PEDIATRIC PATIENT INFORMATION

CHILD'S NAME_____ MOTHER'S NAME_____

ADDRESS:_____ FATHER'S NAME_____

TOWN/STATE/ZIP _____ HOME PHONE:_____

MOTHER'S WORK PHONE_____ FATHER'S WORK PHONE_____

BIRTH DATE_____ AGE_____ BIRTHWEIGHT_____ CURRENT WEIGHT_____

SEX: _____ NO. OF SIBLINGS _____ BIRTH LENGTH_____ CURRENT LENGTH _____

TYPE OF BIRTH: NORMAL VAGINAL _____ FORCEPS _____ BREECH _____ CESAREAN ____
HOME _____ BIRTHING CENTER _____ HOSPITAL ____

PROBLEMS DURING PREGNANCY_____

_____

PROBLEMS DURING LABOR/DELIVERY_____

_____

APGAR SCORE_____ JAUNDICE PRESENT (YELLOW)_____ CYANOSIS (BLUE)_____

CONGENITAL ANOMALIES/DEFECTS:_____

INFANT FEEDING: BREAST_____ BOTTLE_____ FORMULA _____
NUMBER OF HOURS SLEEP PER NIGHT_____
QUALITY OF SLEEP: GOOD _____ FAIR _____ POOR _____

OBSTETRICIAN
OR MIDWIFE:_____ PEDIATRICIAN
OR FAMILY MD _____

DATE OF LAST VISIT TO MD _____ PURPOSE _____

PURPOSE OF TODAY'S APPOINTMENT_____

_____

INSURANCE/BILLING INFORMATION:_____

POLICY #:_____

AUTHORIZATION FOR CARE OF MINOR

I HEREBY AUTHORIZE MANCINI CHIROPRACTIC AND ITS DOCTOR(S) TO ADMINISTER CARE THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD (UPON APPROVAL OF PARENT GUARDIAN)
SIGNED:_____ WITNESSED_____ DATE _____

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY MANCINI CHIROPRACTIC A THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN PROPERTY MANCINI CHIROPRACTIC.
SIGNED:_____ DATE _____

PEDIATRIC CASE HISTORY

PREGNANCY HISTORY: _____

_____

_____

DELIVERY/BIRTH HISTORY: _____

_____

_____

HAS YOUR CHILD EVER BEEN TREATED ON AN EMERGENCY BASIS? _____

IF YES, DESCRIBE: _____

DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD:

_____ RESPOND TO SOUND
_____ HOLD HEAD UP
_____ STAND
_____ FOLLOW AN OBJECT WITH HIS/HER EYES
_____ CRAWL
_____ WALK ALONE
_____ SIT ALONE

CHILDHOOD DISEASES: ____ CHICKENPOX ____ WHOOPING COUGH ____ RUBELLA
____MEASLES ____ MUMPS ____ RUBEOLA
_____ OTHER

PLEASE CIRCLE ANY SYMPTOM THIS CHILD HAS EVER SUFFERED FROM:

DIZZINESS	BACKACHES	HEART TROUBLE	ORTHOPEDIC PROBLEMS
DIABETES	TUBERCULOSIS	HYPERTENSION	SUGAR CONCENTRATION
ARTHRITIS	HEADACHES	ASTHMA	DIGESTIVE DISORDERS
NEURITIS	CHRONIC EARACHES	SINUS TROUBLE	CONSTIPATION
ANEMIA	RHEUMATIC FEVER	COLDS/FLU	DIARRHEA
POOR APPETITE	HYPERACTIVITY	ALLERGIES	BEHAVIORAL PROBLEMS
BED WETTING	CONVULSIONS	PARALYSIS	MUSCLE JERKING
FAINTING	WALKING PROBLEMS	BROKEN BONES	RUPTURES/HERNIAS
NECK PROBLEMS	ARM PROBLEMS	LEG PROBLEMS	"GROWING PAINS"
JOINT PROBLEMS	BLOOD DISORDERS	STOMACH ACHES	OTHER

PRESENT HISTORY: _____

_____

_____

SURGERY: _____

MEDICATIONS: _____

ACCIDENTS: _____

PRESENT HISTORY: _____

MANCINI CHIROPRACTIC
DR. CAROL M. MANCINI
440 MAIN ST. SOUTH
SOUTHBURY, CT 06488
P 203 262-6347
F 203 267-6156

CONSENT FOR TREATMENT OF A MINOR CHILD

I hereby authorize Dr. Carol Mancini and whoever she may designate as her assistants to administer chiropractic care as she deems necessary to:

NAME OF CHILD _____

RELATIONSHIP TO CHILD _____

SIGNATURE OF PARENT OF LEGAL GUARDIAN _____

DATE: _____

WITNESS: _____

Mancini Chiropractic
A Creating Wellness Center
Tel (203)-262-6347
Fax (203) 267-6155

Dr. Carol Mancini
Certified in Chiropractic Pediatrics
440 Main Street South
Southbury, CT 06488

Informed Consent to Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy by the chiropractic physician and /or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services maybe performed by Carol Mancini, D.C. or other licensed Physicians of Chiropractic who my treat me now or in the future at this office. I have had the opportunity to discuss with Dr. Carol Mancini and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and others procedures. I understand that no guarantee can be given as to the results or outcome of my care.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment: including, but not limited to fractures, disc injuries, dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interest at the time, based upon the facts then known. The most common and likely side effect of treatment is muscle stiffness and soreness lasting one to several days.

Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stoke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before this stroke.

I have had the opportunity to read this form and my questions are answered to by satisfaction. I intend this consent form to cover the entire course for treatment of my present condition(s) and for any conditions(s) for which I seek treatment at this facility.

_____ _____

Print Patient's Name Date

_____ _____

Signature of Patient, Guardian, Translator or Interpreter Date

Based on my personal observation and the patient's history and physical exam, I conclude that throughout the informed consent process the was:

___ Of legal Age ___ Consent given through Guardian ___ Appears unimpaired and competent

___ Fluent in English or assisted by a translator or interpreter ___ Signed in form voluntarily

_____ D.C. _____

Signature of Chiropractor Date

MANCINI CHIROPRACTIC

Dr. Carol Mancini

FINANCIAL AGREEMENT

We have attempted to provide you with the necessary information to determine the type of care you require and also financial information you may need to determine how your wish to handle your financial obligation to Mancini Chiropractic. We wish to make it very clear that your health is your sole responsibility, or your guardian. These polices apply only to the services actually performed and in no way obligate the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinued care.

HEALTH INSURANCE - You can choose either of the payment plans using your health insurance to finance your care at Mancini Chiropractic:

Submit your bills to your insurance company, Payment is expected at each visit. We will be happy to provide the appropriate information for your claim submission

Elect Mancini Chiropractic to submit your insurance claims. Although you are totally responsible for all charges incurred in this office. Mancini Chiropractic will submit these forms to your insurance company if you assign benefits to this office. You will pay for your yearly deductible and co payment at the time of each visit. If your insurance company fails to pay its share, you are responsible for paying your balance in full.

If you choose to assign benefits and your insurance company sends payment directly to your, that payment must be immediately endorsed and sent to Mancini Chiropractic. Remember, your contract with your insurance company is between you and them. Therefore, Mancini Chiropractic cannot enter into any disputes that may arise. However, we will be more than happy to complete any reports or send out records as requested.

Even if we are a network provider under your managed heath care plan, it is primarily your responsibility to know how your coverage works. This means that it is your responsibility to know any requirements for coverage of your care including but not limited to any need prior physician referral, treatment plans, plan limitations, and any other plan requirements.

Finally, please understand that we do not base your treatment program on your insurance coverage and neither should you. There is a limit to what your insurance company will pay. Many times, insurance coverage stops in the middle of a treatment program. If you discontinue your treatment, you may be walking out of our office with the same problem you walked in with. Therefore, we have committed to work around any financial problems as long as you have the commitment to achieve maximum health potential.

Cash - Payment is due at the time of service. Special arrangements for payment will be made on an individual basis

Workmans Compensation - My employer has agreed to pay for the services rendered by this office. I understand I am responsible for any portion of this bill that my employer or his/her insurance company refuses to pay

Medicare -We are a non-participating provider. Payments are due at time of service. You will be reimbursed directly by medicare for services they determine to be medically necessary.

Personal/Auto Accident - Although my insurance or lawsuit may eventually pay Mancini Chiropractic, I understand I may be asked to pay a weekly payment to be determined. If I used my insurance at any time , I understand I am responsible for all costs not covered. If I retain any attorney for litigation I must have my attorney issue a Letter Of Protection guaranteeing payment to this office. Any remaining balances will be my responsibility.

In the event I fail to pay as per agreed, I understand a monthly service charge will accrue on all outstanding balances. I also understand I am fully responsible for any attorney fees this office may incur in the cost of collections of my account.

_____ _____

PATIENT SIGNATURE DATE

MANCINI CHIROPRACTIC
440 MAIN STREET SOUTH
SOUTHBURY CT 06488
PH 203-262-6347
FAX 203-267-6156

CAROL M. MANCINI, D.C.
"Family care with a personal touch"

ACKNOWLEDGEMENT OF PRIVACY NOTICE BY MANCINI CHIROPRACTIC, LLC

By signing this form, you acknowledge you have read and understand the Notice of Privacy Practices from Mancini Chiropractic, LLC. The notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The notice of Privacy Practices is subject to change. If the notice is changed, you may obtain a revised copy by visiting our website at www.Mancinichiro.com.

____I have read and understand the Notice of Privacy Practices but I choose not to receive a written copy.

____I acknowledge receipt of a written copy of the Notice of Privacy Practices from Mancini Chiropractic, LLC.

_____ _____

Patient /Guardian **Date**

_____ _____

Compliance Officer **Date**

NOTICE OF PATIENT PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how *Mancini Chiropractic, LLC* may use and disclose your health information and how you can access this information. This Notice explains how we use and share your health information and describes your rights and our legal duties under federal and state privacy laws.

Who This Notice Applies To

This Notice of Privacy Practices applies to our chiropractic practice and all related services we provide, including those performed by our support staff and business associates who help deliver or manage your care. We follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Notice applies to you as a patient of our practice and to any services we provide in connection with your care.

If you have any questions about this Notice, please contact our Privacy Officer or any staff member in our office.

Privacy Officer: *Michele Bridge*

Practice Name: *Mancini Chiropractic, LLC*
Address: *440 Main St South, Southbury, Ct. 06488*
Phone: (203) 262-6347

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

We may change the terms of this Notice from time to time. When we make a significant change, we will post the revised version in our office and, if applicable, on our website. You may obtain the current version at any time by contacting our Privacy Officer or asking at the front desk. You may contact our Privacy Officer in person at our office, by mail at the address above, or by phone.

WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information about you that may identify you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for that care.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION

Federal law (HIPAA) permits us to use and disclose your protected health information for treatment, payment, and health care operations without a separate written authorization, as described in this Notice.

Treatment

We may use or disclose your PHI to provide, coordinate, or manage your health care and related services. This includes sharing information with other health care providers involved in your care.

Payment

We may use or disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, determining eligibility or coverage, utilization review, and related activities.

Health Care Operations

We may use or disclose your PHI to support the business operations of this practice, including quality assessment, employee training, internal audits, and administrative activities.

We may use sign-in sheets or call you by name in the waiting area as part of our normal operations, in a manner consistent with applicable privacy requirements.

BUSINESS ASSOCIATES

We may share your PHI with third-party "business associates" who perform services for us (such as billing, IT support, or transcription). These entities are required by contract to protect the privacy and security of your PHI.

To the extent applicable, we will require, through our agreements with that business associate, that they protect those records in accordance with applicable Part 2 confidentiality requirements.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. These include:

- Disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- Disclosures that constitute a sale of PHI
- Other uses and disclosures not described in this Notice

Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2

Certain records related to Substance Use Disorder (SUD), if present in your record, receive additional confidentiality protections under federal law (42 C.F.R. Part 2).

Our primary services are chiropractic care. We are not a substance use disorder (SUD) treatment program as defined by federal law. However, we may receive or maintain information related to SUD treatment if you or another provider shares that information with us.

If our office maintains such information—such as information received from other providers, hospitals, or patient disclosures—those records generally will not be used or disclosed without your specific written authorization, except as otherwise permitted or required by federal law.

A standard authorization to release medical information may not be sufficient to permit disclosure of SUD-protected records. When required by law, we will obtain an authorization that specifically covers SUD information and complies with 42 C.F.R. Part 2. You may revoke your authorization for us to disclose SUD-protected records at any time by submitting a written request to our Privacy Officer. Revocation will not affect disclosures already made in reliance on your prior authorization.

Most patients seen in our chiropractic practice will not have records covered by these special rules. This section applies only if we receive or maintain information from an SUD treatment program.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may use or disclose your PHI without your authorization in the following situations:

Public Health & Safety - For public health activities, reporting communicable diseases, preventing serious threats to health or safety, and as required by law.

Health Oversight - To health oversight agencies for audits, investigations, inspections, and compliance activities.

Abuse, Neglect, or Domestic Violence - As required or permitted by law to appropriate authorities.

Workers' Compensation - As authorized to comply with workers' compensation laws.

Required by Law - When disclosure is required by federal, state, or local law.

Important Note About SUD Records: Some disclosures described in this section do not apply to records protected by 42 C.F.R. Part 2. Please see the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for information about how we handle SUD-protected records.

LEGAL PROCEEDINGS & LAW ENFORCEMENT

We may disclose PHI in response to a valid court order, subpoena, discovery request, or other lawful process as permitted by law.

Important: Records protected under federal Substance Use Disorder confidentiality regulations (42 C.F.R. Part 2), if applicable, may only be disclosed pursuant to a court order that specifically authorizes such disclosure or as otherwise permitted by federal law. A subpoena or legal request alone may not be sufficient for disclosure of SUD-protected information.

If we maintain records protected by 42 C.F.R. Part 2, those records are subject to stricter rules than other PHI. Please refer to the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for details.

YOUR RIGHTS

You have the right to:

- **Inspect and Copy** – You may inspect and obtain a copy of your PHI, subject to certain legal exceptions and reasonable, cost-based fees.
- **Request Restrictions** – You may request limits on certain uses or disclosures of your PHI; however, we are not required to agree to all requests.
- **Confidential Communications** – You may request that we communicate with you by alternative means or at alternative locations.
- **Amend** – You may request that we amend your PHI if you believe it is incorrect or incomplete.
- **Accounting of Disclosures** – You may request an accounting of certain disclosures of your PHI as defined by law.
- **Breach Notification** – If there is a breach of your unsecured PHI, we will notify you as required by applicable law.
- **Paper Copy** – You may request a paper copy of this Notice at any time.

To exercise any of these rights, please submit a written request to our Privacy Officer.

SPECIAL RIGHTS REGARDING SUD RECORDS

If our office maintains records protected under 42 C.F.R. Part 2, you have additional rights related to those records. Disclosure of such information generally requires your written authorization, and you may revoke that authorization at any time. Revocation will not apply to disclosures already made in reliance on your authorization.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services by visiting www.hhs.gov/hipaa or calling 1-800-368-1019.

To file a complaint with our office, please contact the Privacy Officer at the address or phone number listed above. You will not be penalized or retaliated against for filing a complaint.

EFFECTIVE DATE

This Notice of Privacy Practices is effective as of:

February 16, 2026
