PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name ______________________________________

Address ____________________________________

City _______________ State______ Zip__________

Home phone _________________________________

Birth date __________________

SS#_______________________________________

Age ________ Gender Weight__________

ABOUT THE PARENT

Name____

Employer____

Work address ______________________________________

Work phone __________________Cell__________________

Type of work ______________________________________

E-mail address______________________________________

Social Security # ___________________________________

Insurance Co:_______________________________________

Insured's Name:_____________________________________

Insured's SS#:_______________________ DOB:_________

VACCINATIONS

Have you chosen to vaccinate your child? **Yes** **No**

If yes, circle all that your child has received.

DPT **MMR** **Chicken Pox** **Hepatitis** **Other**

Describe any and all reactions to vaccine(s). _____________

____

REASON FOR THIS VISIT

Describe the purpose of this visit _______________

____

Is the purpose of this appointment related to

Sports **Auto** **Fall** **Home Injury** **Other**

Please explain _______________________________

When did this condition begin? _________________

Has this condition:

Gotten worse **Stayed constant** **Comes and goes**

Does this condition interfere with:

Sleep **Daily routine** **Other activities**

Please explain _______________________________

____

Has this condition occurred before? **Yes** **No**

Please explain _______________________________

Have you seen other doctors for this condition? **Yes** **No**

Doctor's Name(s) ____________________________

Type of treatment ____________________________

Results _____________________________________

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that	Yes	No
* Doctors of Chiropractic work with the nervous system?	☐	☐
* The nervous system controls all bodily functions and systems?	☐	☐
* Chiropractic is the largest natural healing profession in the world?	☐	☐
* If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	☐	☐

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? ____

Have you been adjusted by a Chiropractor before? **Yes** **No** Reason for those visits? ___________________

Doctor's name________________________________ Approximate date of last visit ____________

Has any adult in your family seen a Chiropractor? **Yes** **No**

Has any child in your family seen a Chiropractor? **Yes** **No**

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

☐Drugs / Medicine ☐Tobacco / Alcohol

Please explain ________________________________

Any illness during your pregnancy?______________________

____

How was your delivery? ______________________________

☐Labor chemically induced ☐Labor was Dr. assisted
☐C-section delivery ☐Forceps/Vacuum extraction?
☐Did Dr. pull or twist baby? ☐Premature delivery

Please explain ______________________________________

Did you nurse the baby? **Yes** **No**

Did your baby have colic? **Yes** **No**

Feeding problems? **Yes** **No**

Vaccinations? **Yes** **No**

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐Allergies
☐ Asthma
☐ Attention problems
☐ Bed wetting
☐ Breathing problems
☐ Colic
☐ Constipation
☐ Digestive problems
☐ Ear problems
☐Frequent colds
☐Headaches
☐Hyperactivity
☐Irritability
☐Skin problems
☐Sleeping disorders
☐Tubes in the ears
☐Vision problems
☐
Other

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:			
…taken antibiotics?	☐	☐	________________
…been hospitalized?	☐	☐	________________
…had a severe fall?	☐	☐	________________
…been in a car accident?	☐	☐	________________
Is your child			
…accident prone?	☐	☐	________________
Had Surgery? Please Explain…			________________
…currently taking any medication (s)?	☐	☐	________________
…having difficulty interacting with others?	☐	☐	________________

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?
____

What changes (if any) in your child's health or behavior would you like accomplished? __________________
____

AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Lund Family Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian:____Date:________________________

HISTORY AND EVALUATION

Chief Concerns:____

____

____

History of Condition:____

____

Birth and Delivery:____

Childhood Injuries / Falls / Accidents:____

Temperament / Attitude:____

Sleep:______________________ **Nutrition:**______________________

Medications:____

What has been done to help this condition (s):____

Family Health History:____

Other:____

EXAM

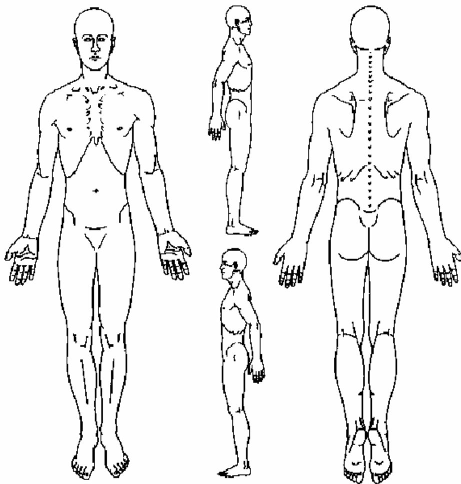
Name:______________________

Date:______________________

Height______ **Weight**:______

Bilateral Weights L__ R__

Short Leg L__ R__



Other Testing:

Posture Analysis

Head Tilt	Rt. Lt.
Ear High	Rt. Lt.
Apparent Cervical Curve	Rt. Lt.
Cerv. Muscle Tension	Rt. Lt.
Shoulder High on	Rt. Lt.
Apparent Thoracic Curve	Rt. Lt.
Thoracic Musc. Tension	Rt. Lt.
Apparent Lumbar Curve	Rt. Lt.
Lumbar Musc. Tension	Rt. Lt.
Illium High On	Rt. Lt.

Subluxation Palpation

OC	
C1	
C2	
C3	
C4	
C5	
C6	
C7	

T1	
T2	
T3	
T4	
T5	
T6	
T7	
T8	
T9	
T10	
T11	
T12	

L1	
L2	
L3	
L4	
L5	
S	
SI	

Comments:

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily and both of our doctors have waiting lists.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you to give a minimum 24 hour advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space.

We are happy to excuse one missed chiropractic appointment without charge. If there is a second missed appointment, you will be charged a $40 cancellation fee which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

Missed Clinical Nutrition appointments will be billed at $45 for every 15 minutes scheduled. For missed massage appointments, patients will be billed at $70 for an hour.

I have read and understand the River Falls Chiropractic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.

I, ________________________________, have received a copy of The Cancellation Policy.

_________________________________ __________

Signature of Patient Date

River Falls Chiropractic

Todd Frisch, D.C. and Melissa Kolb, D.C.

215 North 2nd Street, Ste 201, River Falls, WI 54022 * Phone: 715-425-6665 Fax: 715-425-6677

Financial Disclaimer

Dear Patient,

Welcome to **River Falls Chiropractic**! We are pleased that you have chosen our clinic to address your healthcare needs. We would like to take a few minutes to explain what you can expect from your insurance company as well as what we in turn expect from you.

Your benefit under your insurance plan for chiropractic care may not cover all of your visits to our office. You are financially responsible for co-payments, co-insurance and deductibles for covered services. Services exceeding benefit limits or considered maintenance or preventative are not reimbursable by your plan. You are also financially responsible for all non-covered services. Please feel free to discuss any questions with our accounts department.

If your doctor feels that care will not be a covered expense based on the type of care you are receiving, it may be in your best interest to discuss one of the several financial plans we have available.

- If at anytime there is a change in your insurance benefits it is **YOUR RESPONSIBILITY TO NOTIFY THE FRONT DESK. WE CAN NOT BE RESPONSIBLE FOR BACK BILLING IN THESE SITUATIONS.**
- Please understand that any benefit quoted to you by this office is **NOT A GUARANTEE** that your insurance co. will make payment on your claims.

YOUR CO-PAY, CO-INSURANCE, AND OR DEDUCTIBLE IS DUE AT THE TIME OF YOUR VISIT. We welcome payments in advance by **cash**, **check**, **Visa**, **MasterCard**, **and debit cards.**

Also note: If you are filing your claims through AUTO INSURANCE or WORKMAN'S COMPENSATION, the insurance may not settle in your favor or your case may be denied, at which point you will be responsible to pay your balance.

By signing this statement, you acknowledge you understand the services you are receiving may not be covered by your health plan, and in that situation you would be 100% responsible for all charges incurred.

______________________________________ _____________

Signature Date

River Falls Chiropractic

Todd Frisch, D.C. and Melissa Kolb, D.C.

215 North 2nd Street, Ste 201, River Falls, WI 54022 * Phone: 715-425-6665 Fax: 715-425-6677

Non-Covered Services: Financial Disclosure Form

Chiropractic services typically covered by health insurance policies include:

Chiropractic adjustment for acute clinical conditions

Limited treatment of symptom flare-ups or exacerbations.

Services that we expect to **NOT** be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility are outlined below. Your financial responsibility is limited to services received during the treatment dates below.

Treatment plan start date:_____/_____/_____Treatment plan end date:_____/_____/___

Non-covered Services and Cost Per Visit*	
Exam(s) (MEDICARE/MEDICARE Replacement)	$50-75
Maintenance Care Spinal Adjustments	$50
X-Ray(s) to detect subluxation	$95
Durable Medical Equipment (Braces, Orthotics, Ice Pack)	Depends on Product
Decompression Therapy	$75-150
Nerve Scan	$35

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Name:____

Patient's Signature:____ Date:__________