ChiropracticPlace
Family Wellness Centers

CONFIDENTIAL

PEDIATRIC HEALTH RECORD

___New Patient
___Reactivate
___Other

PLEASE PRINT:

CHILD'S FULL NAME_____ PARENT'S HOME PHONE_____

PARENT'S FULL NAME_____ PARENT'S WORK PHONE_____

PARENT'S STREET/P.O. ADDRESS_____

CHILD'S BIRTHDATE_____CHILD SSN:_____

CITY/STATE/ZIP_____

DID ANYONE REFER YOU TO OUR CLINIC?_____ WHO?_____

HISTORY OF THE PRESENT ILLNESS/INJURY

PLEASE BE SPECIFIC:

CHIEF COMPLAINT

PLEASE DESCRIBE YOUR CHILD'S PAIN OR CONDITION

CONSTANT, COMES AND GOES, GETTING BETTER/WORSE, STAYING THE SAME, ETC.

FOR WHAT CONDITION ARE YOU CONSULTING THE DOCTOR?_____

_____

_____

WHEN DID IT BEGIN?_____

SINCE THAT TIME HAS THE PROBLEM GOTTEN ____BETTER? _____WORSE? _____STAYED THE SAME?

HOW DID IT OCCUR?_____

DO THE SYMPTOMS CHANGE WITH THE TIME OF DAY?_____

LIST ANY VISIBLE BUMPS, SCRAPES, CUTS, ETC. ON YOUR CHILD:_____

_____

REMEDIES TRIED:_____

YES	NO	
___	___	HAS THERE BEEN A CHANGE IN EATING HABITS? IF SO WHAT?_____
___	___	HAS THERE BEEN A CHANGE IN SLEEPING HABITS? IF SO, WHAT?_____
___	___	DOES YOUR CHILD CRY IF A PARENT ATTEMPTS TO CHANGE ITS SLEEPING POSITION? _____
___	___	DOES YOUR CHILD WAKE UP CRYING FREQUENTLY AT NIGHT?_____
___	___	ARE THERE ANY OTHER ALTERATIONS OF CHILD'S NORMAL SLEEP PATTERN?_____
___	___	DOES YOUR CHILD HAVE A FEVER OF UNKNOWN ORIGIN?_____
___	___	DOES YOUR CHILD HAVE A LOSS OF APPETITE OR OTHER RECENT EATING DISORDERS?_____
___	___	DOES YOUR CHILD HAVE A RECENT CHANGE IN "BATHROOM" HABITS?_____
___	___	HAS YOUR CHILD RECENTLY BECOME IRRITABLE/ RESTLESS/ GRUMPY, ETC?_____

WHAT MAKES THE CONDITION BETTER?

_____

_____

WHAT MAKES THE CONDITION WORSE?

_____

_____

_____

PAST MEDICAL HISTORY

YOUR CHILD'S BIRTH:

WAS THE CHILD'S DELIVERY ____VAGINAL __CESAREAN _____

WAS THE CHILD BORN ____HEAD DOWN ___BREECH ____SHOULDER DOWN?___

WHERE WAS THE CHILD BORN? ___HOSPITAL ___AT HOME __OTHER_____

YES NO

___ ___ WERE EXTRACTION AIDS (FORCEPS/SUCTION) USED DURING DELIVERY?_____

___ ___ WAS THE LABOR PROLONGED? HOW LONG WAS LABOR?_____

___ ___ WAS THE CHILD BORN ON TIME? LATE? EARLY? _____

___ ___ WAS THERE MORE THAN ONE FETUS?_____

___ ___ WAS THERE ALCOHOL/SMOKING DURING PREGNANCY?_____

___ ___ IS THE CHILD VACCINATED?_____

___ ___ WAS/IS THE CHILD BREASTFED?_____

___ ___ HAS YOUR CHILD EVER SEEN A CHIROPRACTOR BEFORE? WHEN?_____

DOCTORS NAME AND LOCATION:_____

FOR WHAT CONDITION?_____

HOW MANY TIMES HAS THE CHILD HAD THIS CONDITION BEFORE?____0-3 TIMES? ____4+ TIMES?

___ ___ HAS YOUR CHILD SEEN ANYONE ELSE FOR THIS CONDITON? WHEN?_____

WHERE TREATED?_____ BY WHOM?_____

RESULTS:_____ DIAGNOSIS:_____

___ ___ ALLERGIES? TO WHAT?_____

___ ___ IS YOUR CHILD MEETING DEVELOPMENTAL MILESTONES?_____

___ ___ DOES YOUR CHILD TAKE PRESCRIPTION DRUGS OVER-THE-COUNTER DRUGS, VITAMINS, SUPPLEMENTS?

PRODUCT/DRUG	REASON	FREQUENCY	DOSAGE	HELPING?

YES NO

___ ___ HAS YOUR CHILD EVER BEEN IN AN AUTOMOBILE ACCIDENT?_____

WHEN?_____ WAS ANYTHING INJURED? WHAT?_____

_____

HOW WAS IT TREATED?_____

RESULTS OF TREATMENT? (COMPLICATIONS/ COMPLETE RECOVERY)_____

___ ___ WAS YOUR CHILD RIDING IN A "CAR SEAT"?_____

WAS THE CARSEAT IN THE ___REAR SEAT? ___FRONT SEAT? FACING ___FORWARD ___BACKWARD

___ ___ WAS YOUR CHILD IN A "BOOSTER SEAT"?_____

___ ___ DID THE AIRBAGS GO OFF?_____

WAS YOUR CAR STRUCK FROM THE ___REAR ___FRONT ___LEFT SIDE ___RIGHT SIDE?_____

YES NO

___ ___ HAS YOUR CHILD EVER HAD ANY MAJOR ILLNESS, INJURIES, FALLS, HOSPITALIZATIONS, OR SURGERIES?_____

FIRST: WHEN?_____ WHAT WAS INJURED?_____

HOW WAS IT TREATED?_____

RESULTS OF THE TREATMENT: (COMPLICATIONS/FULL RECOVERY)_____

SECOND: WHEN?_____ WHAT WAS INJURED?_____

HOW WAS IT TREATED?_____

RESULTS OF THE TREATMENT: (COMPLICATIONS/FULL RECOVERY)_____

YES NO

___ ___ HAS YOUR CHILD EVER HAD X-RAYS? WHEN?_____WHAT BODY PARTS?_____

FAMILY HEALTH HISTORY

HEALTH STATUS (IF DECEASED, FROM WHAT?)

MOTHER:_____

FATHER:_____

SISTERS:_____HOW MANY?_____

BROTHERS:_____HOW MANY?_____

Office Use Only: (Vitals age 2 yrs+)

Height_____ inches; Weight_____ lbs; Pulse_____;

Blood Pressure _____/_____(sitting / standing/ supine)

Staff Initials _____

SYSTEM REVIEW QUESTIONS

HAS YOUR CHILD HAD ANY PROBLEMS WITH THE FOLLOWING AREAS? (PLEASE MARK Y FOR YES OR N OR NO IN EACH OF THE FOLLOWING:)

1.___EYES
2.___EARS, NOSE, MOUTH, THROAT
3.___HEART
4.___LUNGS/BREATHING
5.___INTESTINES
6. ___URINARY
7. ___MUSCLES
8. ___NERVES
9. ___SKIN
10. ___PSYCHOLOGICAL
11.___INTERNAL ORGANS
12.___BLOOD
13.___ALLERGIES
14.___OTHER_____

PLEASE DESCRIBE:_____

_____

MY SIGNATURE IS AN ACKNOWLEDGEMENT THAT ALL OF THE ABOVE STATEMENTS ARE TRUE. I HEREBY AUTHORIZE THE DOCTOR TO EXAMINE AND TREAT MY CONDITION AS HE/SHE DEEMS APPROPRIATE THROUGH THE USE OF CHIROPRACTIC HEALTH CARE, AND I GIVE AUTHORITY FOR THESE PROCEDURES TO BE PERFORMED. I ALSO GIVE PERMISSION FOR MY CASE TO BE USED FOR RESEARCH PURPOSES IF IT IS SO APPROVED.

PATIENT SIGNTURE:_____ DATE:_____

GUARDIAN SIGNATURE:_____ DATE:_____

D.C./C.A. SIGNATURE:_____ DATE:_____

ChiropracticPlace
Family Wellness Centers

INFORMED CONSENT: CHIROPRACTIC CARE & ADJUSTMENTS

I hereby request and consent to receiving Chiropractic Manipulations (Adjustments) and other Chiropractic procedures, including various Physical Therapy Modalities, Exercise Therapies and any other Supportive Therapies as deemed appropriate by the Doctors of Chiropractic and performed by the Doctors of Chiropractic or Licensed Support Staff employed by, associated with, or serving as back-up support for, Chiropractic Place now or in the future.

I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that, while Chiropractic care is remarkably safe and effective and provides many patients with benefits including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but are not limited to: soreness, fractures, disc injuries, rib injury, physiotherapy burns, soft tissue injury, stroke, dislocations and sprains. With that understanding, I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment, which is in my best interest, during the course of the procedure the doctor has deemed appropriate at that time based upon the facts then known.

I also understand that there are treatment options available for my condition other than Chiropractic procedures. These treatment options include, but are not limited to: rest; self-administered care; over-the-counter analgesics; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I acknowledge that the Doctor of Chiropractic has discussed with me the following items:

- Explanation of my current condition;
- Proposed Chiropractic procedures;
- Risks of not receiving or undergoing any treatments or procedures.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to cover the entire course of treatment for my current condition and for any future condition(s) for which I seek treatment. This consent is for Chiropractic care and procedures to be performed on me, or for the patient named below (for whom I am legally responsible), whether in my presence or absence.

Patient Name (Print)	Patient Signature	Date
Guardian/Legal Representative Name (Print)	Guardian/Legal Representative Signature	Date

ChiropracticPlace
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INFORMED CONSENT: PHYSICAL THERAPY MODALITIES

I hereby request and consent to receiving Physical Therapy Modalities, Exercise Therapies and any other Supportive Therapies as deemed appropriate by the Doctors of Chiropractic and performed by the Doctors of Chiropractic or Licensed Support Staff employed by, associated with, or serving as back-up support for, Chiropractic Place now or in the future.

I understand and am informed that with Chiropractic care, as in the practice of medicine and all other health care modalities, results are not guaranteed and there is no promise of a cure. I further understand and am informed that, while Chiropractic care is remarkably safe and effective and provides many patients with benefits including pain relief and enhanced health, there can be associated risks, just as in the practice of medicine. Potential risks include, but are not limited to: soreness, fractures, disc injuries, rib injury, physiotherapy burns, soft tissue injury, stroke, dislocations and sprains. With that understanding, I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment, which is in my best interest, during the course of the procedure the doctor has deemed appropriate at that time based upon the facts then known.

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Patient Name (Print)	Patient Signature	Date
Guardian/Legal Representative Name (Print)	Guardian/Legal Representative Signature	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's Notice of Privacy Practiced. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and accreditation.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

_____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____

Staff Signature _____ Date _____

ChiropracticPlace

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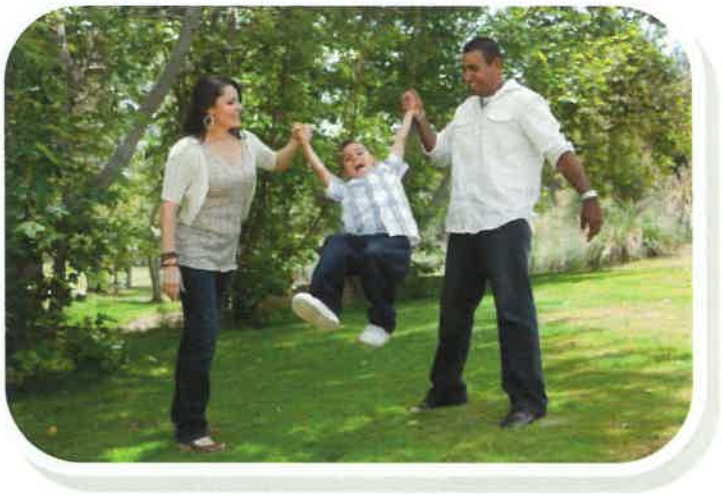

POLICIES & CONSENTS

www.mychiropracticplace.com

WELCOME

Welcome to Chiropractic Place! We appreciate your trust in selecting us for your health care needs. Chiropractic Place (CP) strives to provide the best care for all of our patients and seeks to have our patients actively involved in their care and rehabilitation as much as possible. Our clinics offer a variety of Chiropractic treatments, exercises, therapies and modalities to best meet your needs. Chiropractic care is for the whole family. We care for individuals of all ages and welcome referrals.

OFFICE POLICIES

Firearms: Firearms are not allowed on the premises of any CP clinic or office.

Changes/Updates: Patients are responsible for promptly notifying clinic of any changes in their insurance coverage, contact information, legal guardianship, or other pertinent data that may affect their billing or care.

Appointments: It is important that patients follow the recommended plan of treatment to maximize their healing and recovery time. If you need to reschedule an appointment, it is appreciated if you can contact our office within 24 hours prior to the appointment. Our clinics also will do our best to accommodate walk-in appointments or same-day appointment requests.

Email Reminders: CP offers Email appointment reminders as an option to patients.

> ***Note: Time sensitive issues such as medical emergencies should not be communicated via email because hours may pass between when a message is sent and when it is received and acted upon. Sensitive and highly confidential subjects should not be discussed because of the potential for the messages to be intercepted or transmitted to unintended recipients.***

Text Reminders: CP offers Text appointment reminders as an option to patients.

> ***Note: Text messages will be sent for patient appointment reminders only. Any changes to appointment dates and/or times must be made via phone or in person. Text responses will not be received by Chiropractic Place. Standard text messaging rates may apply.***

FINANCIAL POLICIES

Payment Methods: Our clinics accept Cash, Check, Credit/Debit Cards (Mastercard/Visa/Discover/American Express).

Claims Submission: As a courtesy, CP will submit claims to your primary insurance and, if applicable, your secondary insurance on your behalf. This includes Medicare and Medicaid. Please submit a copy of all insurance cards upon arrival.

Insurance Verification: As a courtesy, CP will call to verify benefits and eligibility; however, CP is not responsible for any erroneous data provided to us by your insurance carrier. CP does not guarantee that your insurance will pay. Patients are responsible for understanding their health care policy benefits and limitations. If for some reason your insurance claim is denied, you are responsible for the full amount of the bill. If you have any questions regarding your eligibility or benefit coverage, please contact your insurance carrier to discuss your policy.

Deductibles, Copays, and Non-Covered Services: Payment of Deductibles, Copays and Non-Covered items are due at the time of service. Please be prepared to pay upon appointment check-in.

ChiroHealth USA: Is a Medical Discount Plan that provides service discounts through plan participation with ChiroHealth USA and it is not a health insurance plan. This is available to ALL patients interested in receiving a discount for services not covered by insurance and for high deductible insurance plans. It involves an affordable annual membership that covers the patient and immediate family members. Ask for a brochure, or speak with clinic staff for more information.

Work Comp: If a Worker's Compensation carrier does not accept liability, the patient will be financially responsible for all services.

Personal Injury & Auto: Charges will be submitted to the applicable insurance company (auto, health, liability, responsible party's insurance). Denied services will be the patient's responsibility.

Minor Patients: The legal guardian accompanying a minor is responsible to authorize treatment and provide payment for services. Billing statements will be sent to the legal custodian.

Medicare: Please note that Medicare does not pay for all of your health care costs; however, even though Medicare may not pay for a service, it does not mean you should not receive that service. Medicare Part B recognizes payment for the following Chiropractic services only: Spinal Manipulation (a/k/a Chiropractic Adjustment).

A calendar-year deductible is required for all Medicare patients. After your deductible has been met, Medicare pays 80% of the approved Spinal Manipulation. The patient is responsible for the remaining 20% Co-insurance.

Items not covered and the patient's full financial responsibility are: Exams, X-rays, Extremity Adjustments, Therapies, Nutritional Supplements, DME's/Supports, Exercise Programs, and Maintenance Care. Please note that it is our policy to obtain X-rays and perform periodic Exams as part of our treatment protocol, even though they are Non-Covered services and the patient's financial responsibility. Patients will have an opportunity to decide if they would still like receive the service(s) if not covered by Medicare via the use of an Advanced Beneficiary Notice (ABN) form.

Medicare Supplemental Plan: Medicare supplemental policies are designed to coordinate with Medicare and are plan-specific. Larger co-payments and additional benefits may apply. Some supplemental plans may pay for the Deductible and Co-insurance depending upon patient's policy. Please provide a copy of the Medicare supplemental insurance card at the same time the Medicare card is provided.

Medicaid: Please note that Medicaid covered services may vary by state. Medicaid recognizes payment for the following Chiropractic services only: Spinal Manipulations (a/k/a Chiropractic Adjustment) and X-rays when performed in conjunction with an Exam. (Please note that it is our policy to obtain X-rays and perform periodic Exams as part of our treatment protocol, even though they are Non-Covered services and the patient's financial responsibility.) Proof of insurance eligibility is required each month. Co-payments must be paid on the same day the service is provided. Non-Covered services are the patient's financial responsibility and due at time of service. Patients will have the opportunity to decide if they would still like to receive the service(s) if not covered by Medicaid.

Supplements / Durable Medical Equipment (DME):
Payment for these items is due at the time of purchase.

Returns / Exchanges / Refunds:
We do not accept returns or exchanges for opened or used items (supplements, DME's, therapy items, etc.), unless under manufacturer's warranty. Other items may be returned to the clinic of original purchase unopened and unused within 15 days of purchase for a refund or exchange.

ACCOUNT QUESTIONS

Patient Account Questions:
Contact our external billing company, UP Solutions, at 563-242-1170

CONSENTS & AUTHORIZATIONS

- **Notice of Privacy Practices** - I acknowledge that I have received the Notice of Privacy Practices and have separately signed the "Acknowledgement of Receipt of the Notice of Privacy Practices."

- **Authorization for Use & Disclosure of Protected Health Information (PHI)** - I understand that by signing below I authorize the Use and Disclosure of my Protected Health Information (PHI) described herein and in the Notice of Privacy Practices that has been provided to me. I also acknowledge that CP has reserved the right to make changes to the privacy practices as necessary. If CP makes any changes, a revised Notice of Privacy Practices will be provided to me. I understand those changes will apply to any of my PHI that CP maintains.

  Check if additional Use and Disclosure authorization also appies:

  ☐ I consent to use and disclosure of my patient health care records to the following person(s), including those involved in my care or payment for that care. [Specify person(s) below]:

  _____ _____
  (Person Name) (Relationship)

  _____
  (Address)

  _____ _____
  (Person Name) (Relationship)

  _____
  (Address)

  Unless indicated by me otherwise, CP may use professional judgment and experience with common practice to make reasonable inferences of my best interest in allowing a person acting on my behalf to pick up supplies, X-rays or other similar forms of PHI as applicable.

  Copy of Consent – I understand I am entitled to a copy of this Consent and Policy Brochure and I will inform clinic staff if I choose to have a copy. The original will be retained in my patient file.

  Effect of Declining Consent -I understand that this consent is a condition of my treatment with CP and if I decide not to sign this consent, treatment may be declined.

Right to Revoke – I understand this consent is in effect until I choose to revoke it and I have the right to revoke it at any time by giving written notice. I acknowledge that such revocation will not affect any action CP took in reliance on this consent before receiving the revocation. I also understand that upon revocation, CP may decline to continue treatment.

- **Release of Information** - I authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in my case.

- **Assignment of Direct Payment** - I authorize any and all benefit payments to be made on my behalf directly to CP.

- **Financial Policies** - I understand and agree to adhere to the Financial Policies as outlined above and described herein.

- **Office Policies** – I understand and agree to adhere to the Office Policies as outlined above and described herein.

- **Email or Text Reminders** – I understand the policies outlined above and described herein and authorize Email or Text appointment reminders to be sent to me. I further understand that I can unsubscribe from email communications or discontinue text reminders at any time by providing written notice. I understand that this is an optional service and is provided as a courtesy only.

  ☐ I am NOT interested in receiving Email or Text messages for appointment reminders.

  -OR- Select one (optional):

  ☐ Email Address: _____

  ☐ Cell Phone #:_____

  Carrier Name_____

- **Diagnostic Procedures, Xrays & Examinations**
  I hereby request and consent to receiving Diagnostic Procedures, including X-rays, and Chiropractic Examinations from the Doctors of Chiropractic and/or licensed support staff employed by, associated with, or serving as back-up support for CP.

  This consent is for these procedures to be performed on me, or for the patient named herein (for whom I am legally responsible), whether in my presence or absence.

PATIENT SIGNATURE

By affixing my signature below, I acknowledge that I have fully read and understand the items listed above. I hereby consent, authorize and acknowledge the policies, consents and items as listed above and described herein and as outlined within the Notice of Privacy Practices provided by Chiropractic Place:

_____

Patient Name (Print)

_____ _____

Patient Signature Date

_____ _____

Legal Guardian/Representative Name (Print) Relationship

_____ _____

Legal Guardian/Representative Signature Date