GREATER ROCHESTER CHIROPRACTIC

LISTEN KNOW HEAL PROTECT

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Pediatric Patient Information (Birth to Age 5)

Patient's Name: _____ Today's Date: _____

Gender: ___M ___F Date of Birth: _____ /_____ /_____ Age: _____ Social Security #: _____

Address/City/State/Zip: _____

Pediatrician's Name: _____

Pediatrician's Address/Phone:_____

Whom may we thank for referring your child to our practice? _____

Parent's Name(s):_____

Parent's Phone Number(s):_____

Parent's Email Address (optional-for appointment reminders):_____

Siblings (names and ages):_____

Pregnancy/Birth History

(If your child is adopted, please answer to the best of your ability.)

What was your child's gestational age (weeks/days) at delivery? _____

During pregnancy, was your child ever diagnosed with IUGR? If yes, what was the cause of the growth restriction (if known)? _____

Type of delivery: ___Vaginal ___VBAC ___C-Section

What interventions were used during delivery (induction, medications/epidural, fetal monitor, forceps, vacuum, other)? _____

Were there any problems or significant events during the birthing process? If yes, please describe:

_____

_____

_____

Where was your child born? _____

Delivering OB/Midwife: _____

After your child was born, did he/she ever require an evaluation or stay in the Special Care Nursery or NICU? If yes, please describe why: _____

_____

_____

If it applies to your family, are you currently feeding your child by any of the following?

___nursing ___exclusive pumping ___donor milk ___formula ___combination

Do you currently have, or have you in the past had concerns about your child's feeding abilities? _____

Description of Condition

Describe the reason(s) for your visit today: _____

When did the symptoms begin? How did they start? _____

What seems to make the symptoms better? _____

What seems to make the symptoms worse? _____

What, if any, are the effects of the problem on body function and daily activities? _____

Have you seen another doctor or health care provider for these symptoms? If Yes, please indicate the name and type of provider(s): _____

Is there any additional information about the reason for this visit that you would like the doctor to know?

Current Health and Wellness

Does your child have any ongoing diagnoses, health problems, or do you have any concerns about their health (in addition to the reason you brought them in today)? _____

Please list any medications/supplements your child is currently taking, including over-the-counter medications: _____

_____

Has your child met age appropriate growth and developmental milestones? ___Yes ___No

If No, is your child receiving support (where) or needing support? _____

_____

How does your child sleep at night? _____

Has your child been immunized? ___Yes ___Delayed Schedule ___No ___Declined

If Yes, are the immunizations up to date? _____

Have you noticed any reactions to immunizations? If Yes, please describe: _____

_____

Please list any illnesses, surgeries, or hospital visits with reasons and approximate dates: _____

_____

_____

Does your child have any allergies you are aware of? If Yes, please list:_____

_____

_____

Has your child had any ear infections? ___Yes ___No If Yes, at what age(s)? _____

Date of last physical examination: _____

Has your child had previous chiropractic care: ___Yes ___No

Consent to Treat a Minor

I hereby authorize the doctors at Greater Rochester Chiropractic to evaluate and administer chiropractic care as deemed necessary to my child at this and future visits. I understand I am welcome and encouraged to ask questions at any point before, during, or after treatment(s). I acknowledge that I am financially responsible for any and all fees charged by Greater Rochester Chiropractic and the payment will be made as soon as services are provided.

Printed Name of Parent/ Legal Guardian: _____

Signature of Parent/Guardian: _____

Relationship: _____

Date: _____

Witness (office staff):_____

GREATER ROCHESTER CHIROPRACTIC

OFFICE FEE POLICY and HIPAA CONSENT

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1) **I am ultimately responsible for determining my policy's chiropractic coverage.** This includes understanding co-payments, co-insurances, deductible amounts, limits on number of visits, the need for referrals/authorizations and maximum reimbursements available for chiropractic services. (This is easily done by calling the Member Services phone number that is on your insurance card.)
2) **I am responsible for paying any charges that are NOT covered by my policy** (i.e. Pillows, supplements, etc) or that are DENIED by my insurance company (Health, Auto/No Fault, or Personal Injury) for ANY reason.
3) **As per my insurance contract and our Office Policy, payment is due at the time of service for any Co-Pay, Co-Insurance or Deductible amounts (except for No Fault cases)**. If full payment is not an option please speak to the Office Manager to arrange a payment plan. If your account becomes 90 days delinquent, we have the right to deem it a collection item and it will be turned over to a collection agency. *There will be a $20.00 fee added to your account for any check that is returned by our bank for "Insufficient Funds."*
4) **Should I fail to give 24 hours notice when canceling an appointment, or should I fail to show up for a scheduled appointment, I may be charged a $50.00 Missed Appointment Fee.**
5) **Greater Rochester Chiropractic reserves the right to cancel or not schedule future appointments if I do not follow this agreement.**

___ **I have health insurance:** Co-Payments are required to be paid at the time of service. We accept cash, checks, Visa and Master Card. Your plan may require that you meet a deductible before plan benefit allowances are made. In these cases, full payment is due at the time of service and will be applied by your carrier toward your deductible.

Your plan may also require that you obtain a PCP (Primary Care Physician) referral. Most plans require referrals be made prior to your first visit. You will be responsible for payment if you do not obtain referrals within 30 days of the office visit (back-dated to your first visit) or if your PCP denies referral for any reason.

___ **I have Medicare Part B or a Medicare Advantage-type Policy:** Medicare does not cover the cost of the new patient initial exam ($40.00) or any physiotherapy ($15.00) (ie: ultrasound, electrostim, etc.) done in the office. The only covered benefit is the actual Chiropractic Manipulative Therapy (CMT). Attached is an "Advance Beneficiary Notice" (ABN) form to sign stating that you have been informed of these non-covered fees along with your choice to have them performed or not. Once you meet your yearly deductible, you are responsible for 20% of Medicare's allowable fees as well as any supplemental treatment choose to receive.

Your plan may also require that you obtain a Primary Care Physician (PCP) referral. Most plans require referrals be made prior to your first visit. You will be responsible for payment if you do not obtain referrals within 30 days of the office visit (back-dated to your first visit) or if your PCP denies referral for any reason.

___ **My injury occurred at work (Workers' Compensation):** Greater Rochester Chiropractic does not participate with the New York State Workers' Compensation Board, therefore you are responsible for payment. Treatment for work-related injuries is not covered by your health insurance. You will be charged the discounted non-insurance fee. New Patient Initial Visit fee is $110.00. Subsequent Visit Fee is $50.00.

___ **I was involved in a Motor Vehicle Accident (No-Fault) or Personal Injury (PI):** You are responsible for filing an accident report with your automobile insurance carrier or at the place of injury and providing Greater Rochester Chiropractic with all necessary information related to the case. Claims will go to the insurance carrier and payment will be made directly to the doctor. Please be aware that some policies have a Medical Deductible that must be paid to the doctor by the patient before any insurance benefits will be paid by the insurer. *Should your NF or PI carrier deny payment for your case, you will become liable for payment of the services rendered.*

___ **I do NOT have health insurance:** Your first visit includes consultation, exam and treatment/adjustment. Follow up visits include treatment/adjustment. New Patient Initial Visit fee is $110.00. Subsequent Visit Fee is $50.00.

We will be happy to provide you with a detailed receipt for your FSA/HSA and out-of-network benefits

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Please read and sign the back ⟶

OFFICE FEE POLICY and HIPAA CONSENT (continued)

HIPAA STATEMENT/CONSENT:

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practices Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to the following appointment reminders that will be used by the Practice: a) an e-mail will be sent to me if I request it be done.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

*****I have read and understand the foregoing Office Fee Policy and HIPAA Consent and all of my questions have been answered to my full satisfaction in a way that I can understand.*****

Patient Name: _____
(please print)

Legal Representative's Name: _____ **Relationship:** _____
(e.g., Guardian, Parent if a minor) ***(please print)***

Patient or Legal Representative's Signature: _____ **Date:** _____

If you wish, you will be provided a copy of this signed statement

Witness: _____ ***(office staff)*** ***(Rev 03.2018)***