WELCOME TO BATTLE BORN CHIROPRACTIC!

Battle Born Chiropractic is a place where people come and feel like family. It is about LIFE, people, health and community. The kid friendly environment, homelike atmosphere, and lively music are unique and unlike the typical doctor's office. Battle Born Chiropractic is a safe oasis which facilitates your best possible chiropractic adjustment, and the well-being of your body, mind and spirit.

At Battle Born Chiropractic you will be cared for as a unique individual. The following pages are for you to provide vital information and a brief outline of your life's story. Much of this information will be discussed in our first appointment. Dr. Rachel believes in addressing the whole person, not just one specific problem. We are a sum total of all of our life's experiences up to this present moment. The more information you can provide, the better she can serve you. Dr. Rachel is honored to contribute to your and your family's enhanced quality of life on your path to health, happiness and wellness.

Please make sure to fill out this Intake paperwork and email it to drrachel@battlebornchiropractic.com or office@battlebornchiropractic.com or you can fax it to 775-470-5402, AT THE LATEST, by the Thursday before your first appointment. This gives Dr. Rachel the time to review your paperwork before your consult and exam. If this is not done, your appointment will be cancelled and need to be rescheduled.

Thank you! Can't wait to see you!

Pediatric (Teenager)
Intake Form

Child's Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name(s): _____

Cell Phone: _____ Additional Phone: _____

Parent/Guardian Email: _____

Birth Date: _____ Gender: _____ Adopted: ☐ Yes ☐ No

Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____

Name of siblings and ages: _____
How did you hear about us? ☐ Facebook ☐ Instagram ☐ Internet Search
☐ Family/Friend (WHO MAY WE THANK FOR REFFERRING YOU? _____)
☐ Midwife _____ ☐ Doula _____
☐ Lactation Consultant _____ ☐ Other _____

Previous Chiropractic care? YES ☐ NO ☐ Chiropractor: _____ Last Visit: _____
Reason for seeking services at Battle Born Chiropractic:

_____

Is there anything about your child's spine or nerve system that I should know?

_____

Is your child experiencing any symptoms? If so, explain:

_____

_____

What is your level of commitment to you and your child's life and well-being?
High: _____ Medium: _____ Low: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature: _____ **Date:** _____

Lifestyle History:

Name of Pediatrician/MD/APRN: _____

Describe your child's sleeping pattern: _____

_____

Known food sensitivities/allergies: _____

Typical Diet: ☐ Mostly whole, organic foods ☐ Pretty average ☐ High amount of processed food

Number of meals each day: _____ Number of snacks each day: _____

What did your child have for breakfast, lunch and dinner yesterday? (Be honest)

_____

Please Circle Dietary Intake: Fruits Vegetables Meats Grains Dairy Nuts/Seeds Sugar Eggs Seafood

How much water does your child drink daily? _____

What exercise does your child do and how often? _____

_____

List any supplements your child takes: _____

_____

Has your child been vaccinated? ☐ No ☐ Yes If yes, which ones and list any reactions to them:

_____

_____

Has your child ever been on antibiotics? ☐ No ☐ Yes How many courses? _____

_____

History of Physical Stress (ex. Sports, school, surgeries, accidents, falls, trauma):

_____

_____

History of Chemical Stress (ex. Food, alcohol, drugs, medications, tobacco, environmental toxins):

_____

_____

History of Emotional Stress (ex. School, family, friends, life):

_____

_____

Any sports participation and age began? Please include sports and number of hours each week.

_____

_____

How many hours does your child using screen time daily (cell phone, ipad, tv, computer)? _____

How many outside hours per week does your child have?_____ How heavy is your child's backpack? _____

What are your Top 3 Health Goals for your Child? _____

_____

_____

_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____
Parent or Guardian: _____ Signature: _____ Date: _____
Witness Name: _____ Signature: _____ Date: _____

Terms of Acceptance

When a person seeks chiropractic care and I accept a person for such care, it is essential for both to be working for the same objective. The following definitions help to clarify some of the fundamentals of chiropractic.

HEALTH: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." – World Health Organization

VERTEBRAL SUBLUXATION: a misalignment of one or more vertebrae in the spinal column that alters function, which inhibits the body's ability to fully express its inherent potential.

ADJUSTMENT: The specific application of forces to facilitate the body's correction of vertebral subluxation. This is done by the use of a chiropractor's hands on your back and/or a small instrument.

Battle Born Chiropractic offers to provide chiropractic care to correct the vertebral subluxation. Dr. Rachel's objective is to eliminate major interference of the nerve system for the expression of the body's natural ability to heal and grow. Other procedures may be used to help your body maintain the benefits of the adjustments. If during the course of a chiropractic neuro-spinal analysis we encounter non-chiropractic or unusual findings, we will advise you to seek the services of another healthcare specialist.

At Battle Born Chiropractic, health is a dedicated and active process that is achieved through our partnership with the objective of optimizing your health and life.

I, _____ have read and fully understand the above statements.

All questions regarding Dr. Rachel's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

_____ _____

Parent/Guardian Signature **Date**

Consent to evaluate and adjust a minor child:

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.

Battle Born Chiropractic, LLC

Dr. Rachel Whitman

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 1, 2019, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect.

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials' information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to

PRIVACY OFFICER, Battle Born Chiropractic

6490 S. McCarran Blvd. BLDG D1, Ste. 28

Reno, Nv 89509

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received, reviewed,
(Patient Name)
understand and agree to the Notice of Privacy Practices of Battle Born Chiropractic, LLC and Dr. Rachel Whitman, D.C., which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

Print Name: _____

Parent/Guardian Signature: _____ **Date:** _____

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

Battle Born Chiropractic has made a good-faith effort to obtain an acknowledgement of

_____ 's receipt of our Notice of Privacy Practices. In spite of
(Patient Name)

these efforts, Battle Born Chiropractic has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

_____ Patient Unavailable

_____ Patient Physically Unable

_____ Patient Unwilling

In effort to obtain the patient's acknowledgement, Battle Born Chiropractic has attempted to provide patient with a Notice of Privacy in the following manner (check all that apply):

_____ Personally _____ Mail _____ Phone Follow Up ____ Other: _____

Signature: _____ **Date:** _____

Print Name of Physician: _____

Please direct any questions to:

Dr. Rachel Whitman, D.C.
Office Phone: 775-826-2676
6490 S. McCarran Blvd. BLDG D1, Ste. 28 Reno, Nv 89509

Financial Policy

Collection of Patient Balance:

- Dr. Rachel Whitman is an Out of Network Provider with all insurance companies and is a Non-Participating Provider with Medicare.
- As a Non-Participating Provider with Medicare, Battle Born Chiropractic will collect payment directly from Medicare Patients at the time of service. Medicare is the only provider Battle Born Chiropractic will submit claims to on behalf of the patient, and the patient may be reimbursed for the portion of the charges for which Medicare is responsible.
- Payment is expected in full at the time of service. If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit. All balances remaining unpaid after 30 days may be turned over to a collection agency.
- Battle Born Chiropractic can provide you everything you need to be reimbursed by your insurance based on your benefits.

Returned Checks:

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction.

Appointments:

- Any **missed** appointments are a missed opportunity for someone else on our community to be seen! If unable to keep an appointment, please be respectful of our time, and theirs, by rescheduling **at least 24 hours in advance**. **ANY** missed/canceled visits without 24 hour notice, the patient will be charged **$65** for each visit. The patient will be responsible for payment.
- **LATE POLICY**: It is the responsibility of the patient to arrive on time for the scheduled appointment. Battle Born Chiropractic allocates designated time slots throughout the day to honor not only our patients time but our doctors' as well. We do not offer any grace period for scheduled appointments. If the patient is running late, it is their responsibility to communicate with the office by calling in with reason. Any patients running more than 10 minutes late will forfeit their appointment and are subject to be charged in full for the missed appointment.

Financial Policy Question:

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator, Dr. Rachel Whitman.

Patient Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following:

•You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that you do not bill insurance companies directly, but I authorize the release of my information should I choose to seek reimbursement.

•I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize you or another provider to exchange this information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, and/or any pertinent health-related information.

Parent/Guardian Signature: _____ **Date:** _____

Release Form for Media

I, _____, do hereby grant or deny permission to Battle Born Chiropractic to use the image of myself/my child, _____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or videos taken of myself/my child for use in materials that include, but may not be limited to, printed materials such as brochures and newsletters, videos, and digital images such as those on Battle Born Chiropractic website, Facebook and/or Instagram.

☐ Deny permission to use mine/my child's image at all.

☐ Grant permission to use mine/my child's image in the following ways (mark all the apply):

- ☐ Limited usage: I want mine/my child's image used within the Battle Born Chiropractic Office setting only (not in the larger community)
- ☐ Limited usage: I want mine/my child's image used for educational materials only (not marketing). This could be either within Battle Born Chiropractic office or in the larger community. One example of this could be videos in parent education classes.
- ☐ Limited usage: I want mine/my child's image used on printed materials only (no digital or video use).
- ☐ Unrestricted usage: I give unrestricted permission for mine/my child's image to be used in print, video, and digital media. I agree that these images may be used by Battle Born Chiropractic for a variety of purposes and that these images may be used without further notifying me. I do understand that mine/my child's last name will not be used in conjunction with any video or digital images.

Parent/Guardian Signature: _____ **Date:** _____