vitality
CHIROPRACTIC

WELCOME!

Thank you for choosing Vitality! Are you ready for you and your child to experience a healing approach like you've never experienced before? Our custom Chiropractic sessions will help guide you and your child to discover the amazing wellness potential within.

Our Healing and Wellness Approach

Healing and wellness are processes, not events, and we are not a "quick fix" practice. We strive to create a relationship with you and your child as we assist you in achieving your overall health and wellness goals. Our holistic approach to health transforms the physical body's alignment and spirit to help achieve better balance.

Your Child's Chiropractic Sessions:

You and your child's experience with Vitality starts with a pain control therapy or a fully customizable HydroMassage to relax the body and mind. You will then be escorted with your child into the adjusting room for your child to receive the Chiropractic Adjustment using light touch and gentle instruments. We also incorporate Lifestyle Coaching and all the TLC that makes Vitality unique. Please allow 30 minutes for each session. The sessions are never procedures done *to* the child, but instead are creative healing experiences *with* your child. The parent/guardian is always encouraged to observe the sessions.

Payment & Insurance: You will be required to pay for your sessions at the time they are rendered. The new patient exam is $50 (age 10 and over) or $30 (age 10 and under) and the session fee is $75 for children age 5 and older, $50 for children age 5 and under. If your insurance company covers chiropractic care it is possible you may receive some reimbursement. We will assist you with that process by printing you a "Superbill," that you send in. Vitality is not a participating provider for any insurance company.

Parent/Guardian Initial _____

Diagnosis: We do not diagnose or treat any symptom, disease, or condition. If you have questions about naming or treating symptoms, we encourage you to consult with a medical doctor. It is important to understand that we do not imply that any particular session or series of sessions will "cure" any symptom, disease, or condition.

Parent/Guardian Initial _____

HydroMassage: Anyone experiencing one or more of the following conditions, or have a condition that heat or massage would have an adverse effect should get physician approval prior to use: *Heart or circulatory problems, inflammatory conditions such as phlebitis, varicose veins or thrombosis, swollen joints, acute inflammations, severe bruising, skin infections, contagious diseases, a high temperature, pain radiating to the arms or legs when the back is massaged, any other conditions in which heat or massage would be harmful.* Please use caution after use of HydroMassage equipment. Some users report sensations of dizziness or lightheadedness following their HydroMassage session. I acknowledge that I have read the above contraindications, and that my use of the HydroMassage equipment is completely voluntary. I hold JTL Enterprises Inc. / HydroMassage, and Vitality Chiropractic completely harmless for any injury resulting from the use of the HydroMassage equipment.

Parent/Guardian Initial _____

24 Hour Scheduling Policy: Missed, Late or Rescheduled appointments, unless emergency or weather related, must be within a 24-hour notice period, or you will be subject to a $25 fee.

Parent/Guardian Initial _____

Parent/Guardian Signature Date

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DATE / /

CHILD'S NAME AGE DOB / / SEX M / F

ADDRESS CITY STATE ZIP

PARENT/GUARDIAN #1 RELATIONSHIP

PHONE M( ) HM( ) WK( )

EMAIL

ADDRESS ☐ SAME CITY STATE ZIP

PARENT/GUARDIAN #2 RELATIONSHIP

M( ) HM( ) WK( )

EMAIL

ADDRESS ☐ SAME CITY STATE ZIP

Who may we thank for referring you to Vitality?

CONSENT TO CARE FOR A MINOR

I (we) being the parent/guardian(s) of the above named minor do hereby authorize, request, and direct Vitality Chiropractic, Dr. Kent Sifford, and staff to perform examinations and any care that in their judgment is recommended while the child is under the care of Vitality until legal age.

Parent/Guardian Signature Date

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ASSESSMENTS

The following sections will assess where the child is from a holistic approach, to determine the child's baseline. Please fill out comments for any that need further explanation to the best of your knowledge.

Section 1: Pregnancy: Please (x) if any of these scenarios applied to the child's birth mother during pregnancy term.

__ Excessive Wt Gain/Loss
__ Surgery
__ Recreational Drugs
__ Alcohol Intake
__ Premature Contractions
__ Caffeine (any type)
__ Illnesses
__ Hospitalizations
__ Immunizations
__ Bleeding
__ Smoking
__ Back Pain
__ Complications
__ Medications
__ Allergic Reactions
__ Vitamins/Minerals
__ Full-term Pregnancy
__ Prenatal Classes
__ Chiropractic Care
__ Good Attitude

Please comment on any of the (x) above or on anything not listed:

_____

_____

Section 2: Labor, Delivery and Birth: Please (x) any that apply to child.

__ Birthing Center
__ Home Birth
__ Premature Birth
__ Cesarean Birth
__ Vaginal Birth
__ Medications
__ Forceps/Suction
__ Circumcision
__ Silver Nitrate
__ Vitamin K
__ Excessive Crying
__ Unusual Coloring
__ 12+ hours labor
__ Complications
__ Choking
__ Nursing Problems
__ Breast Milk
__ Formula
__ Sleeping Difficulty
__ Surgery

Please comment on any of the (x) above or on anything not listed:

_____

_____

Section 3: Health Profile: Please (x) any that apply to child.

__ Childhood Illness
__ Auto Accidents
__ Drug Reactions
__ Serious Childhood Falls
__ Ear Problems
__ Sports
__ Allergies
__ Caffeine
__ Vaccinations
__ Child Unconscious
__ Back Pain
__ Secondhand Smoke
__ Skin Problems
__ Surgeries
__ Diarrhea
__ Artificial Sugar
__ Vaccine Reactions
__ Urinary Problems
__ Antibiotics
__ Extremity Pain/Limping
__ Sleeping Problems
__ Bed Wetting
__ Constipation
__ Heavy Backpack
__ ADD Symptoms
__ Inhalers
__ Emotional Traumas
__ Abnormal Stool
__ Headaches
__ Eye Problems
__ Other

Please comment on any of the (x) above or on anything not listed:

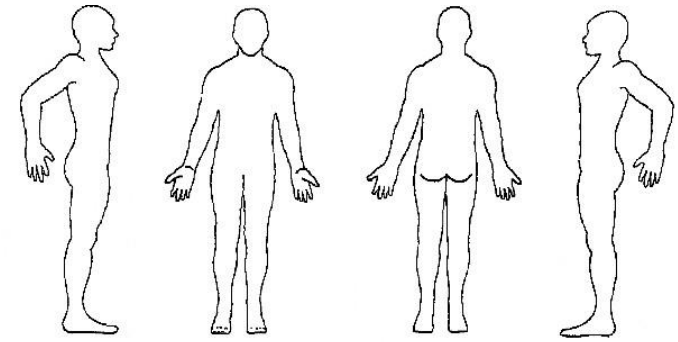
_____

_____

Current Medications & Purpose: _____

Any Medical Diagnoses: _____

Section 4: Specific Health Issue: Address the child's specific health issue here if applicable.

PLEASE FILL IN WITH DETAIL	FOR OFFICE USE ONLY
What is the health issue?	
When did it start?_____/_____/_____ M D YYYY Is this the first time you've experienced it? If no, when?	
What does the child do that makes it feel better?	
What does the child do that makes it feel worse?	
Does child feel any sensations? ☐Sharp ☐Dull ☐Numb ☐Tingling ☐Stabbing ☐Tightness ☐Other _____	
Rate child's pain on a 1-10 scale. '0' is no pain: /10	
Is child experiencing anything radiating? (circle) Right arm Right leg Left arm Left leg Other: _____	
Where on child's body is the issue? (circle)  Right Front Back Left	
Describe child's issue: ☐ Staying Same ☐ Getting Better ☐ Getting Worse	
How often is child experiencing this health issue? ☐ Intermittently (0-25%) ☐ Occasionally (26-50%) ☐ Frequently (51-75%) ☐ Constantly (76-100%)	
Does child's issue interfere with any of the following? ☐ Sleep ☐ Walking ☐ Sitting ☐ Standing ☐ Playing	
List any other solutions and/or practitioners utilized for this issue:	
Height:____'____" Weight: _____lbs. Shoe size: _____	

Section 5: Expectations: Goals and expectations for your child's journey at Vitality.

EXPECTATIONS	FOR OFFICE USE ONLY
Why did you choose Vitality?	
What would your short-term expectations look or feel like for the child?	
What would your long-term expectations look or feel like for the child?	
Do you have any questions on our Chiropractic approach? (HydroMassage, Chiropractic Care, and/or Lifestyle Coaching)	
Do you have any other lifestyle goals for the child?	
Is there anything else you would like Vitality to know about the child?	

If you are ready to work together to discover the amazing wellness potential within your child…
then you are in the right place! I look forward to connecting with you! ~ Dr. Kent Sifford

Notice of Privacy Practices (HIPAA)

This notice describes how chiropractic and personal information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Uses and Disclosures: Here are some examples of how we might use or disclose your health care information:

Dr. Sifford or a Vitality Chiro+Energy staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

Vitality Chiro+Energy may have to disclose your examination and adjustment records and your payment records to another party, such as an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

Vitality Chiro+Energy may need to use your health information, examination, and adjustment records and your payment records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.

Our Privacy Pledge: We respect your privacy. Other than disclosures mentioned above, we will not sell your health information.

Permitted Uses and Disclosures without your consent or authorization: Under Federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances. All other circumstances of using your health information require your written consent.

We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider. We are permitted to use or disclose your health information if we provide health care services to you as an inmate.

We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.

We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Your right to revoke your authorization: You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

If we have already released your health information before we receive your request to revoke your authorization. I 64.508 (b)(5)(i)

If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization, please write to us at: Vitality Chiro+Energy, 750 Sheridan Lake Rd., Rapid City, SD 57702

Your right to limit uses or disclosures: If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your re- strictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from anoth- er health care provider.

Your right to receive confidential communication regarding your health information: We normally provide information about your health to you in person at the time your receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home, or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information: You have the right to inspect and / or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and / or copy your health information to be in writing.

Your right to amend your health information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records: You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except: those disclosures required for your treatment, to obtain payment for your services, or to run our practice, those disclosures made to you, those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care, those disclosures for national security or intelligence purposes

those disclosures made to correctional officers or law enforcement officers, those disclosures that were made prior to the effective date of the HIPAA privacy law. We will provide the first accounting within any 12month period without charge. There is a fee for any additional requests during the next 12months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice: If you have agreed to receive a privacy notice by email, you may request a paper copy at any time.

Our duties: We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for an adjustment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure: Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain: You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to: DHHS, Office of Civil Rights, 200 Independence Ave., SW, Room 509F, HH Building, Washington, DC 20201. To contact us: Vitality Chiro+Energy, 750 Sheridan Lake Rd., Rapid City, SD 57702

This notice is effective as of 2005. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received copy of this notice.

Patient Name Printed	Date
Patient Signature	Authorized Provider Representative
Personal Representative Printed	Personal Representative Signature
Description of personal representative's authority to act for the patient	