C.A.F.E. OF LIFE
CHIROPRACTIC WELLNESS CENTER

PATIENT APPLICATION FORM:
CHILD

WELCOME and THANK YOU for trusting us with your child/children applying as patient(s) in our clinic. We are a very unique team specializing in researched, evidence-based, spinal pediatric adjusting and postural rehabilitation that has helped infants, young children, and even teenagers with early onset to advanced spinal distortion and injuries known to cause developmental and lifelong health problems. Because of this specialized approach, we may not accept your child as a patient until we are absolutely certain we know the cause of their condition; perform the necessary tests to determine the optimal program of correction, and we are completely confident you and your child place their health as a TOP PRIORITY. At that time we will make specific recommendations. Thank you again for giving your child the opportunity to apply as a patient.

_____

PATIENT NAME

_____

DATE COMPLETED

Patient Information

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Birth Date: _____ /_____ /_____

City, State, Zip: _____ Cell Phone: ( ) _____

Name of Mother/Guardian: Home Phone: ( ) _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (if different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

Name of Father/Guardian: Home Phone: ( ) _____

Birth Date: _____ /_____ /_____ (Age) _____ Marital Status: S M D W Work Phone: ( ) _____

Home Address (if different): _____ Cell Phone: ( ) _____

City, State, Zip: _____ Email: _____

Employer Name: _____ Occupation: _____

How were you referred to this office? _____

Purpose For This Visit

Reason for this visit: _____

Is this related to an accident or specific injury (other than auto or work-related)*? ❑ Yes ❑ No If yes, when: _____ /_____ /_____

If your child's symptoms are the result of an auto accident or work-related injury, please ask the front-desk person for the corresponding application.

Describe incident or reason for onset of symptoms: _____

_____

Please use the *General Symptoms Chart* on the next page to provide a detailed notation of your child's symptoms.

When did these symptoms begin? _____ /_____ /_____ Are they: ❑ Constant ❑ Intermittent ❑ Activity-related

Are they getting worse? ❑ Yes ❑ No Do they interfere with: ❑ School ❑ Sleep ❑ Hobbies/Play ❑ Daily Routine

Explain: _____

_____

What activities aggravate these symptoms? _____

Is there anything that relieves your symptoms? ❑ Yes ❑ No If yes, explain: _____

Has your child experienced these symptoms before (if not accident/injury related)? ❑ Yes ❑ No

If yes, explain: _____

_____

Has your child been treated for this? ❑ Yes ❑ No When was the last treatment? _____ /_____ /_____

Name of treating practitioner/facility? _____

What treatment(s) was performed? _____

_____

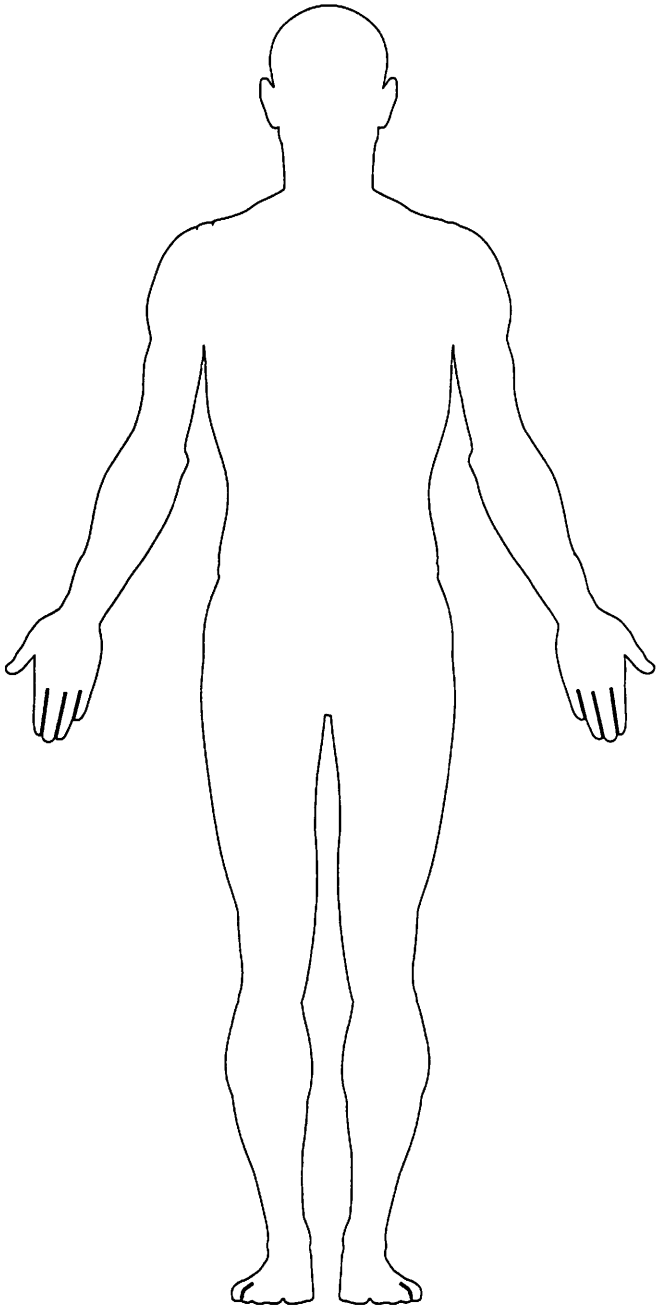
How did your child respond? _____

_____

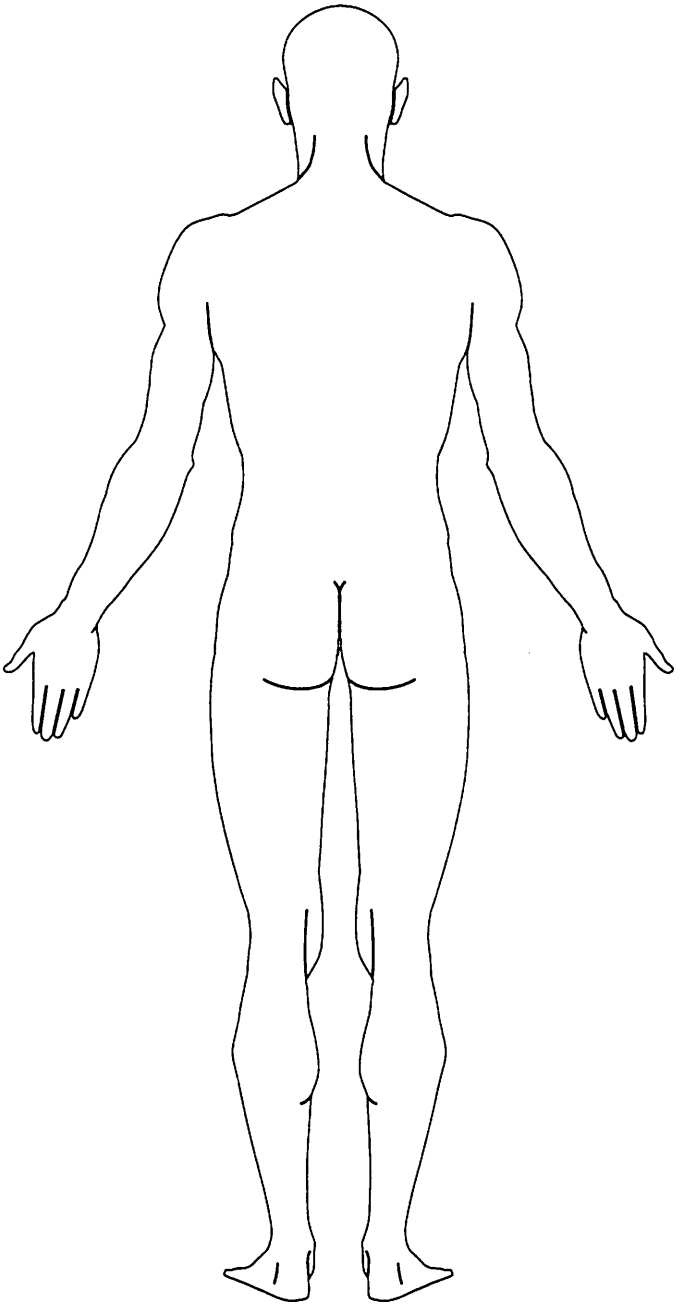
GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your child's symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	T = TINGLING
P = PINS & NEEDLES	F = STIFFNESS	O = OTHER



FRONT



BACK

If you marked "O" for Other on any part, please explain below:

Health Conditions *continued...*

CERVICAL SPINE (NECK)

Misalignment of the individual vertebrae or distortion of the complete cervical curve (neck) originating in the neck or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Neck Pain
____ Pain in shoulders/arms/hands
____ Numbness/tingling in arms/hands
____ Hearing disturbances
____ Weakness in grip
____ Colic
____ Sore throats
____ Auto-Immune Diseases
____ Headaches
____ Dizziness
____ Visual disturbances
____ Coldness in hands
____ Thyroid conditions
____ Ear Infections
____ Learning disabilities
____ Other (please explain)
____ Sinusitis
____ Allergies/Hay fever
____ Recurrent colds/Flu
____ Low Energy/Fatigue
____ TMJ/Pain/Clicking
____ Flu/Stomach disorders
____ Hyperactivity/ADD

Explanation(s): _____

_____

_____

THORACIC SPINE (UPPER BACK)

Misalignment of the individual vertebrae or distortion of the upper thoracic curve (upper back) originating in the upper back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Heart Palpitations
____ Shingles
____ Upper Back Pain
____ Recurrent Lung Infections/Bronchitis/Pneumonia
____ Heart Murmurs
____ Shortness Of Breath
____ Pain On Deep Inspiration/Expiration
____ Asthma/Wheezing
____ Tachycardia (fast heart beat)
____ Other (please explain)

Explanation(s): _____

_____

_____

THORACIC SPINE (MID BACK)

Misalignment of the individual vertebrae or distortion of the mid thoracic curve (mid back) originating in mid back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Mid Back Pain
____ Pain in Ribs/Chest
____ Indigestion/Heartburn
____ Liver problems
____ Tired/Irritable after eating or when not having eaten for a while
____ Nausea
____ Ulcers/Gastritis
____ Reflux
____ Spleen problems
____ Diabetes
____ Hypoglycemia
____ Diabetes
____ Other (please explain)

Explanation(s): _____

_____

_____

Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span.[1] Please answer the following questions accurately so we may determine the full extent of your child's condition.

HISTORY OF TRAUMA

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Were involved in a car accident (***if you check this item, please ask the front desk person for the corresponding form***)
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)

Explanation of (*) item(s): _____

_____

BIRTH EXPERIENCE:

How long was labor? _____

Describe any complications: _____

_____

Type of delivery: ❑ Vaginal ❑ C-Section ❑ Vacuum Extraction ❑ Forceps Assistance

VACCINATION HISTORY

What vaccinations has your child received (please note at what age and where each was received):

1. _____ Age: ____ ❑ Mos. ❑ Yrs. Where received: _____
2. _____ Age: ____ ❑ Mos. ❑ Yrs. Where received: _____
3. _____ Age: ____ ❑ Mos. ❑ Yrs. Where received: _____
4. _____ Age: ____ ❑ Mos. ❑ Yrs. Where received: _____
5. _____ Age: ____ ❑ Mos. ❑ Yrs. Where received: _____

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

____ Swelling, redness, heat/hardness of site
____ Body rash or hives
____ High fever (over 103 degrees)
____ High-pitched screaming
____ Extreme sleepiness or unresponsiveness
____ Body twitching or paralysis
____ Breathing problems (asthma, etc.)
____ Excessive bleeding or anemia
____ Head banging
____ Excessive diarrhea or chronic constipation
____ Loss of memory/foggy state
____ Muscle weakness
____ Chronic ear or respiratory Infections
____ Vision or hearing disturbances
____ Joint pain
____ Crossing of eyes
____ Seizures
____ Other (please explain)

Explanation(s): _____

_____

_____

_____

1. Postural and Degenerative Kyphosis: Freeman JT. Posture in the Aging and Aged body. JAMA 1957, Oct 19: 843-846.

Health Conditions *continued...*

LUMBAR SPINE (LOW BACK)

Misalignment of the individual vertebrae or distortion of the lumbar curve (low back) originating in the low back or a compensation from postural distortions in other areas of the spine may result in many health conditions. Has your child experienced any of these symptoms presently or in the past?

Please indicate (N) = Now, (P) = Past next to all conditions you've experienced or both if applicable.

____ Pain in hips/legs/feet
____ Numbness/tingling in your legs/feet
____ Frequent/difficulty urinating
____ Menstrual irregularities/cramping (females)
____ Weakness/injuries in hips/knees/ankles
____ Recurrent bladder infections
____ Muscle cramps in legs/feet
____ Other (please explain)
____ Low back pain
____ Coldness in legs/feet
____ Constipation/Diarrhea

Explanation(s): _____

_____

_____

OTHER

Please list any health conditions not mentioned: _____

_____

Please list any medications (include name, dose, for what condition, and how long your child has been taking it): _____

_____

_____

_____

Please list any surgeries (include type of surgery and date it was performed): _____

_____

_____

_____

Family Health History

Have any of your family members ever been diagnosed with the following? ***If so, please indicate "P" for your child (patient), and "O" for Other than your child, or both if applicable (Items marked with an asterisk, please offer a detailed list or explanation).***:

____ ADD
____ Arthritis
____ Broken bones/fractures
____ Circulatory problems
____ Ear Infections
____ Fetal drug exposure
____ Heart disease
____ High blood pressure
____ Kidney Disease
____ Measles
____ Neurological problems
____ Pneumonia/Bronchitis
____ Scoliosis
____ Spinal Bifida
____ Tuberculosis
____ Allergies/Hay fever*
____ Asthma
____ Cancer
____ Crohn's/Colitis
____ Eczema
____ Food allergies*
____ Heart murmur
____ HIV
____ Liver disease
____ Metal implants
____ Osteoporosis
____ Polio
____ Seizure disorder
____ Stroke
____ Varicose veins
____ Anemia
____ Bed wetting
____ Cerebral Palsy
____ Depression
____ Eczema/Psoriasis
____ Gall bladder
____ Hepatitis
____ Infectious disease
____ Lumbago
____ Migraine headaches
____ Paralysis
____ Rash
____ Sickle cell anemia
____ Thyroid problems
____ Whooping cough
____ Appendectomy
____ Blood sugar problems
____ Chicken pox/shingles
____ Diabetes
____ Epilepsy/seizures
____ Headaches
____ Hernia
____ Influenza
____ Lung disease
____ Mumps
____ Pleurisy
____ Rheumatic fever
____ Small Pox
____ Tonsillectomy
____ Other*

Explanation of (*) item(s): _____

_____

Experience with Chiropractic

Has your child seen a Chiropractor before? ❑ Yes ❑ No Who?_____

Reason for visit(s): _____

Did the previous chiropractor take 'before' and 'after' x-rays? ❑ Yes ❑ No What was the diagnosis? _____

Did he or she recommend a specific course of treatment? ❑ Yes ❑ No Did they recommend a Home Health Care program? ❑ Yes ❑ No

If yes, what?_____

How long was your child treated? _____ Last treatment: _____/_____/_____

How did your child respond? _____

Are you aware of any poor posture habits in your child? ❑ Yes ❑ No Is there any history of spinal problems in your family? ❑ Yes ❑ No

If yes, explain: _____

_____

_____

Pregnancy Release

This is to certify that to the best of my knowledge that my child is not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____/_____/_____

Guardian Signature _____ Date _____/_____/_____

Authorization of Care

I authorize and agree to allow the doctor and/or his designated staff to work with my child's spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if my child/charge does not follow the doctors and/or staff's specific recommendations at this clinic that he/she will not receive the full benefit from these programs; and that if I terminate this care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature _____ Date _____/_____/_____

Patient's Name Printed _____

If patient is not your biological child, but a legal charge requiring guardianship for treatment, please complete the following:

Date Guardianship Awarded _____ County, State of Guardianship _____

I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.

Guardian Signature _____ Date _____/_____/_____

In Case of Emergency

Name _____ Relationship _____

Work Phone ( ) _____

Home Phone ( ) _____

Cell Phone ( ) _____

Insurance

We may accept assignment of insurance benefits. By signing this policy, you agree to assign your insurance benefits to this clinic. In cases where benefits are not assignable or in any case where your benefit is processed directly to you regardless of assignment, you agree to submit any payments received along with the explanation of benefits to this clinic within 10 days of receipt unless you have paid for the services represented by said payment in full at the time of service. In no case will an assignment alleviate you of your obligation for payment of services received.

Your insurance plan is a contract between you and your insurance company. This clinic is not a party to that contract and therefore cannot modify the terms of that contract. Payment for treatment you receive from this clinic is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you provide us with the necessary billing information, assign your benefits to this clinic and agree to permit us to release the necessary medical information required to secure payment. In the event we do accept assignment of benefits we require that you provide a credit card with authorization to bill that account any balance or make other payment arrangements. We will make every effort to ensure that your insurance carrier properly processes your services for payment. In some circumstances we may require your assistance. If your insurance company has not paid your account in full within 60 days and you refuse to assist us in dealing with your carrier, the balance will be automatically be transferred to your credit card or the extended payment plan.

NOTE: Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance program. If you are unsure as to the nature of the service you are receiving, please ask your doctor. For coverage information, it is your responsibility to review your benefit contract.

ITEMIZED RECEIPTS, aka. "SUPERBILLS"

Our fees and charges are based on the cost of doing business and providing patients with the highest quality of care possible. This office does not participate with any insurance provider or accept such an assignment. Patients are responsible for payment of any services provided. You will be given a receipt with a description of services received, more commonly referred as a "superbill", along with the related charges that you, in turn, can submit to your own insurance company for possible reimbursement, as well as retain for your personal records.

DECLARATION

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The doctor's office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services? ❑ Yes ❑ No

Signature of Person Authorizing Care:

_____ Date _____/_____/_____

Relationship to Insured _____ Date of Birth _____/_____/_____

Employer _____

Primary Insurance Company_____ Policy#_____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____-_____-_____

Secondary Insurance Company_____ Policy#_____

Address Phone # ( ) _____

Insured's Name _____ Insured's Social Security #: _____-_____-_____

ASSIGNMENT OF BENEFITS. AUTHORIZATION FOR RELEASE OF INFORMATION AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

Assignment of Benefits/Financial Responsibility
The undersigned hereby authorizes C.A.F.E. of Life Chiropractic, Dr. Alfonso Di Carlo (hereinafter "the Provider") to file on my behalf for payment of any medical benefits arising out of any insurance or health plan benefits and hereby assign the benefits to the Provider. I certify that the information reported with regard to my insurance coverage, health care benefits and medical history is accurate and complete. I understand that I am liable for payment to the Provider for all co-insurance, co-pays and deductibles as required by my insurance or health benefits plan and I also acknowledge that I am responsible for payment of any charges not covered by my insurance or health benefits plan. Payment is required at the time services are rendered unless other payment arrangements are made, in advance.

Designation of Authorized Representative
The undersigned also designates the Provider to the fullest extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") as provided in 29 CFR 2560-503-l(b)(4) and under any applicable state and federal law to pursue claims and appeals on my behalf and exercise all rights connected with my health care benefit plan or insurance policy including but not limited to initial claims determinations, appeals of any benefit determinations, obtaining records and related plan documents. claiming on my behalf medical or other health care benefits, pursuing insurance or plan reimbursement and to pursue any other applicable remedies as may be necessary and with regards to my health benefit plan or insurance policy along with any incidental powers and duties to effectuate same.

Authorization for Release of Information
The undersigned authorizes the Provider to release any medical or other information necessary to determine benefits to my insurance carrier, employer, plan administrator, or any other payer including any information regarding my illness and treatments and for the processing of benefits or insurance claims generated in the course of examination or treatment. The undersigned hereby authorizes _____(employer) to furnish to the Provider a copy of all health care plans documents or information requested by the Provider and pursuant to 29 U.S.C. § 1024(b)(4). which includes but is not limited to the latest summary plan documents, plan descriptions, latest annual reports, terminal reports, applicable collective bargaining agreements, trust agreements, contracts or other instruments.

Revocation and Acknowledgement
A photocopy of this authorization shall be considered the same as the original and can be used to process insurance or health benefit claims. The undersigned acknowledges that he/she has the right to revoke this authorization and designation of authorized representative, in writing, by sending notification to the Provider; however, the undersigned understands that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I also understand that if I suspend or terminate my care and service, any fees for professional services rendered to me will be immediately due and payable. I further agree that should my insurance company fail to remit payment within 60 days or if my current policy prohibits directs payment to the doctor, then I hereby will endorse the paychecks or make payment of my entire balance incurred to C.A.F.E. of Life Chiropractic. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney(s) involved in this case; and hereby release this office of any consequence thereof. I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to this office. The professional or medical expenses benefits allowable, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment according to the financial policy of the above assignee. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize the use of this form as signature on file on all my insurance submissions.
I have read and understand the preceding information:

_____ **Patient's Name (Please Print)**

_____ **Dr. Alfonso Di Carlo**

_____ **Signature of Insured and/or Claimant, if other than insured**

_____ **C.A.F.E. of Life Chiropractic (Signature)**

Date _____/_____/_____

Tax ID# 23-3066485

C.A.F.E. of Life Chiropractic
Dr. Alfonso Di Carlo
4540 Hamilton Blvd. * Allentown, PA 18103
(610) 366-1336

PATIENT CONSENT FORM - HIPAA

Our Notice of Privacy Practices provides information about how C.A.F.E. of Life Chiropractic, Inc. (the "Practice") may use and disclose protected health information ("PHI") and electronic protected health information ("EPHI") about you. The Notice became effective on April 13, 2003, and contains a Patient Rights section describing your rights under the law. Please review our Notice thoroughly before signing this Consent form. The terms of our Notice was revised as of November 13, 2006 (pf-hipaa-03310302).

You have the right to request that we restrict how PHI & EPHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you acknowledge and consent that our Practice may use and disclosure PHI & EPHI about you for treatment, payment and health care operations. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form expires on 12/31/2090.

The patient understands that:

- PHI & EPHI may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has had the opportunity to review this notice and request a copy.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their PHI & EPHI but the Practice does not have to agree to those restrictions.
- The Practice may display your name, and contact you via email and with your signed consent to release any photographs taken of postural alignment; which is a routine part of your medical record.

It is the practice of this office to provide chiropractic care in an "open adjusting" environment and patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT for taking patient history procedures which are completed in a private, confidential setting. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures' of health information.

Patient Name:_____Signature: _____

Date_____Witnessed by: _____
(Signature of Practice Representative)

Name of Parent/Guardian (if signed by other than patient or minor):_____

Relationship to Patient: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below 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 named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc 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, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if I wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

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

Name of Patient:_____

Signature of Patient:_____

Name Printed of Guardian/Parental and Relationship to Patient:_____

Guardian/Parental Signature:_____

Date:_____

Doctor of Chiropractic Name:_____

Signature of Doctor of Chiropractic:_____

Date: