Welcome to Body Balance…
Your Family Chiropractic Office

Thank you for choosing our office for chiropractic care. We, at Body Balance Chiropractic, are committed to providing your family with the highest quality of care available so that you and your family can enjoy an active, healthy, long life. We will be working together to help you and your family reach your health and lifestyle goals.

If you ever have any questions about your chiropractic care, please don't hesitate to ask one of our highly educated chiropractic team members. All of your questions, even the ones you haven't even thought of yet, will be answered during your Chiropractic Report.

Your confidence in us as a health care provider is the best compliment we can receive. Chiropractors have become the primary care doctors for millions of people around the world. Regardless of your reason for visiting our office today, our goal is to become your family's trusted provider and resource for living a healthy lifestyle throughout your lifetime.

Yours in Health,

Dr. Andrew Burns, Dr. Andrew Rackovan and Staff

Body Balance Chiropractic-Pediatric (Age 1-5) Andrew Burns, D.C., P.C.-Andrew Rackovan, D.C.

Child's Name: ______________________________ Today's Date: ____________
Please Print First MI Last

Address: ______________________________ Social Security #: ____________

City: ____________ State: ______ Zip: ________ Home #: ____________

Date of Birth: ____________ Age: ______ □ Male □ Female

Mom Name: ______________________ (First, Last) Dad Name: ______________________ (First, Last)

DOB: ____________ SS #: ____________ DOB: ____________ SS #: ____________

Cell #: ____________ Cell #: ____________

Work #: ____________ Work #: ____________

Insurance Co. ____________ ID #: ____________

Insured Parent Employer Name: ______________________

Parent's E-mail Address: ______________________

BIRTH INFORMATION

Type of birth: □ Vaginal □ Forceps □ Breech □ Cesarean □ Home □ Birthing Center ______ □ Hospital ______

Birth Weight: ________ Birth Length: ________ Apgar Scores: ________

At birth: Jaundice (yellow) □ Yes □ No Cyanosis (blue) □ Yes □ No

Medication taken during pregnancy? □ Yes □ No ______________________ Epidural: □ Yes □ No

Please list any problems during pregnancy and/or labor: ______________________

____

____

Congenital Anomalies/Defects: ______________________

Infant Feeding: □ Breast □ Bottle □ Formula Other food or drink information: ______________________

____

#of hours child sleeps daily: ________ Quality of sleep: □ Good □ Fair □ Poor

Explain: ______________________

# of siblings: ______ Please list names and ages: ______________________

MEDICAL INFORMATION

Pediatrician and/or Family MD Name: ______________________ Location: ____________

Date of last visit to doctor: ____________ Purpose of that visit: ______________________

____

Immunization History: ______________________

____

Has your child ever been treated on an emergency basis? □ Yes □ No Please describe: ______________________

____

HEALTH INFORMATION

Reason for visit today: ____

____

____

Condition started on: ____

Is condition getting progressively worse? ☐ Yes ☐ No Please describe: ______________________

Other doctors seen for this condition: ______________________________

Any home remedies? ____

DEVELOPMENTAL HISTORY- at what age did the child:	CHILDHOOD DISEASES- age of the child when occurred:
Respond to sound: ________	Chicken pox: ________
Crawl: ________	Rubella: ________
Follow an object with their eyes: ________	Rubeola: ________
Hold head up: ________	Whooping cough: ________
Stand: ________	Mumps: ________
Sit alone: ________	Measles: ________
Walk alone: ________	Other: ________

Has this child ever suffered from (please check all that apply):

☐ Diabetes	☐ Bed Wetting	☐ Convulsions	☐ Neck Problems
☐ Fainting	☐ Tuberculosis	☐ Backaches	☐ Heart Trouble
☐ Dizziness	☐ Stomach Aches	☐ Allergies	☐ Orthopedic Problems
☐ Asthma	☐ Walking Problems	☐ Rheumatic Fever	☐ Hypertension
☐ Sugar Concentration	☐ Headaches	☐ Blood Disorders	☐ Broken Bones
☐ Sleeping Problems	☐ Digestive Disorders	☐ Sinus Trouble	☐ Leg Problems
☐ Diarrhea	☐ Constipation	☐ Paralysis	☐ Joint Problems
☐ Arm Problems	☐ Hyperactivity	☐ Chronic Earaches	☐ Colds/Flu
☐ Arthritis	☐ Neuritis	☐ Anemia	☐ Poor Appetite
☐ Behavioral Problems	☐ Muscle Jerking	☐ Ruptures/Hernias	☐ "Growing Pains"

☐ Any other Problem: ____

Present Health History or Additional Information: ______________________________

____

Has the child had any surgeries? ☐ Yes ☐ No What and When? ______________________

____

Accidents: ____

MEDICATIONS: ______________________	VITAMINS: ______________________
______________________	______________________
______________________	______________________

Family Health History

	Heart Disease	Arthritis	Cancer	Diabetes	Other ________
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

______________________	______________________	______________________
Parent's Signature	Relationship to Patient	Date

BODY BALANCE CHIROPRACTIC
INFORMED CONSENT FORM
TERMS OF ACCEPTANCE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on ________________________ by Andrew Burns, D.C., P.C. and/or Dr. Andrew Rackovan D.C.
Patients Name
I will have an opportunity to discuss with the doctor the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care including, but not limited to, fractures, disc injuries, strokes, dislocations and strains/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or will have explained to me the above consent. I will also have an opportunity to ask questions about its content, and by signing below agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I have read and fully understand the above statements. I therefore accept chiropractic care on this basis.

____ ________________

Patients/Guardian Signature **Date**

Family members: ____________________ ____________________
____________________ ____________________
____________________ ____________________

Body Balance Chiropractic
Financial Policy and Fees

We believe a clear definition of policies regarding financial matters will allow both you and the doctor and staff to focus on the main issue – regaining and maintaining your health. We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. **You will be expected to pay for your chiropractic care at the time the services are rendered unless you arrange an Active Life Plan in advance.** Active Life Plans include yearly, monthly, weekly or extended **Corrective Adjustment Plans** payment options. These Active Life Plans are designed to be the most cost effective way to keep you and your family as healthy as possible. Details of these plans will be discussed with you during your Chiropractic Report.

I understand and agree that health and accident insurance policies are solely an arrangement between an insurance company and me, the insured. I authorize the office to contact my (our) employers(s), insurance company(s), attorney(s), and/or adjustor(s) to verify benefits and eligibility and/or to prepare and send any claims, reports and/or file information to assist me in payment by the insurance company, adjustor and/or attorney. I authorize assignment of payment of all health/injury benefits to Body Balance Chiropractic which will be credited to my account. I realize that insurance may pay for some or none of the services.

I clearly understand and agree that all services I receive are charged directly to me and I am responsible for complete payment. If my PPO/HMO, adjustor, Work Comp, Auto Liability/Med Pay, TPA (Third Party claims Administrator), or attorney denies payment because of failure to comply with coverage requirements or any other reason I am still responsible for complete payment. If I stop care before my balance is paid, any remaining balance due for prior services will remain my responsibility for complete payment regardless of outstanding insurance claims.

Should my account fall delinquent without balance being paid by me, insurance, TPA, or attorney, then collection agency services against me may be retained. I understand that any collection agency related charges incurred by our office would be added to my balance due. I will be charged a fee of $25.00 for any personal check payment returned as "insufficient funds" or "stop payment" plus the original amount of the check.

I have read, understand and agree to the financial policies defined above.

____________________________________ ______________

Patient/Parent Signature **Date**

Family Members: ____________________ ____________________

____________________ ____________________

____________________ ____________________

Services	**TOS Fees**
New Patient Exam	$95.00
X-Rays (per view)	$50.00
Therapeutic Exercise	$35.00
E-Stim	$10.00
Adjustment	$45.00

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposed that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved I your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when you physician is ready to see you. We may use or disclose you protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law. Communicable Disease: Health Oversight: Abuse of Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroner, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we mast make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures

Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization

At any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information.

You have the right to request a restriction of your protected health information
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must stat the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrew as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2015**

Body Balance Chiropractic
910 Brookwood Center
Fenton, MO 63026
636-717-0600

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

____ ____________________

Patient/Guardian Signature **Date**

Family members: ____________________ ____________________

____________________ ____________________

____________________ ____________________