SYNERGY OVIEDO
CHIROPRACTIC

New Pediatric Patient Application Form

Dear Parents,

Congratulations on taking this very important step towards improving your child's health potential. We are honored that you have placed your trust in our practice to help care for your child. Our doctors have had the privilege to serve many children and families. We have worked closely with local Pediatricians and are happy to reach out to yours, upon request, to explain what we find as well as our treatment plan. The Synergy Oviedo Chiropractic concept offers your family more…

Synergy Oviedo Chiropractic offers a collaboration of multiple healing arts that produces a greater level of health than the sum of the individual healing approaches. Synergy creates amazing individual health which in turn impacts the whole family allowing them to achieve their goals with joy, love, and enthusiasm.

The following information will help discover your child's specific needs and allow us to fully address the root cause of their condition. We work as a team, using many different healing arts (Chiropractic, Medicine, Massage, Physical Therapy), to help you add life to all of their years.

Our New Patient process typically takes two visits. Your first visit allows us to thoroughly listen to your needs and concerns and carefully evaluates your spine and nervous system. We offer on site state of the art digital x-ray technology, and only perform x-rays on children if we feel they are necessary. We are sensitive about x-ray testing. Your follow up consultation will be one of the most important visits you have here as we will outline for you and your family your results and recommended action plan. You child may also begin your care here on your second visit.

We promise to take the time to listen to you and your child and make this experience an enjoyable one. Please call today at (407) 505-4320 if you have any questions.

Welcome to our Synergy Family,

Dr. Eric Janowitz and Team Synergy

1791 East Broadway Street, Oviedo, FL 32765 www.SynergyOviedo.com

SYNERGY OVIEDO CHIROPRACTIC

New Patient Application

Title: Mr. Mrs. Ms. Dr.

Last Name: _____ First Name: _____ MI: _____

Nick Name: _____ Date of Birth: ____/____/____ SS #: _____-___-____ Marital Status: ____

Home Address: _____ Apt#: _____

City: _____ State:_____ Zip: _____ Home Phone: (____) _____

Cell Phone: (____) _____ E-Mail_____

Work Phone: (____) _____ May we contact you at work? ☐ Yes ☐ No

Employer Name: _____ Occupation:_____

Insurance Co: _____ Group ID#: _____ Ins ID #: _____

Name of Insured: _____ Insured's Date of Birth: ____/____/____

Spouse Name: _____ Occupation:_____

Financially responsible person if other than patient:

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____) _____

Date of Birth: _____/_____/_____ SS#: ____-___-_____ Relationship to Patient: _____

Employer Name: _____ Employer Phone: (____) _____

Emergency contact

Last Name: _____ First Name: _____

Contact Phone: (____) _____ Relation to patient:_____

Referral Source:

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

Or, where did you hear about our office? _____

Pediatric History Form

Dear Parent of a New Patient,

It is a pleasure to welcome you to our family of happy and healthy Chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help serve your child better, please complete the following information prior to their appointment in order for us to focus on discovering the cause of your child's health concerns.

Child's Name: _____ Date of Birth: _____ Sex: Male Female

Names of Parents / Guardians : _____

CAUSE

The Human body is designed to be healthy. The primary system in the body which coordinates health is the Central Nervous System. The healthy function of every cell, every system, and every organ is dependent upon the integrity of the Central Nervous System. The bones of the skill and the vertebrae of the spine house and protect the Central Nervous System.

From the birth process until the present, events have occurred in your child's life which may have caused interference and damage to this delicate system. Physical, emotional and chemical stresses, which are common in our contemporary lifestyles, can result in misalignment and damage the spinal column. This interference is called Vertebral Subluxation Complex.

This form will help reveal the causes of the Vertebral Subluxation which interfere with the optimal function of your child's nervous system and therefore impair your child's inborn health potential.

Vertebral Subluxation Assessment

1. Purpose for contacting us? _____
2. Other Doctors seen for this condition (include Doctor's name and Prior Treatments)

3. Other Health Problems? _____
4. Check any of the following conditions that your child has suffered from***:***

   colic irregular sleeping patterns night sweats seizures tantrums ear infections allergies asthma headaches poor digestion repeated infections or colds fevers bed wetting learning disorders ADD or ADHD

5. Family History: _____
6. Previous Chiropractor's name: _____ Date of Last Visit: _____

   Reason for care:_____
7. Name of Pediatrician: _____ Date of Last Visit: _____

   Reason for care: _____

   Are you satisfied with the Care your Child has received there? _____

Prenatal and Past Health History on Next Page:

1. Name of Obstetrician / Midwife: _____
2. Experts around the world agree. Intervention during the birth process may cause neurological trauma, damage and even death. According to the World Health Organization, children in twenty-two other countries have a greater survival rate than in the United States.
    a. Did the child's mother have ultrasound during this pregnancy? _____ how many? _____
    b. Place of birth: home ____ birthing center ____ hospital ____
    c. Type of birth: vaginal ____ induced labor ____ emergency c-section ____ planned c-section ____
    d. Medications during Pregnancy? ____ Type _____
    e. Medications during Delivery? ____ Type _____
    f. Cigarette / Alcohol use during pregnancy? ____
    g. What position did the mother deliver in? _____
    h. Birth Trauma: twisting, pulling _____ vacuum extraction _____ forceps _____
    i. Newborn trauma (medical procedures): _____
3. Repeated studies are now informing us that breast-feeding develops strong and healthy immune, neurological and digestive systems.
    a. Was your child breast fed? ____ How long? _____
    b. Was your decision supported by your health care provider? _____
    c. Formula fed for how long? _____ Type:_____
    d. Introduced to solids at: _____ Months
    e. Food / Juice Allergies or Intolerances? _____ List: _____
4. According to the National Safety Counsel, approximately 50% of infants have fallen onto their heads their first years of life. Another study reveals that 250,000 children are injured at playgrounds annually. Can you recall such jolts, falls or traumas to your child?

    _____
5. Which of the following high impact sports does your child play? (i.e. Football, Soccer, Baseball, Basketball, Gymnastics, Karate, Hockey, Wrestling, Dance, Other)

    _____
6. Has your Child ever been involved in a car accident? ____ Describe: _____
7. Has your Child been seen on an emergency basis? ____ Describe: _____
8. Prior surgeries: _____
9. Other than five hours per day sitting in the classroom, does your child spend prolonged time sitting? _____ In front of a computer or Television? _____
10. How would you rate your child's diet? _____

11. Number of doses of Antibiotics your child has taken:
    a. During the past 6 months: _____
    b. Total during his / her lifetime: _____
12. Number of doses of Other Prescription or Over the Counter Medications your child has taken:
    a. During the past 6 months: _____
    b. Total during his / her lifetime: _____
    c. List: _____
13. The child's immunes system, like all other developing systems of the body, is both intricate and delicate. It strives for a state of homeostasis and balance in the body. Long term effects from interfering with this process with artificial vaccinations are just being uncovered. Were you adequately informed of the risks of vaccinating you child? _____ Did your child experience any behavioral, emotional or physical changes after any vaccination? ____ Please describe:
    _____
14. Chronic postures from either the parent or your child can be an indicator of stress on your child's nervous system.
    a. Do you, now or in the past, hold your child on only one hip or arm? ____
    b. If the crib was along a wall, was the child placed in opposite sides of the bed to prevent chronic one sided head rotation to see his parents? _____
    c. Have you noticed any head tilting that was more dominant on one side (while in a car seat, changing diapers, or laying down) ___ Describe: _____

CORRECTION

Today we are becoming more aware how current technological lifestyles and practices expose our children's nervous systems to continuous stresses. These result in Vertebral Subluxations.

Current scientific research is showing the direct relationship between the function of the Central Nervous System and the immune system function. The integrity of the Central Nervous System is therefore imperative to a healthy immune system in your growing child.

Today, your child has the opportunity to have a spinal analysis by a Doctor of Chiropractic; the only health care provider qualified to locate, analyze and correct the Vertebral Subluxation with the Chiropractic Adjustment is the beginning of greater health and well-being for your child.

AUTHORIZATION TO TREAT A MINOR

I, _____ , hereby authorize Dr. Janowitz and whoever he may designate as their representative to administer chiropractic care, as he may deem necessary, to my son/daughter

_____. Dated _____

_____ ____ _____
Witness Name Parent/Legal Guardian Name

_____ ____ _____
Witness Signature Parent/Legal Guardian Signature

SYNERGY OVIEDO CHIROPRACTIC

AUTHORIZATION TO RECEIVE MEDICAL RECORD INFORMATION

OVIEDO MEDICAL CLINIC, LLC dba SYNERGY OVIEDO CHIROPRACTIC is hereby authorized to request the release of any medical records, laboratory test results, and radiographic & diagnostic imaging results, pertinent to the health care of the above named patient from, but not inclusive of, any insurance carrier, adjustor, attorney, or other health care provider.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

OVIEDO MEDICAL CLINIC, LLC dba SYNERGY OVIEDO CHIROPRACTIC is also authorized to release any medical records pertinent to the health care of the above named patient to, but not inclusive of, any insurance carrier, adjustor, attorney, health care provider, or immediate family member, upon receipt of the signature of the above named patient or the signature of the patient's legal guardian. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage (in the event that claims are submitted to an insurance company on your behalf) for services rendered by said OVIEDO MEDICAL CLINIC, LLC dba SYNERGY OVIEDO CHIROPRACTIC.

INFORMED CONSENT FOR CHIROPRACTIC TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Eric Janowitz and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Eric Janowitz, including those working at the clinic

I understand I will have the opportunity to discuss with the doctors of Synergy Oviedo Chiropractic, and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, 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, and is in my best interests.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

YOUR FINANCIAL RESPONSIBILITY

Payment is due when services are rendered unless prior arrangements (including insurance participation) have been made. The individual(s) above understands that a $30 returned check fee will be charged should payments be made via check. The above individual(s) will also be responsible for any appropriate collection or attorney's fees which may accrue if it is necessary to engage collection services to pursue payment of any outstanding balance.

Patient Name: _____

_____ _____

Signature of patient or parent/legal guardian Date

_____ _____

Witness of patient or guardian's signature Date

Synergy Oviedo Chiropractic
Patient Health Information Privacy Agreement
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Synergy Oviedo Chiropractic** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Synergy Oviedo Chiropractic.** I understand that diagnosis or treatment of me by **Eric Janowitz. D.C**. or other doctors at Synergy Oviedo Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

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. **Synergy Oviedo Chiropractic** is not required to agree to the restrictions that I may request. However, if **Synergy Oviedo Chiropractic** agrees to a restriction that I request, the restriction is binding on **Synergy Oviedo Chiropractic** and **Eric Janowitz. D.C.** Unless Synergy Oviedo Chiropractic is notifiedotherwise, I consent to being contacted by Synergy Oviedo Chiropractic by telephone, mail, or other electronic means in order to confirm appointments, advise me of any shift closings, provide newsletters, or invite me to any special events. I also consent to having my picture taken in order for the doctors to help analyze my posture.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Eric Janowitz. D.C.** or **Synergy Oviedo Chiropractic** has taken action in reliance on this consent.

My “protected health information” (PHI) 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.

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment in one of our closed private exam rooms. A doctor or trained staff member is happy to speak with you about your condition or other matters in the closed private exam room upon your request.

Our office has an open, family-centered approach to wellness and we believe it is in all our patient‟s best interests to have the support and cooperation of their families. Therefore, our office strongly encourages that the spouse or significant other be present when the doctor goes over the patient‟s report and recommendations for treatment and wellness. If you object to the presence of your spouse or significant other at your report, please let us know immediately so we can best determine how best to serve you including making special arrangements or, if necessary, refer you to another chiropractor.

In addition, we may disclose your PHI to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your health care treatment.

I understand I have a right to review and a copy has been provided to me, upon my request, **Synergy Oviedo Chiropractic's** 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 the Synergy Oviedo Chiropractic. The Notice of Privacy Practices for Synergy Oviedo Chiropractic is provided at 1791 East Broadway, Oviedo, FL 32765.

This Notice of Privacy Practices also describes my rights and the **Synergy Oviedo Chiropractic's** duties with respect to my protected health information.

Synergy Oviedo 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 and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Name of Patient or Personal Representative	Date
Signature of Patient or Personal Representative	Description of Personal Representative's Authority