INPP Child Screening Questionnaire

Patient Name: _____ Date: _____ / _____ / _____ Age: _____ Sex: _____

Research (published in The British Journal of Occupational Therapy, October 1998) has shown that a score of 7 or more "yes" answers on the questionnaire below indicates that further investigation for underlying neuro-developmental delay is advised for children **over 7 years of age**.

Please check all that applies

☐ Is there any history of learning difficulties in your immediate family?
☐ Were there any medical problems during pregnancy?
☐ Was the birth process unusual or prolonged in any way? E.g. CS, Forceps, etc.
☐ Was your child born early or late for term (more than 2 weeks early or more than 10 days late?
☐ Was your child's birth weight below 5lbs (pounds)?
☐ Did your child have any difficulty feeding in the first weeks of life, or in keeping food down?
☐ Was your child extremely demanding in the first 6 months of life?
☐ Did your child miss out the "motor stage" of crawling on his or her tummy and creeping on hands and knees?
☐ Was your child late at learning to walk (16 months or later would be considered late)?
☐ Was your child late at learning to talk (2-3 word phrases at 18 months or later would be considered late)?
☐ Did your child have difficulty in learning to dress himself or herself, for example, do up buttons or tie shoelaces beyond the age of 6-7 years?
☐ Does your child suffer from allergies?
☐ Did your child have an adverse reaction to any of his or her vaccinations?
☐ Did your child suck his or her thumb beyond the age of 5 years?
☐ Did your child continue to wet the bed, albeit occasionally, above the age of 5 years?
☐ Does your child suffer from travel sickness?

Above 7 years of age

☐ Did your child find it very difficult to learn to tell the time from a traditional (as opposed to digital) clock?
☐ Did your child have an unusual degree of difficulty learning to ride a bicycle?
☐ Did your child suffer from frequent ear, nose, throat or chest infections at any time in development?
☐ In the first 3 years of life, did your child suffer from any illnesses involving extremely high temperatures, delirium or convulsion?
☐ Does your child have difficulty catching a ball, doing forward rolls/somersaults and stand out as "awkward" in PE classes?
☐ Does your child have difficulty sitting still for even a short period of time?
☐ If there is a sudden unexpected noise, does your child over-react?
☐ Does your child have reading difficulties?
☐ Does your child have writing difficulties?
☐ Does your child have copying difficulties?

Additional Information

☐ Has your child had a diagnosis?
If yes, please enter below any additional information that you think may be relevant regarding the possible diagnosis of your child, including previous diagnosis info: _____

_____

_____

_____

FIT FOR LIFE HEALTH SERVICES, P.A.
2960 IMMOKALEE RD SUITE 1 & 2 NAPLES FL 34110
SUZANNE SEEKINS, D.C.,C.C. CHRIS OURGANIAN, D.C. LINDSAY S.T. DODD, D.C.
LINDSAY ORTH, D.C. LORI KREULEN, D.C.

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMTAION

1. 1. I, _____, hereby authorize **Fit For Life Health Services, P.A.**
(Name)
to use and /or disclose to my insurance company for the following specific protected health information.: Progress notes, X-Ray notes, and any other requested correspondence.
2. I understand that this authorization is valid until patients' treatment is completed.
3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, recalls, statements, and anything else necessary for your care.
4. I expressly acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:
_____
_____
6. I understand that this authorization maybe revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand that the revocation of this authorization will not have effect on disclosures occurring prior to the execution of nay revocation.
7. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
8. I understand that my health care and payment for my healthcare will not be affected if I do not sign this form
9. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.
10. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
11. This authorization is valid as of _____/_____/_____, the date I have signed below.

_____ _____
Patient Name (Printed) Patient or Legal Guardian Signature

HIPAA Notice of Privacy Practice for Fit For Life Health Services, P.A.

Protecting the privacy of your Personal Health Information ("PHI") is important to us. Our Notice of Privacy details how information about you may be used and disclosed and how you can get access to that information.

By checking the lines below I authorize being contacted for practice reminders by:

Mail _____;
Email_____; at email address _____;
Telephone numbers; including Text and or Voicemail: _____
(put phone # if different from personal information section) _____;

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____
If applicable - Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

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AUTHORIZATIONS & RELEASES

Consent for Treatment

Chiropractic care; like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. (As a comparison, another interesting fact: 1.2 percent of patients taking one NSAIDS (example: Aspirin, Motrin, Ibuprofen) daily are hospitalized for upper GI problems per year. That is over one in one hundred! Plus, taking one aspirin per day for three years increases the risk of developing cancer by eighty percent!) Prior to receiving care at this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. I the undersigned, hereby authorize, **(please check which one you are appointed with)** ☐ Dr. Suzanne Seekins ☐ Dr. Lindsay Dodd ☐ Dr. Chris Ourganian ☐ Dr. Lindsay Orth ☐ Dr. Lori Kreulen and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests and administer treatment necessary.

Signature: X_____Date:_____

Consent for Treatment of Minor

I hereby request and authorize Dr._____, and whomever he/she designate as his/her assistant(s), to perform diagnostic tests and render Chiropractic adjustments and other treatment as he/she deems necessary to my (indicate relationship to child) _____:_____
(child's name)

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____ _____ _____
Guardian Signature Date Witness

Authorization to Release Medical Information

I authorize the release of my medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this office is correct and complete. **Initial: X**_____

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AUTHORIZATIONS & RELEASES

Request for Payment of Benefits to Provider of Care

I hereby authorize my Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to FIT FOR LIFE HEALTH SERVICES, P.A., and the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given any power of attorney to endorse/sign my name on any and all draft for payment of my bill.

I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account

_____ _____ _____

Signature legal representative Date Witness

Assignment of Benefits & ERISA

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Minor Name:_____

Signature of Guardian:_____ Date:_____