Date_____

Office of Dr. Donald K. Elmore
1315 Haywood Road
Greenville, SC 29615

Pediatric Case History

Dear Prospective New Patient,

Please complete this information to the best of your ability. Your answers will help us to determine if your child is a candidate for chiropractic care.

Personal Information:

Patient Name_____ Street Address_____
City_____ State___ Zip_____ Home Phone #_____
Social Security #_____Birth Date_____ Age____ Male__ Female__

Parents' Information:

Mother's Name:_____ Work #_____
Mother's Cell #_____
Father's Name:_____ Work#_____
Father's Cell #_____

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

Health Information:

Primary Care Physician:_____
Purpose of this visit?_____
Other Doctors seen for this conditioin?___Yes___No
If yes, Doctors' names and prior treatment:
_____
_____
Other Health Problems?_____

Previous chiropractic care:____Yes____No If yes, Chiropractor's Name_____
If yes, did your child receive good results?_____

Please check any of the following conditions your child has suffered from in the past:

__Ear Infections	__Scoliosis	__Seizures	__Chronic Colds	__Headaches
__Asthma/Allergies	__Digestive Problems	__ADHD	__Recurring Fevers	__Growing Pains
__Colic	__Bed Wetting	__Car Accident	__Temper Tantrums	__Other_____

List any surgeries or congenital conditions:
_____
_____

AUTHORIZATION TO ADMINISTER CARE

INIT___ I authorize Dr. Donald K. Elmore and whomever he may designate as his assistant to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

INIT___ I authorize the release of any medical information necessary to process my insurance claim and I also certify that all information given to this office is correct and complete.

X-RAY NOTE

INIT___ The amount paid to Dr. Donald K. Elmore for x-rays is for examination only. The x-ray negatives will remain property of this office, as required by federal law. X-rays may be seen at any time.

PAYMENT INFORMATION

IT IS THE POLICY OF THIS OFFICE THAT ALL VISITS BE PAID IN FULL AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

Please choose the option that is best suited to your needs:

__ CASH-You either do not have insurance or your insurance does not cover chiropractic.

__ INSURANCE-Please give your insurance card to the front desk so that we may keep a copy on file.

Consent To Treat a Minor

Being the parent or legal guardian of this child, I hereby authorize Dr. Donald K. Elmore and staff to examine and administer care to my child by the name of_____as the doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Signature:_____ Date:_____

Due to your current complaint, check off any activity that is restricted or more difficult for you to perform.
Please Circle the 3 that are most important to you.

I find it difficult to:

- ○ Care for Family Members
- ○ Carry Groceries
- ○ Sleep or Lay down
- ○ Climb Stairs
- ○ Cook
- ○ Care for pets
- ○ Drive
- ○ Sit for a long period
- ○ Stand for a long period
- ○ Sit at a Computer
- ○ Do Household Chores
- ○ Lift/Care for Children/Grandchildren
- ○ Read
- ○ Self Care: Bathing
- ○ Self Care: Dressing
- ○ Self Care: Shaving

It is difficult at work to:

- ○ Change positions
- ○ Extended Computer Use
- ○ Perform my work duties

It is difficult to do my Hobbies:

- ○ Gardening
- ○ Yard Work
- ○ Ceramics
- ○ Crafts
- ○ Scrapbooking
- ○ Playing Musical Instrument
- ○ Sewing
- ○ Wood Working
- ○ Other_____

Restricted from Sports:

- ○ Basketball
- ○ Baseball
- ○ Football
- ○ Golf
- ○ Running
- ○ Cycling
- ○ Swimming
- ○ Soccer
- ○ Softball
- ○ Tennis
- ○ Volleyball
- ○ Cheerleading
- ○ Walking
- ○ Horseback Riding
- ○ Hiking
- ○ Exercising
- ○ Weight Lifting
- ○ Attending Sporting Events
- ○ Coaching Sports

Other activities I find it difficult to do:

_____
_____
_____
_____
_____

_____
Patient Signature

Office of Dr. Donald K. Elmore
Donald Keith Elmore, DC LLC

Informed Consent to Treat

Patient Name: _____

Please read this entire document prior to signing it. It is important that you understand the information contained herein. Please ask any questions or share any concerns prior to signing.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or mechanical instruments upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination, and treatment ou are consenting to the following procedure:

- spinal manipulative therapy	- orthopedic testing	- vital signs
- range of motion testing	- postural analysis	- palpation
- muscle strength testing	- hot/cold therapy	- EMS
- radiographic studies	- basic neurological testing	- ultrasound

The material risk inherent in the chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains, separations, and burns. Some types of manipulation to the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examinations to screen for contraindications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, OTC analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted " other treatment" options, you should be aware that there are risks benefits of such options and you may wish to discuss them with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Minor Children

___ I give my consent to treat my minor child, whether they be my blood child or within my legal custody or guardianship.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risk, I hereby give my consent to that treatment.

Dated: _____ **Dated:_____**

_____ **_____**

Patient's Name **Doctor's Name**

_____ **_____**

Patient's Signature **Doctor's Signature**

_____

Signature of Parent or Guardian
(If treating minor)

HIPAA- Health Insurance Portability And Accountability Act

Office of Dr. Donald K. Elmore
1315 Haywood Road
Greenville, SC 29615
(864) 244-2999

The following is an explanation of our Privacy Policies for this office:

1. Our office does NOT distribute or make available to any outside source your private personal health information.
2. Your information is secure and is used only in submitting claims to third party carriers for payment of services.
3. Our office is set up as an open adjusting environment.
4. Our office may send you seasonal cards or birthday cards.
5. Our office may call you to confirm or reschedule an appointment if necessary.
6. A family member can be present when hearing the results of your exam and tests.

A more detailed explanation of our privacy policy is available for you to read and take a copy with you. Please ask the front desk for it.

By signing, I have read, understand, and agree to the privacy policies for this office. I understand that I can take a copy of this policy for my records. I understand that, if I do not agree with these policies, I can and will notify Dr. Elmore of my concerns in writing.

Patient Signature_____Date_____

Office Policies for Maximum Chiropractic Effectiveness

Welcome to the Chiropractic office of Dr. Don Elmore! Our purpose is to educate and adjust as many families as possible toward optimal health through natural chiropractic care. To help you receive the greatest benefit from your care in our office, all potential patients are accepted for care based on these policies:

(**Please initial below**)

HOME CARE

___**CONSISTENCY**-The relationship that best serves you is one of mutual responsibility. **You are expected to do your part** in the healing process by making necessary lifestyle changes such as: exercises, traction, stretches, and other such suggestions. Your health progress is affected by your willingness to take part in the healing process. If you have any question, let us know.

___**BROKEN APPOINMENTS**-Broken or missed appointments **severely** affect your results. To keep your progress on schedule, it is necessary to **reschedule any missed appointments within 24 hours**. If you repeatedly miss or reschedule your appointments, we may regretfully have to release you from care. The best results come from consistent care.

___**FAMILY**-Ours is a family practice, seeing newborns and grandparents alike. Once you understand that the nervous system controls and coordinates all functions of the body and that subluxations interfere with proper nerve flow, we expect that you would want to have your family checked for subluxations**. During the first two (2) weeks of your care, we will be happy to check your family at no charge!**

OFFICE CARE

___**QUESTIONS/TIMELINESS**-Certainly, an adjustment only takes a few minutes. We do as much as we can to decrease the waiting time in the office. If you have a question for Dr. Elmore which might be more involved than time allows, simply let the front desk know, and he will call or email you at your convenience.

FINANCES

___**FINANCES**-Our office charges fair, usual, and customary fees. Your commitment to financial exchange allows us to continue to provide the highest quality of health care environment and experience. If for any reason you can not keep your financial agreement, **please inform our front desk immediately to eliminate any misunderstandings**. If you have the desire to receive care in this office, we will make every attempt to make affordable arrangements. Office balances will remain under $300 unless prior arrangements have been made.

___**INSURANCE**-For the convenience of our patients, our office will file your insurance electronically if contracted to do so. Please remember that insurance is a contract between you and the company. We will file in a timely manner and provide any basc reports needed, but any unpaid portions **including co-payment, deductible, and non-covered services are your responsibility**.

___**INTERRUPTION OF CARE**-In the unlikely event it becomes necessary to discontinue your care for any reason, all outstanding fees for services rendered become immediately due and payable.

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

Signed_____Witness_____Date_____