Vitality!

3061 Brickhouse Court, Ste 107
Virginia Beach, VA 23452
757.491.2598
Vitality757.com ✓ Support@Vitality757.com

Intake for Prepubescent Minor

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____

State: ____ Zip: _____ Referred By: _____

Birth date: _____ Age: _____ Place of Birth: _____

Height: _____ Weight: _____ Sex ___ Guardian Name: _____

Email address: _____

Best Contact Number: (_____) _____ is this cell, home, or work?

Secondary Contact Number: (_____) _____ is this cell, home, or work?

Is it ok to send you appointment reminders via text message? Y N

Children under 18 are considered minors in the state of Virginia. Please sign to authorize treatment for your child in your absence. (eg: child brought to appointment by grandparent, babysitter.)

I, _____authorize for my child, _____ to receive
(guardian print name) (child print name)
medical treatment from Dr. Janine Lex and staff in my absence.

Signature: _____ Date: _____

Please rank current & ongoing problems by priority and fill in the other boxes as completely as possible.

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			

Medications & Supplements

Please list all current Prescription medications

Name	Strength	How Many	How often / when

Please list all over the counter medications

Name	Strength	How Many	How often / when

Please list all current Vitamins & supplements

Name	Strength	How Many	How often / when

Check for yes

_____ Have you had prolonged or regular use of NSAID's? (Advil, Aleve, Motrin, Aspirin, Tylenol, ect)

_____ Have you had prolonged or regular use of antibiotics

_____ Have you had prolonged or regular use of steroids? (prednisone, nasal allergy inhalers)

Medical History

Check if apply (either past or current)

- [ ] Asthma
- [ ] Chronic Bronchitis
- [ ] Emphysema (COPD)
- [ ] Pulmonary Hypertension
- [ ] Chronic Sinusitis
- [ ] Pneumonia
- [ ] Sleep apnea
- [ ] Tuberculosis
- [ ] Blood pressure
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Blood clots
- [ ] Hemophilia
- [ ] Factor v Leiden
- [ ] Coronary artery disease
- [ ] Heart attack
- [ ] Congestive heart failure
- [ ] Coronary artery blockage
- [ ] Carotid artery stenosis
- [ ] arrhythmia
- [ ] High Cholesterol
- [ ] High triglycerides
- [ ] Reflux (heartburn)
- [ ] Stomach ulcers
- [ ] Gall Bladder Disease
- [ ] Liver disease
- [ ] IBS
- [ ] Crohn's disease
- [ ] Ulcerative colitis
- [ ] Celiac disease
- [ ] Elevated blood sugar (pre-diabetic)
- [ ] Diabetes (youth onset, treated with insulin)
- [ ] Diabetes (adult onset, treated with diet)
- [ ] Diabetes (Adult onset, treated with insulin)
- [ ] Obesity
- [ ] Overweight
- [ ] Underweight
- [ ] Anorexia
- [ ] Bulimia
- [ ] Low thyroid (Hypothyroidism)
- [ ] Hashimoto's thyroiditis
- [ ] High Thyroid (Hyperthyroidism)
- [ ] Thyroid nodules
- [ ] Graves disease
- [ ] Goiter
- [ ] Stroke
- [ ] Migraines
- [ ] Seizures
- [ ] ADD / ADHD
- [ ] Brain injury / concussion
- [ ] Depression
- [ ] History of suicide attempts
- [ ] Anger management problems
- [ ] Bipolar disorder
- [ ] Post-Traumatic stress disorder
- [ ] Arthritis
- [ ] Rheumatoid arthritis
- [ ] Gout (arthritis)
- [ ] OSteopenia (weakening bones)
- [ ] Osteoperosis (weak bones)

Medical History

Check if apply (either past or current)

- ☐ HIV
- ☐ Hepatitis
- ☐ Herpes
- ☐ Mononucleosis (CMV)
- ☐ Epstein-Barr Virus
- ☐ Multiple Sclerosis
- ☐ Lupus SLE
- ☐ Chronic Fatigue syndrome
- ☐ Fibromyalgia
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Testicular cancer
- ☐ Colon Cancer
- ☐ Skin Cancer
- ☐ Lung cancer
- ☐ Bladder Cancer
- ☐ Kidney Cancer
- ☐ Thyroid Cancer
- ☐ Pancreatic cancer
- ☐ Lymphoma Cancer
- ☐ Leukemia cancer
- ☐ Other cancer
- ☐ Eczema
- ☐ Hives
- ☐ Athlete's foot
- ☐ Psoriasis
- ☐ Acne
- ☐ Vitiligo
- ☐ Enlarged prostate
- ☐ Impotency treatments

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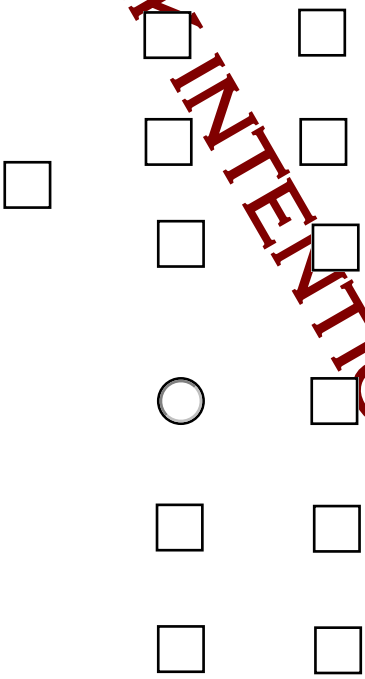

Surgical History

Type _____ year _____

Type _____ year _____

Type _____ year _____

Type _____ year _____

Type _____ year _____

Type _____ year _____

Type _____ year _____

Type _____ year _____

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Notification of Privacy Practices **Signature Required on Page 2**

In accordance with the Health Insurance Portability and Accountability Act of 1996, as of April 14, 2003 all health care providers are required to provide their patients and have on file a 'Notice of Privacy Practice' statement.

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

Janine Lex Chiropractic & Acupuncture LLC (dba Vitality!) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Notification of Privacy Practices

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Reminders.
We may contact you for appointment reminders and rescheduling.

Change of Ownership.
In the event that Janine Lex Chiropractic & Acupuncture LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

 You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

 You have the right to inspect and copy your health information.

 You have a right to request that Janine Lex Chiropractic & Acupuncture LLC amend your protected health information. Please be advised, however, that Janine Lex Chiropractic & Acupuncture LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

 You have a right to receive an accounting of disclosures of your protected health information made by Janine Lex Chiropractic & Acupuncture LLC .

 You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Janine Lex Chiropractic & Acupuncture LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Janine Lex Chiropractic & Acupuncture LLC is required by law to comply with this Notice.

Janine Lex Chiropractic & Acupuncture LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

This notice is effective as of March 11, 2008.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Janine Lex Chiropractic & Acupuncture LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

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Financial Policy

Vitality! is a cash practice. Payment for services is due as services are rendered. Credit card, cash, and check are accepted forms of payment. We have incorporated several payment options:

1. **Pay Per Visit**. When services are rendered
2. **Care Credit**. Financing through GE provides you with several interest-free payment plans for simple monthly payments over 6 or 12 months.
3. **Prepayment.** A prepayment of $1500 entitles you to 10% off all services in the office.

Cancellations
Any appointment missed or cancelled with less than 24 hours notice is subject to a missed appointment fee equal to that of the scheduled appointment time.

Insurance
1. Vitality! **does not process any form of insurance**. If you are a patient of Dr. Lex, following your visit you will be provided with a sales receipt (superbill) of services rendered which you may personally submit to your insurance provider. The superbill has the procedural and diagnostic codes insurance companies require for claims.
2. All insurance companies and policies differ, and are in a constant state of flux. Our office is "out-of-network" with most companies. WE DO NOT GUARENTEE ANY FORM OF REIMBURSEMENT ON SUBMITTAL.
3. **We do not participate with any state or federal Medicare or Medicaid plan.**

Our goal is your health and wellness. Insurance is an incomplete system that can limit the doctor's ability to spend adequate time with the patient, and provide the best care for each individual.

Signing below indicates that you understand and agree to abide with the Financial Policy of Vitality!

Patient's Signature: _____Date: _____
(if patient is a minor, guardians signature)

□ Please check this box if you would like a copy of this document

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Minor Medical Authorization Form

You may leave this blank if not applicable.

Children under 18 are considered minors in the state of Virginia.
Please sign to authorize treatment for your child in your absence.

(eg: child brought to appointment by grandparent, babysitter, drives themselves.)

I, _____authorize for my child, _____
(guardian print name) (child print name)

to receive medical treatment from Dr. Janine Lex and staff in my absence.

Signature: _____ Date: _____

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If we need to acquire records, test results, or x-rays from **other** health organizations, they are legally required to receive this signed form from us.
This form **does not** allow us to release your information to any other source.

Authorization for the Release of Information

TO: _____

I, the patient, hereby authorize the release of all medical records to Dr. Janine Lex, and authorize communication with other healthcare practitioners concerning my care.
This includes x-rays, MRI's, and laboratory results.

_____ _____
Patient (or guardian) Signature Date of Birth

_____
Print Name

_____ _____
Witness Date

Requesting Physician
Dr. Janine Lex
3061 Brickhouse Court, Ste 107
Virginia Beach, VA 23452
Ph. 757.491.2598 Fax: 757.493.3980
support@JanineLex.com

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT
CONFIDENTIAL / HIPPA-Approved Form

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We require this form to be signed and on file.
Please complete even if you do not receive Medicare benefits.

I, _____, acknowledge that Janine Lex Chiropractic & Acupuncture (dba *Vitality!* Functional Medicine) has informed me that Medicare will not be billed by this office for any service provided in this office. Dr. Janine Lex is not a Medicare Provider.

I agree that **I will not bill** Medicare for any of my services provided in this office.

I **do** / **do not** receive Medicare benefits.
(circle one)

Signed: _____

Date: _____

Witness: _____

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