CHILD HEALTH PROFILE & PERMISSION - Completed by Parent

Initial Visit Date: ______/______/______

Name of Parent: ______________________ Name of Child: ______________________

Address: ____

City/State/Zip: ____

Work #: ______________ Home #: ______________ Cell #: ______________

Date of Child's Birth: _____/_____/_____ Child's Age: _______ Child's Gender: Male / Female

How did you hear about our office? ____

Has your child ever received Spinal Adjustments or Network Spinal Analysis Entrainments by a Doctor of Chiropractic before? YES NO If yes, when and by whom? ______________ Total time receiving care?____

Have you or your spouse ever received Chiropractic care? YES NO Network Care? YES NO

What other natural forms of healthcare has your child received? ______________________

What do you hope for your child to receive from Chiropractic care in this office? ______________
____
____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HEALTH HISTORY

Were you physically ill prior to or during the pregnancy? YES NO ______________________

Was the pregnancy difficult? YES NO ______________________

Did you have any falls, accidents or physical injuries during the pregnancy? YES NO ______________

Was your labor chemically induced? YES NO ______________________

Were you conscious / semiconscious / unconscious? ______________________

Was the birth: ____drug induced ___forceps or suction ___C-section ___breech
___natural ___prolonged ____cord around the neck

Was the birth: __at home ___in a birthing center ___in a hospital ___other ______________

Was your child incubated or isolated? YES NO ______________________

Was your child: __bottle fed __breast fed __other ______________________

Has your child experienced any of the following? (If so please list when and any further comments you wish to share):

__Headaches __Allergies __Ear infections __Breathing problems __Fatigue __Irritability

__Hyperactivity __Flu __Frequent colds __Bloody noses __Meningitis __Diarrhea __Colic

___Constipation ___Rashes ___Milk or Lactose Intolerance ___Bed Wetting ___Asthma
___ADD/ADHD ___Sleeping Disorders ___Digestive Problems ___Others ______________________

Has your child ever been unconscious? Yes No ____

Has your child ever used crutches or corrective braces? Yes No ________________________________

Is your child accident-prone? Yes No ____

Has your child had any major falls? Yes No ____

Has your child ever been involved in an auto accident? Yes No _________________________________

Has your child ever been hospitalized or had surgery? Yes No __________________________________

Has your child ever had any broken bones or sprain injuries? Yes No ___________________________

Is you child currently on any medications? Yes No ____

Please list medications: ____

Has your child been vaccinated? Yes No ____

Is your child active in any sports? Yes No If yes, which ones? __________________________________

Is your child hyperactive? Yes No ____

Does your child have learning disorders? Yes No ____

Does your child have poor posture? Yes No ____

Is your child nervous, or has anyone suggested that your child was nervous? Yes No ______________

How would you rate your child's physical health?

___excellent ___good ___fair ___poor ___getting better ____getting worse

How would you rate your child's emotional/mental health?

___excellent ___good ___fair ___poor ___getting better ____getting worse

Is there anything else you wish to share which may help us to better understand your child?

I hereby authorize Dr. Ginni Gross, D.C., at Touch Light Chiropractic, and whomever she may designate, to administer care necessary to my child named above.

Parent/Guardian's Name: ____

Parent/Guardian's Signature : _________________________________ **Witness:** _____________________

Date: ____

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Informed Consent to Receive *Network Spinal Analysis™ (NSA)* Care

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor, Ginni Gross who provides ***Network Spinal Analysis (NSA)*** Care, a low force approach which has unique outcomes and clinical results. The practitioner(s) chooses to practice NSA, as Dr. Ginni is professionally and personally confident in regard to the safety and effectiveness of this form of care. This office provides care in accordance with the ***Council on Chiropractic Guidelines*** and the ***Canon of Ethics of the Association for Reorganizational Healing Practice***, and my doctor(s) has been trained in traditional chiropractic care and certified in the procedures of ***Network Spinal Analysis (NSA)*** Care. The purpose of this consent form is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.*** NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office.

I am aware that I will be receiving gentle touch Network Adjustments, also called Entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension, and ease patterns. At regular intervals, following commencement of my care, reassessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and reorganize my spine. ***NSA is advanced through a series of Levels of Care.*** Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with the greater spinal stability, the redistribution of energy, and the transfer of internal information, are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioner(s) may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs.

Please read and sign the following:

I hereby request and consent to the performance of Network Entrainments/Adjustments, including wellness education and any supportive healing modalities on me (or on the practice member named below, for whom I am legally responsible) by the doctor of chiropractic, Ginni Gross, and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic, Ginni Gross, including those working at Touch Light Chiropractic or any other office, whether signatories of this form or not. It has been explained to my satisfaction, and I understand that care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease or malady. Instead, it is a form of

wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

I have had the opportunity to discuss with the doctor of chiropractic, Ginni Gross, and/or with other office personnel, the nature and purpose of the ***Network Spinal Analysis (NSA)*** Care offered in this office. I understand results are not guaranteed and there is no promise of cure.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of body-mind, emotion, and consciousness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to develop new strategies for wellness and spinal and nervous system integrity, as a chiropractor the sole condition of concern is that of vertebral subluxation. In NSA care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nervous system integrity, subluxations are corrected. The only condition we offer to diagnose and correct is vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I further understand and have been informed that there are other treatment options available to me other than the ***Network Spinal Analysis (NSA)*** Care provided in this office and that I have the right to a second opinion and to secure other options if I have concerns to the nature of my symptoms and treatment options.

I have read, or have had read to me, the Consent to Receive Network Spinal Analysis TM (NSA) Care and understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.

______________________________ ______________________________

Signature of Practice Member (Or Guardian, Parent, Representative) Print Name and Relationship if signing for Practice Member

______________________________ ______________________________

Printed Name of Practice Member Date ______________________________

Printed Name of Witness

______________________________ ______________________________

Signature of Witness Date

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

Touch Light Chiropractic, (the "Practice") is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and history as well as the care and treatment you receive from the Practice and other health care providers. This notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment of your care, health care operation of the practice and for other purposes permitted or required by law. This notice also details your rights regarding your PHI.

This Practice employs multiple doctors of Chiropractic and practitioners at any given time. However for purposes of compliance with the Health Information Portability and Accountability Act (HIPAA) Privacy rules, all doctors are deemed to be a part of a single Organized Health Care Arrangement, which means that they operate as an integrated unit; that they will share protected health information in order to carry out chiropractic care (including coverage for each other), payment for services rendered and health care operations; that this notice provided serves as a joint notice made by each doctor, practitioner and staff person and that each of them will abide by the terms of this notice.

We provide most on-going care in an "open adjusting/entrainment" area. It is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. This means that statements made by you or employees of the Practice during treatment may be overheard by others. There are various interpretations under federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting/entrainment" environment are incidental matters. If you have comments or information you wish to share privately when you come into the entrainment room please inform the doctor or staff and we will accommodate your needs.

In the course of your care at Touch Light Chiropractic, we may use or disclose personal and health related information about you in the following ways:

*Your PHI, including your clinical records may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your name, address, phone number and health care records may be used to correspond with you during or after your care. This may include contacting you regarding: appointment reminders, recommendation notices, birthdays, holiday, referral thank-you's, practice events, or other health related information (i.e. Newsletters, e-mails, etc.) that may be of interest to you, as well as other similar correspondence.

Further you have the right to inspect or obtain a copy of the information we will use for these purposes. If you are not at home to receive an appointment reminder call, a message may be left on your answering machine. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. This request must be made in writing. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care to you in an emergency or if we are required by law to provide care and are unable to obtain your consent after attempting to do so.

*If we are ordered by courts or another appropriate agency. Also, when required by law (i.e. case of child abuse and neglect) or for special government functions (i.e. military, veteran) and correctional institutions in the case of inmates.

*If you are involved in a Workers' Compensation claim, we may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

*If we contract with a business associate to provide a service necessary for your treatment, payment for your services, and health care operations (i.e. practice or front desk coverage, billing or transcription service, etc.).

Any use or disclosure of your PHI, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home please advise us in writing.

You have the right to inspect or request a copy of your PHI for seven years from the date the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. The Practice has 30 days to comply. Requests to inspect, copy, or amend your health related information must be made in writing.

We are required by law to maintain the privacy of your patient file and the PHI therein. We are also required to provide you with this notice of our privacy practices with respect to your PHI and to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made we will notify you in writing as soon as possible following the changes.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities please let our staff know.

Your signature indicates your authorization of the policies outline in this notice.

______________________________ Name (printed) ______________________________ Signature

______________________________ Date