CURIS FUNCTIONAL HEALTH
PEDIATRIC HISTORY FORM

Today's Date: _____

PATIENT DEMOGRAPHICS

Child's Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Birth Height: _____ Birth Weight: _____ Current Height: _____ Current Weight: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Birthdate: _____-_____-_____

Mother's Phone: Home _____ Work _____ Mobile _____

Father's Name: _____ Birthdate: _____-_____-_____

Father's Phone: Home _____ Work _____ Mobile _____

Pediatrician/Family MD: _____ City/State: _____

Last Visit Date: _____-_____-_____ Reason for visit: _____

CHILD'S CURRENT PROBLEM

Purpose of this visit: ○ Wellness Check-up ○ Injury or Accident ○ Other

Please explain: _____

If your child is experiencing **pain/discomfort, please identify where and for how long:**

_____

_____

1. When did the problem first begin? Date: _____-_____-_____ ○ Unknown ○ Gradual ○ Sudden
2. Has this problem occurred before? ○ No ○ Yes If yes, when? _____
3. Any bowel or bladder problems since this problem began? ○ No ○ Yes **If yes,** describe: _____

   _____
4. Have you seen any other doctors for this problem? ○ No ○ Yes **If yes**, whom? _____
5. How long ago? _____ Days _____ Weeks _____ Months _____ Years
6. What were the results of past treatment? _____
7. How is this problem NOW?

   ○ Rapidly Improving ○ Improving Slowly ○ About the Same ○ Gradually Worsening ○ On and Off
8. Please list any medication(s) taken for this problem: _____
9. Has your child ever sustained an injury playing organized sports? ○ No ○ Yes **If yes,** please explain:

_____

10. Has your child ever sustained an injury in an auto accident? ○ No ○ Yes **If yes,** please explain:

_____

_____

HAS YOUR CHILD EVER SUFFERED FROM - *Check all that apply*

○ Headaches	○ Orthopedic Problems	○ Digestive Disorders	○ Behavioral Problems
○ Dizziness	○ Neck Problems	○ Poor Appetite	○ ADD/ADHD
○ Fainting	○ Arm Problems	○ Stomach Aches	○ Ruptures/Hernia
○ Seizures/Convulsions	○ Leg Problems	○ Reflux	○ Muscle Pain
○ Heart Trouble	○ Joint Problems	○ Constipation	○ Growing Pains
○ Chronic Earaches	○ Backaches	○ Diarrhea	○ Asthma
○ Sinus Trouble	○ Poor Posture	○ Hypertension	○ Walking Trouble
○ Scoliosis	○ Anemia	○ Colds/Flu	○ Sleeping Problems
○ Bed Wetting	○ Colic	○ Broken Bones	○ Fall off swing
○ Fall in baby walker	○ Fall from bed or couch	○ Fall from crib	○ Fall down stairs
○ Fall off bicycle	○ Fall from high chair	○ Fall off slide	
○ Fall from changing table	○ Fall off monkey bars	○ Fall off skateboard/skates	

○ Allergies to _____

○ Other: _____

I understand that I am directly and fully responsible to Flower Mound Chiropractic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration, I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____ - _____ - _____

Parent or Legal Guardian's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Flower Mound Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (print)

_____ ____/____/____ _____ *Office Initials*
Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our front desk staff for further explanation.*

☐ The first day of my last menstrual cycle was on ____/____/____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below, I am acknowledging that the doctor has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration, I therefore do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____
Patient Name (print)

_____ ____/____/____ _____ *Office Initials*
Patient or Authorized Person's Signature Date

Flower Mound Chiropractic - NOTICE OF PRIVACY PRACTICES

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization.

PERMITTED DISCLOSURES:

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. Emergency - in the event of a medical emergency we may notify a family member.
5. For Public health and safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or public.
6. To Government agencies or Law enforcement - to identify or locate a suspect, fugitive, material witness or missing person.
7. For military, national security, prisoner, and government benefits purposes.
8. Deceased persons - discussion with coroners and medical examiners in the event of a patient's death.
9. Telephone calls or emails and appointment reminders - **we may call your home and leave messages** regarding a missed appointment or notify you of changes in practice hours or upcoming events.
10. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours), including an X-ray disc.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr Nick Ponomarenko, D.C. at (972-539-2323) If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Flower Mound Chiropractic NOTICE REGARDING YOUR RIGHT TO PRIVACY

I have received a copy of Flower Mound Chiropractic Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name Date

_____

Patient's Signature

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your protected health information (PHI) will be used by this office and/or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used or disclosed. It describes your rights as they concern the limits use of health information including your demographic information collected from you and created or received by this office. You may review the notice prior to signing this consent. You may request a copy at the front desk. This office reserves the right to modify the Privacy Practices outlines in the notice.

Restriction on the use or disclosure of your information: You may request a restriction on the use or disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment or health care operations.

Revocation of consent: You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I _____ (**print**) acknowledge that I have reviewed the above information and **(A)** do or **(B)** do not authorize this office to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster for the purposes of processing my claim for benefits and payment of services rendered to me. I do understand that if I choose to refuse release of this information, that my PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Flower Mound Chiropractic may speak with the following individuals or entities about PHI:

Spouse: _____

Parent/Child: _____

Employer: _____

Attorney: _____

Other: _____

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

Dr Nick Ponomarenko, D.C.
Flower Mound Chiropractic
5810 Long Prairie Road, Suite 300
Flower Mound, TX 75028

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, any and all medical benefits and/or any insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of all medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative 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, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) 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 chose in action or right 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.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_____

Patient Signature

_____

Date

Procedure Code Acknowledgment

Dear Patient,

We would like to take this moment to explain our billing process and procedures. Please read this carefully so you will understand how we bill our insurance carrier for services provided at this office.
We provide chiropractic, massage, and various corrective therapy services from this clinic and we would like you to be aware of common billing codes that we may use so that you can understand exactly what services were provided to you when you receive an explanation of benefits from your insurance carrier to avoid any confusion. We also want to make sure that you know the explanation of benefits that you will receive in the mail from your insurance carrier is NOT a bill. Dr. Nick will discuss any payment that you will be responsible for before treatment is provided.

Commonly used codes:
Evaluation and Examination Codes: 99203 & 99212; this is your initial Exam and re-exam codes that are a billable service.

Strapping Codes: Commonly strapped areas; mid to low back, shoulders, elbows, wrists, hips, knees, ankles, and feet. Please be aware that these may show up as a "surgical procedure" on your explanation of benefits, however it is not. This taping is used to stabilize, protect, and increase healing process to an injured area.
Other common codes:

Manual Therapy: 97140, 97150 & 97530 Massage Therapy: 97124 Heat Therapy: 97010
Electrical Stimulation: 97014 Traction: 97012 Adjustment Codes: 98940, 98941 & 98943

By signing this, you acknowledge our billing system and coding. If you have any questions, please feel free to ask the office staff or Dr. Nick Ponomarenko for clarification.

_____ _____

Patient's Signature Date

MAINTENANCE POLICY

Chiropractic, massage, and various physical therapy treatments are an important part of helping you achieve optimal health. However, your ability to access these benefits as provided by your insurance company is subject to the rules, regulations, and policy language set forth in your specific insurance plan. Often times there is a misunderstanding regarding what types of treatments are "covered and deemed 'medically necessary'". It is important to note that all insurance companies have detailed policy language that indicates chiropractic, massage, and physical therapy for **MAINTENANCE** are **NOT** considered medically necessary.
Please read the following examples of corporate medical policies regarding "maintenance therapies"

BCBS Premera
When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is considered maintenance therapy. **Maintenance therapy is not a covered benefit.**
BCBS Regence, & BCBS
Chiropractic maintenance therapy is considered **not medically necessary.**
Aetna
Once a maximum therapeutic benefit has been achieved, continuing chiropractic are is not considered medically necessary and thus is not covered. **Preventative or maintenance therapy is not covered.**
Centers for Medicare Services (CMS)
MEDICARE: When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. **Maintenance therapy is no considered medically necessary.**
Once a functional status has been remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulation **treatment is considered maintenance therapy and is not medically necessary.**
United Health Care
Once a maximum benefit has been reached, continuing chiropractic care is considered **not medically necessary.**
Chiropractic therapy is considered to be maintenance therapy is any of the following apply:

- Further clinical and functional improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment has become supportive rather than corrective in nature.
- The treatment plan seeks to prevent disease, promote health, and prolong and enhance the quality of life.
- Therapy is performed to maintain or prevent deterioration of a chronic condition, including but not limited to intermittent treatment for recurrent symptoms unrelated to a new injury.

By signing below, I acknowledge that I have been informed regarding the medical necessity of Maintenance Care and I understand that it is not a covered benefit under my insurance plan and agree to pay out-of-pocket for these services.

Patient Name:_____ Signature:_____ Date_____

PREMERA BLUE CROSS Regence Aetna CMS CENTERS for MEDICARE & MEDICAID SERVICES UnitedHealthcare