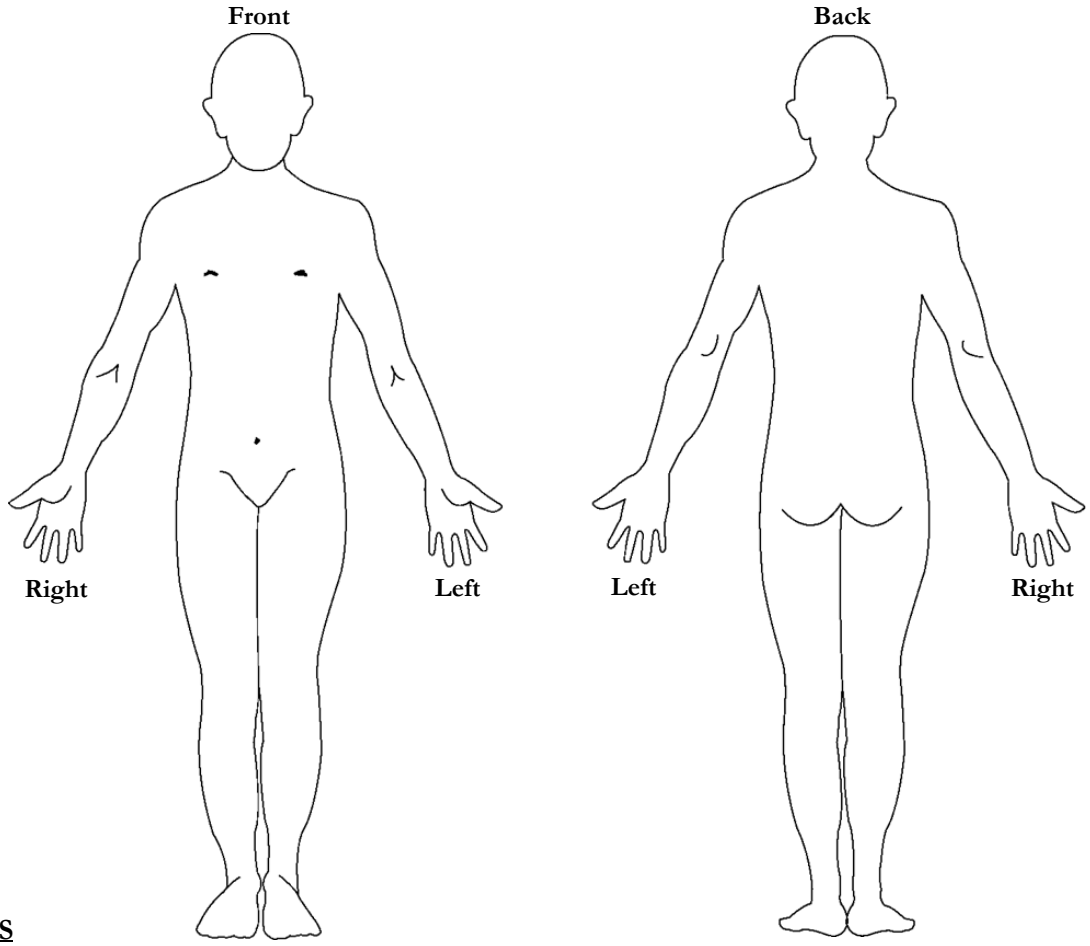
CONFIDENTIAL PATIENT INFORMATION

PAIN DIAGRAGM SHOW ALL AREA(S) OF PAIN OR UNUSUAL FEELINGS *****Skip Page if no pain present*****

Mark the areas on this body where they feel the described sensations.

- Use the appropriate symbols. Mark areas of radiation. Describe in words if the symbols. Include all affected areas

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /



EXPECTATIONS

I would like to have the following benefits from ***Functional Neurology Treatment*** and/or ***Chiropractic Care***: (Check all that apply)

☐ Relief of a symptom or problem

☐ Relief and prevention of a symptom or problem

☐ Preventive maintenance plan which includes diet, exercise and chiropractic so that I stay as healthy as possible.

☐ Healthier spine and nerve system

☐ Optimal health on all levels

What are the top three health goals?

1. _____

2. _____

3. _____

Name _____ Date _____

PREGNANCY AND BIRTH HISTORY

DURING THE PREGNANCY, WAS THERE:

Any difficulties conceiving	☐ No ☐ Yes	Major emotional upsets	☐ No ☐ Yes	Healthy diet	☐ No ☐ Yes
History of miscarry	☐ No ☐ Yes	Any medications	☐ No ☐ Yes	Any falls	☐ No ☐ Yes
Smoking or drinking	☐ No ☐ Yes	'Morning Sickness'	☐ No ☐ Yes	Any accidents	☐ No ☐ Yes
Exercising	☐ No ☐ Yes	Details:_____			

BIRTH DETAILS: Answer the following to the best of your ability. Please tick all that apply regarding the delivery:

❒ Premature ❒ Term ❒ Late ❒ Caesarean (elective) ❒ Caesarean (emergency)

❒ Vaginal Delivery ❒ Induced ❒ Breech ❒ Forceps ❒ Suction/vacuum

❒ Midwife/doula present ❒ Other details_____

Birthing location: ❒ Hospital ❒Birthing center ❒ Home ❒Other_____

- Were drugs used in the birth? ☐ No ☐ Yes _____
- Was the birth difficult or long? ☐ No ☐ Yes _____
- Were there any complications? ☐ No ☐ Yes _____
- Do you feel the birth was difficult or traumatic for your child? ☐ No ☐ Yes _____
- Was your baby's head misshapen or bruised? ☐ No ☐ Yes _____

Birth Weight: _____ Length: _____ APGAR score: _____ (1 min) _____ (5 min)

FEEDING:

Breast fed. ☐ No ☐ Yes How long? _____ Right and left breast evenly? **Y / N**

Problems with latching? ☐ No ☐ Yes

Formula fed. ☐ No ☐ Yes How long? _____ From what age:_____ Brand:_____

Was/is your child 'colicky'? ☐ No ☐ Yes ❒ Mild ❒ Moderate ❒ Severe

Did/does your child have reflux? ☐ No ☐ Yes

Please list any known allergies, sensitivities or intolerances _____

BIRTH TO SIX MONTHS:

How well did/does your baby sleep: ❒Poor ❒Fair ❒Good ❒Excellent

Y N

❒ ❒ Does/did your baby move his/her bowels daily. With ease? **Y / N**

❒ ❒ Is/was very irritable or unsettled

❒ ❒ Were you or are you currently concerned about the shape of your baby's head?

❒ ❒ Has your child had vaccinations. Any reactions?_____

PHYSICAL DEVELOPMENT

When did your child first roll onto their back _____ Age to sit up without assistance _____

Did you child crawl **Y / N** What age?_____ When did your child walk? _____

Has your child ever had a fall on the head? **Y / N** _____

Has your child ever been in a car accident? **Y / N** _____

CONFIDENTIAL PATIENT INFORMATION

MEDICAL HISTORY

Has the child been treated for any condition by a physician in the past year? ☐ No ☐ Yes

If yes, what condition?_____

Has the child ever been in any accidents, auto, fall down stairs, fall from ladder, etc. (even as a child)?

☐ No ☐ Yes When?_____

Has the child ever broken any bones? ☐ No ☐ Yes _____ Any dislocations? ☐ No ☐ Yes _____

Is the child allergic to anything which you are aware? ☐ No ☐ Yes If yes, name them. _____

Does the child take vitamins, supplements or herbs? ☐ No ☐ Yes If yes, please list them _____

_____

Is the child presently taking any medications or over-the-counter products (aspirin, ibuprofen, etc. included)? ☐ No ☐ Yes

If yes, name them._____

_____

What operations has the child had? (Please list type and year) _____

_____

List any major illness(s) the child has had, with dates (month/year)_____

_____

Give dates if the child has had any of the following (if exact date is unknown, give approximate date)

Lab Tests (Blood or Urinalysis) _____

Imaging (X-Rays, MRI, CT or ultrasound) _____

Does the child have any health problems not listed above? _____

_____

NEUROBEHAVIORAL DISORDERS OF CHILDHOOD

Has your child been labeled with any of the following terms (tick all that apply)?

❒ Dyslexia (difficulty reading)	❒ ADHD Type I - Inattentive Type, Not Hyperactive
❒ Processing Disorders	❒ ADHD Type II - Hyperactive, Impulsive Type
❒ Central Auditory (hearing) Processing Disorder	❒ ADHD Type III - Hybrid; Inattentive, Hyperactive
❒ Dyspraxia (example: cannot tie shoes)	❒ Asperger's Syndrome
❒ Dysgraphia (poor handwriting)	❒ Autism
❒ Learning Disability	❒ Obsessive Compulsive Disorder (OCD)
❒ Language Disorder	❒ Oppositional Defiant Disorder (ODD)
❒ Reading Disorder	❒ Nonverbal Learning Disorder (NLD)
❒ Acalculia (poor calculating/math skills)	❒ Pervasive Developmental Disorder (PDD)
❒ Selective Mutism	❒ Developmental Coordination Disorder (DCD)
❒ Tourette's Syndrome	❒ Conduct Disorder (CD)

Name _____ Date _____

SOCIAL HISTORY

Does smoking occur inside the home? ☐ No ☐ Yes Does a smoker live inside the home? ☐ No ☐ Yes

Are recreational drugs used in the home? ☐ No ☐ Yes What?: _____

Soda/Pop? ☐ No ☐ Yes Quantity _____ cans a day Energy Drinks? ☐ No ☐ Yes Quantity _____ cans a day

Juice? ☐ No ☐ Yes Quantity _____ cans a day Fast Food/Junk Food? ☐ No ☐ Yes Quantity _____ #/week

Any special dietary restrictions? ☐ No ☐ Yes What type? _____

Weekly, how many hours of physical exercise does your child perform? ❒ None ❒ 1-3 hrs ❒ 3-6 hrs ❒ 6+ hrs

Sports/Hobbies/Activities _____

_____

_____

Hours per week of screen time? _____ ❒ Computer ❒ Tablet ❒ Phone ❒ Video Games ❒ TV

Daily how much time does your child spend watching television or playing computer games on average?

❒ <30min ❒ 30min-1hr ❒ 1-2hrs ❒ 2+hrs

What is the highest level of education for parents? _____

Do parents exercise regularly? ☐ No ☐ Yes What kind of exercise for each?_____

_____

Which situation best describes your family:

❒ Both parents work full time ❒ One parent at home full time

❒ One parent at home part time ❒ Single Parent

Any siblings? ☐ No ☐ Yes What are their names & ages?_____

_____

Where does your home lifestyle/environment fit in?

❒ Laid back -- ❒ Healthy/Relaxed -- ❒ Active -- ❒ Stressed -- ❒ Always "on the go" -- ❒ Reactive -- ❒ Out of control

FAMILY HISTORY

- Arthritis: ☐ No ☐ Yes
- Asthma: ☐ No ☐ Yes
- Cancer: ☐ No ☐ Yes
- Diabetes: ☐ No ☐ Yes
- Heart Disease: ☐ No ☐ Yes
- Stroke: ☐ No ☐ Yes
- High Blood Pressure: ☐ No ☐ Yes
- Other _____

FEMALE HISTORY

Beginning date of her last period. _____ Age of Onset of Menses? _____

Date of last pelvic exam._____ Does she get pain or cramps? ☐ No ☐ Yes

Is she on birth control pills? ☐ No ☐ Yes Has she ever been pregnant? ☐ No ☐ Yes

Is she currently pregnant? ☐ No ☐ Yes Have you ever had a cesarean section? ☐ No ☐ Yes

PAST HISTORY – REVIEW OF SYMPTOMS

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Mark if your child have ever had any of the following conditions. Please circle all current problems.

JOINTS & MUSCLES

- ☐ Arthritis
- ☐ Joint pains or aches
- ☐ Muscle pains or aches
- ☐ Stiffness
- ☐ Swollen, tender joints
- ☐ Pain Between Shoulders
- ☐ Joint Replacement(s)
- ☐ Spinal Fusion(s)
- ☐ Herniated Disc
- ☐ Pinched Nerve
- ☐ Numbness
- ☐ Tingling

DIGESTIVE TRACT

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion
- ☐ Bloated feeling
- ☐ Belching or passing gas
- ☐ Gall bladder trouble
- ☐ Ulcers
- ☐ Abdominal pain
- ☐ Irritable Bowel Syndrome
- ☐ Hernia

EYES

- ☐ Glasses/contacts
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Dark circles
- ☐ Blurred vision

EARS

- ☐ Hearing difficulty
- ☐ Ringing in ears
- ☐ Ear aches
- ☐ Ear infections
- ☐ Drainage from ear
- ☐ Itchy ears

MOUTH & THROAT

- ☐ Chronic cough
- ☐ Gagging
- ☐ Often clear throat
- ☐ Sore throat
- ☐ Canker sores

LUNGS

- ☐ Chest congestion
- ☐ Asthma
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Pneumonia
- ☐ COPD

HEART

- ☐ Heart trouble
- ☐ Stroke
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Chest pains

SKIN

- ☐ Acne
- ☐ Hives, rashes
- ☐ Hair loss
- ☐ Flushing, hot flashes
- ☐ Excessive sweating

HEAD/MIND

- ☐ Headaches
- ☐ Migraines
- ☐ Fainting
- ☐ Dizziness
- ☐ Insomnia
- ☐ Epilepsy
- ☐ Poor memory
- ☐ Confusion
- ☐ Poor concentration

NOSE

- ☐ Allergies
- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Sneezing attacks
- ☐ Post-nasal drip

ENERGY & ACTIVITY

- ☐ Weakness
- ☐ Fatigue
- ☐ Apathy, lethargy
- ☐ Attention deficit (ADHD)
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Cravings for sweets
- ☐ Anemia

EMOTIONS

- ☐ Mood swings
- ☐ Anxiety, fear
- ☐ Irritability, anger
- ☐ Depression
- ☐ Aggressiveness
- ☐ Nervousness

WEIGHT

- ☐ Binge eating
- ☐ Food cravings
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight

OTHER

- ☐ Frequent illnesses
- ☐ Diabetes
- ☐ Liver trouble
- ☐ Thyroid trouble
- ☐ Tumors/lumps
- ☐ Cancer

DOCTOR'S NOTES: _____

PATIENT AGREEMENT

Your insurance plan, managed care program, or third party payor provides a *limited* range of benefits compared to the services available at this office. Your carrier provides coverage for "*medically necessary*" services as defined by them, for coverage or "*eligible*" benefits. In other words, no insurance carrier pays for everything. If possible, when the services you receive at this office exceed the covered or eligible benefit limits, or fall outside the payor's definition of "medically necessary" we will attempt to inform you in advance. Please understand that it is virtually impossible to predict in advance, given the literally hundreds of plans in existence today, what the insurance company will or will not pay. We will certainly comply with our contractual obligations when they exist, and apply the "*appropriate*" write-offs and fee reductions, but we make no representation that all services will be covered. As such you are responsible for anything not covered by the carrier that exceeds the benefits described in the insurance booklet provided by your employer or health carrier. We recommend you become familiar with your benefits so there are no surprises for either of us. We will check your benefits and communicate them to you, but you realize that you are responsible for understanding your benefits.

The following is a partial list of the services generally available at this office. Most insurances pay for spinal manipulation to some degree, but the benefits vary. The other services may or may not be covered. Again, check your insurance booklet for a listing of available benefits.

Exams, therapies, spinal manipulation, supplements, orthotics/pillows/supports, ice packs, maintenance or supportive care, physical therapy modalities, rehab, Kinesio Taping, Graston Technique and many other services too numerous to list here.

There are numerous reasons for possible denial by your insurance company. Examples include: No referral from primary care provider, care deemed "not medically necessary", no prior authorization was obtained, treatment extends beyond initial allowance, etc. There are literally hundreds of reasons which your insurance company may give for denial of benefits. As always, we honor our contract with the carriers and apply the appropriate write-offs, but no insurance company pays for everything and you should be come familiar with your benefit package.

PATIENT AGREEMENT & ACCEPTANCE OF LIABILITY

As you know, our office participates with many third party payor programs and as a result it becomes virtually impossible to predict in advance your available benefits. By signing this agreement you acknowledge that *it remains your responsibility to understand your benefits*, and it remains our responsibility to *comply with any contract we have with certain carriers*. As such, we will apply the appropriate reductions and write-offs for "covered benefits" only. **You must pay for all appropriate co-pays, deductibles, and non-covered benefits.** Additionally, you agree that you have been notified that your carrier might deny payment for the services identified above. If your carrier denies payment for any reason, you agree to be personally and fully responsible for payment. If you do not have any insurance coverage, you agree that you are personally and fully responsible for payment. I authorize the use of my signature on all insurance submissions and assign benefits to HCC.

Missed Appointments: If a patient fails to attend a scheduled appointment and/or does not give a 24 hours notice of cancellation a $25.00 fee will be charged. This is the patient's responsibility and cannot be billed to the insurance company. **24-Hour Cancellation Policy:** If you are unable to keep the appointment you have reserved, please call with more than 24 hours notice to avoid being charged. Please call the office phone number to cancel as other methods of communication will not be accepted. Appointments cancelled with less than 24 hours notice will be charged the rate of $25. Dr. Royer may waive fees in advance if there may be a possible schedule conflict or for another reason.

Delayed Payment Charge: A $5 fee will be added to your account if payment is not received within 30 days and an additional $5 fee will be added automatically every month until payment is received. A late fee is merely reimbursement of the costs of collection. This fee will be waived if details are worked out in advance with Dr. Royer and/or if you are still treating with Harmony Chiropractic Center, Inc.

Returned Checks: There will be a $30.00 charge for all returned checks.

Collection Costs: If your account is sent to collections, the responsible party will pay all collection fees, court fees, doctor's fees for any written documentation or correspondence, legal appearances ($300 per hour), attorney's fees or any other fees related to collection on this account. By signing, I also agree and understand that Harmony Chiropractic Center, Inc. may use and disclose all pertinent information to the collection agency in order to collect the balance due. Our office is not required to send statements for unpaid balances more than 60 days past due. After 60 days, unpaid account balances may be forwarded to a collection agency.

Patient's Name	Parent or Guardian Name	Parent or Guardian Signature

Date	Staff Signature

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review Harmony Chiropractic Center, Inc.'s Notice of HIPAA Privacy Practices for protected health information. I acknowledge this is available on HCC's website and at the front desk.

Parent or Guardian Signature	Date

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5800 Monroe St. A11
Sylvania, OH 43560
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INFORMED CONSENT

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent. Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office, we use trained staff personnel to assist the doctor with portions of your consultation, examination, physical therapy application, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Parent Initials	
___	STROKE: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA, Vol. 37 No. 2 June, 1993) estimate that the incident of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.
___	DISC HERNIATIONS: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both in the neck and back. Yet, occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Rarely chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantity their probability.
___	SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.
___	RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment will crack a rib bone, and this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.
___	PHYSICAL THERAPY BURNS: Some of that machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin had different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify the probability.
___	SORENESS: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell you doctor about it.
___	OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.
___	NOT FOLLOWING TREATMENT PLAN: Failure to adhere to the treatment prescribed by your doctor will negatively impact your recovery. It is very detrimental to your health if you do not attend your appointments or if you do not perform exercises as instructed. Attending your appointments with the recommended frequency can help you to continue your progress, prevent a relapse and even help avoid problems in the future.

Chiropractic is a system of health care delivery, and, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

Patient's Name	Parent or Guardian Name	Parent or Guardian Signature	Date

Staff Signature

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