2251 Double Creek Dr, Suite #501, Round Rock, TX 78664
512-246-0220, ext. 2

Child & Adolescent Initial Questionnaire

Appt. Date: _____ Referred By: _____
Name (first, middle, last) _____ Preferred Name: _____
Address_____ City _____ State ____ Zip_____
Home Phone (____) _____ Mom Cell (_____) _____ Dad Cell (_____) _____
Social Security # _____ Date of Birth___/___/___ Age____ ☐Male ☐Female
Mother's Name _____Father's Name _____
Email Address: _____

1. **Tell us about your pregnancy;**
   Did you carry to full term? ☐Yes ☐No If not, how long? _____
   Describe any complications and when they occurred: _____
   _____

2. **Tell us about your delivery and birth of this child:**
   Did you use a midwife? ☐Yes ☐No
   Did you go to a hospital? ☐Yes ☐No
   Did you use an obstetrician? ☐Yes ☐No
   Did you have a C-Section? ☐Yes ☐No
   Was it a difficult birth? ☐Yes ☐No
   Were forceps used? ☐Yes ☐No
   Vacuum Extraction? ☐Yes ☐No
   Were you induced? ☐Yes ☐No
   Did you have an Epidural? ☐Yes ☐No
   How much did the baby weigh? _____

   What was the baby's **APGAR** Score? _____ At 5 minutes? _____

3. **Tell us more:**
   Did you breastfeed? ☐Yes ☐No How long? _____ What formula after? _____
   Did you consume alcohol during your pregnancy? ☐Yes ☐No If so, how much? _____
   Did you smoke? ☐Yes ☐No If so, how much?_____How long? _____
   Did you take any medication during your pregnancy? ☐Yes ☐No
   What type and for what? _____
   _____
   Any exposures to ultrasound? ☐Yes ☐No How many?_____

4. **As a baby/toddler, (birth to 4 years), did any of the following occur?**

☐ Fall from a change table	☐ Frequent crying spells	☐ Play in a Jolly Jumper
☐ Tumble down stairs	☐ Frequent fevers	☐ Frequent colds
☐ Fall out of crib	☐ Frequent bouts of diarrhea	☐ Frequent ear infections
☐ Involved in car accident	☐ Constipation	☐ Colic
☐ Fall off playground equipment	☐ Sleeping problems	☐ Tonsillitis
☐ Did not gain weight	☐ Reaction to vaccination	☐ Other: _____

   Please explain the above: _____

5. **As a young child, (5-12 years), did any of the following occur?**

☐ Fall from a tree	☐ Fall off a bicycle	☐ Fall off playground equipment
☐ Sports accident	☐ Car accident	☐ Bed wetting
☐ Hyperactivity/Autism	☐ Learning difficulties	☐ Stomach pains
☐ Asthma	☐ Allergies	☐ Leg/knee pains
☐ Scoliosis	☐ Other: _____	

   Please explain the above: _____

6. List any vaccinations your child has had:_____
_____
_____
_____

Any reactions to these? ☐Yes ☐No If so, what reaction? Please describe: _____
_____
_____

7. As a child or adolescent, has your child experienced any of the following:

☐ Headaches	☐ Numbness in arms/hands	☐ Foot/ankle/knee pains
☐ Dizziness	☐ Arm/wrist pain	☐ Tingling in arms/legs
☐ Ringing in ears	☐ Sleeping problems	☐ Neck/back pains
☐ Asthma	☐ Allergies	☐ Shoulder pains
☐ Hyperactivity	☐ Stomach problems	☐ Growing Pains
☐ Fatigue	☐ Weight gain/loss	☐ Other _____

Please explain any of the above: _____
_____

8. Which of the problems you have checked off is the worst? _____

Is this problem: (check one): ☐Constant ☐Intermittent ☐Occasional ☐Cyclic
How long has it persisted? _____
When it is at its worst, how does it make your child feel? _____
What have you done about it that has NOT worked? _____
What makes it worse? _____

9. What effect does this problem have on your child's body functions? _____
_____

Does it have any effect on his/her participation in daily activities? ☐Yes ☐No If yes, please explain: _____
_____

10. Describe any hospital stays: _____

11. Approximately how many times have antibiotics been prescribed and for what conditions?
_____

12. List any medications your child is currently taking: _____
_____

13. To summarize, what is your purpose for this appointment? _____
_____

14. Is there anything else you feel we should know? _____
_____
_____

Name of Parent or Guardian: _____ Date: _____

Signature of Parent or Guardian: _____

FAMILY HEALTH HISTORY

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation "C" under his/her column, and those that are past health problems by the designation of "P" under his/her column. Leave blank those spaces which do not apply.

	Father	Mother	Siblings			
Condition:	**Age: _____**	**Age: _____**	**Age: ____**	**Age: ____**	**Age: ____**	**Age: ____**
ADHD						
Allergies						
Arthritis						
Asthma						
Autism						
Back Trouble						
Bed Wetting						
Bursitis						
Cancer						
Chest Pain						
Colic						
Constipation						
Crohns Disease						
Depression						
Diabetes						
Diarrhea						
Disc Problems						
Down Syndrome						
Ear Infection						
Emotion Issues						
Emphysema						
Epilepsy						
Headaches						
Migraines						
Heartburn						
Heart Trouble						
High Blood Press						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney Trouble						
Neck Pain						
Neuritis						
Nervousness						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Acid Reflux						
Other: _____						

RELEASE AND CONSENTS

AUTHORIZATION TO TREAT A MINOR CHILD

I authorize Dr. Blair Spiller and/or Dr. Amanda Ulloa, licensed Doctors of Chiropractic in the state of Texas, to administer diagnoses and treatment as deemed necessary to my son/daughter/other: _____ I also authorize the provider(s) to release any information required to process insurance claims.

Child's Name: _____

Signature of Guardian: _____

Relationship to Patient: _____

Date: _____

CONSENT TO X-RAY EXAMINATIONS

If and when deemed necessary, I do hereby consent to X-ray examination to be performed by an outside facility.

Females: I will notify the doctors if I believe that I could be pregnant so that the proper precautions will be taken.

Last Menstrual Period Date _____

Signature of Responsible Person: _____ Date: _____

HIPAA Consents

Name of Practice: Holistic Chiropractic and Wellness, Inc.
Address: 2251 Double Creek Dr, Suite #501, Round Rock, TX 78664
Privacy Contact: Dr. Blair Spiller, D.C.
Telephone: 512-246-0220

* I hereby authorize Holistic Chiropractic and Wellness, Inc to release periodic status reports from the medical records of the patient listed below. The reports may be released to other physicians or facilities participating in my care.
* I understand my records are confidential and cannot be disclosed without my written authorization, except otherwise provided by law.
* I understand that records pertaining to the diagnosis and/or treatment of HIV/AIDS testing, psychiatric illness and alcohol or chemical abuse dependency will not be released unless I have given my specific consent to release this information.
* I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it and that this authorization will automatically expire on one year from date signed.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.
* I authorize the release of any medical billing or other information necessary to process claims on my behalf.
* I agree to be fully responsible for all lawful debts incurred by myself (or dependents under care) for services received from Holistic Chiropractic and Wellness, Inc.
* I understand that any verbal consent or intent to use photographs or social media network sharing by the patient or provider is protected as valid written consent when patient, other patient, or provider agreed on photographed educational testimonies.

** I understand that I do not have to sign this authorization in order to receive treatment from this practice, but when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I acknowledge that I was provided with the Notice of Privacy Practices of the Chiropractic Practice named at the top of this page.

Printed Name of Patient: _____
Signature of Patient: _____
Date: _____
Patient's Date of Birth: _____

For Personal Representative of the Patient *(only if applicable)*

Print Name of Personal Representative: X_____
Relationship (parent, guardian, etc.): X_____
Signature of Personal Representative: X_____
Reason Patient unable to sign: _____

_____ _____
Practice Employee Date

ALL PATIENTS PLEASE PROVIDE THE FOLLOWING

☐ By checking this box you agree to receive text messages at the number provided. Message frequency varies. Standard message and data rates apply. To opt out, reply "STOP" to any message you receive from us. Reply "HELP" for assistance.

May we release appointment, billing, and medical information to anyone other than you? ☐ YES ☐ NO

Name(s) of the person(s) we may release your information to: _____

Please check one box below:

If our office attempts to contact you and a message/voicemail is left, it is appropriate to leave a:

☐ Detailed message regarding condition, appointments, or payments.

☐ Message to call Round Rock Health & Wellness Center

2025, Patient Name: _____

TO OUR VALUED PATIENTS:

Thank you for choosing RRHWC for your care. We are committed to providing you with the best possible service. Please review our office policies below. If you have any questions, please ask one of our staff to assist you with an explanation.

TIME OF SERVICE PAYMENT

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable and estimated co-insurance and copayments under your insurance policy, deductible amounts, and non-covered services. If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice.

INSURANCE

As a courtesy to you, we will bill your insurance company for the services rendered. You are ultimately responsible for payment of all services including denials, non-covered services, or outstanding balances after your insurance carrier pays. Our staff will give you an *estimate* of what you'll owe each visit. Please be sure to inform the front office staff of any changes in your policy or information. If you do not have your insurance card with you, your account will be considered self-pay until you provide us with the appropriate documents.

REFERRALS

Your insurance may require a prior authorization for some services. It is your responsibility to make sure your PCP has submitted this authorization to your insurance carrier by the time of your visit. Without required authorization, you will be responsible for full payment at the time of service until the required documents are submitted.

NO-SHOW/CANCELLATION POLICY AND FEE

A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. We therefore request that patients who are unable to keep their scheduled appointments notify us in advance so the time might be made available to someone else. We require a minimum notice of 24 hours (or before 1pm on Saturday for a Monday appointment). Appointments that are canceled without required notice, including same day cancellations, will be subject to a fee of $25 for the first cancellation and up to the full service cost for repeated incidents.

GOOD FAITH ESTIMATE

The purpose of this information is to eliminate the major reason that patients do not follow through with the correction of their health problem—finances. We understand how confusing insurance coverage can be. The following is intended to inform you of our charges as accurately as we can. If you do not have health insurance, choose not to bill your health insurance, or if your health benefit plan does not provide coverage for all the health care services you are scheduled to receive, we have self-pay rates that are compliant with our state and federal regulations. We also offer discounted care plans for those not using insurance which will be provided to you at your second visit.

Description of Service	Code Billed	BCBS Rate	Aetna Rate	UHC Rate	Self-Pay Rate
New Patient Exam	99203	$67.70	$91.40	No contracted	$95
Re-exam	99212	$25.82	$46.52	rate, up to $65	$49
Adjustment, 1-2 regions	98940	$21.69	$16.00	allowed per DOS.	$40
Adjustment, 3-4 regions	98941	$22.00	$22.89		$57
Adjustment, extraspinal	98943	$14.54	$15.08		$25
Mechanical Traction	97012	$8.02	$8.01		$15
Therapeutic Exercises	97110	$16.40	$18.06		$25
Manual Therapy	97140	$15.66	$16.42		$25
Neuromuscular Re-Ed.	97112	$19.62	$21.02		$30
K-Tape Application		$10	$10	$10	$10
Total Charge, with exam		Up to $122.26	Up to $147.38	$75	$89-$114*
Total Charge, cont'd care		Up to $70.96	Up to $74.04	$75	$57-$82*

**Service discounts for frequency of care/timely payment, as outlined on individual care plan*

Patient Signature _____Date_____

Staff Signature _____Date_____

2025, Patient Name: _____

Disclaimers:

There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Actual items, services, or charges may differ from the good faith estimate. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more than your Good Faith Estimate, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You can contact us, let us know the billed charges are higher than the Good Faith Estimate, and ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (approximately four months) of the date on the original bill.

If you dispute your bill, we cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, we are required to cease collection efforts. We must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. We also cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with us, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

The initiation of the dispute resolution process will not adversely affect the quality of health care services furnished to you by our practice.

This good faith estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate.

I have received, read, and understand this disclosure.

Patient Signature _____Date_____

Staff Signature _____Date_____

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003
Revised According to New HIPAA Regulations September 23, 2013
Holistic Chiropractic and Wellness, Inc. is committed to protecting your protected health information.
"Protected Health Information" (PHI) may include such items as: medical notes from your doctor, a claim from your provider listing your diagnosis, a medical treatment that you received, or laboratory/diagnostic test results. This notice about protecting your PHI is required by law. It tells you about your rights and how we use and disclose your health information.

YOUR HEALTH INFORMATION RIGHTS

- Request a restriction on certain uses and disclosures of your PHI; however, we are not required to approve your request.
- Request that we notify you about your PHI in a way or at a location that will help you keep your information confidential.
- Receive a list of certain disclosures we have made of your PHI. This is a list of disclosures made by us during a specified period of up to six years *except for disclosures made:*
    - For treatment, payment, and healthcare operations
    - For use in or related to a facility directory
    - To family members or friends involved in your care
    - To you directly
    - Pursuant to an authorization of you and your personal representative
    - For certain notification purposes (including national security, intelligence, correctional, and law enforcement purposes)
    - Before April 14, 2003
- In writing at any time, withdraw your permission for us to disclose your PHI, except for the information that we disclose before you stopped your permission.
- Review and obtain a copy of your own PHI.
- Ask us to change your PHI if you believe it is incorrect or incomplete. We may deny your request and, if so, will give you the reason(s) why the request was denied.
- Receive a paper or electronic copy of this Notice of Privacy Practices upon request.

HOW Holistic Chiropractic and Wellness, Inc. MAY USE OR DISCLOSE YOUR PHI: The examples included with each category do not list every type of use or disclosure that may fall within that category. FOR TREATMENT: We may use and disclose your PHI to a physician or other healthcare provider providing treatment to you.
PAYMENT: We may use and disclose your PHI to obtain payment for services we provided to you. HEALTHCARE OPERATIONS: We may use and disclose your PHI in connection with chiropractic operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
REQUIREMENTS BY LAW: We may use and disclose your PHI when required to do so by law. We may also use or disclose your PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following:

- To prevent or control disease, injury or disability.
- To report disease, injury, birth or death.
- To report child abuse or neglect.
- To report reactions to medications or problems with products or devices regulated by the federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA regulated products or activities.
- To locate and notify persons of recalls of products they may be using.
- To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease.
- To report to your employer, under limited circumstances, information related primarily to workplace injuries or illness, or workplace medical surveillance.

We may also use and disclose your PHI under certain circumstances for the following purposes where the disclosure is:

- About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency.
- To alert law enforcement of a death that we suspect was the result of criminal conduct.
- In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About a crime or suspected crime committed at the workplace.
- In response to a medical emergency not occurring at the workplace, if necessary to report a crime, including the nature of the crime, the locations of the crime or the victim, and the identity of the person who committed the crime.

HEALTH OVERSIGHT ACTIVITIES: We may disclose your PHI to government health agencies for health oversight reasons, such as program audits or licensure reviews.
RESEARCH: We may use your PHI for approved research purposes, such as for study to cure a disease. SPECIAL GOVERNMENT FUNCTIONS: We may, such as protection of public officials or reporting to various branches of the armed services, require the use or disclosure of your PHI.
OTHER USES: We may use and disclose your PHI to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care.

OBLIGATIONS OF Holistic Chiropractic and Wellness, Inc.

- Maintain the privacy of your PHI.
- Provide you with the Notice of its legal duties and privacy practices with respect to your PHI.
- Obtain your written authorization to use or disclose your PHI for reasons other than those listed in this Notice and permitted by law.
- Abide by the terms of this Notice that are currently in effect.
- Notify you if we are unable to agree to requested restriction on how your PHI is used or disclosed.
- Allow reasonable requests you may make to notify you about your PHI in a way or at a location that will help you keep your PHI confidential.

Holistic Chiropractic and Wellness, Inc. reserves the right to change its information practices. The new provisions will be effective for all PHI that Holistic Chiropractic and Wellness, Inc. maintains. Revised notices will be made available to you by written notices.

COMPLAINTS:
If you have a complaint about how Holistic Chiropractic and Wellness, Inc. handles your PHI, or if you otherwise believe that your privacy rights have been violated by Holistic Chiropractic and Wellness, Inc., your complaint should be directed to:
Holistic Chiropractic and Wellness, Inc., 2251 Double Creek Dr, Suite #501 Round Rock, TX 78664 (512) 246-0220
Attention: Privacy Contact
If you are not satisfied with the manner in which Holistic Chiropractic and Wellness, Inc. handles a complaint, you may submit a formal complaint to the U.S. Secretary of Health and Human Services in Washington, D.C. There will be no retaliation by Holistic Chiropractic and Wellness, Inc. if you file a complaint.