YOST Family Chiropractic
3993 100th Street • Urbandale, IA 50322 • 515.278.YOST
www.YostFamilyChiropractic.com

Child's Name:_____ Date:_____ Referred By:_____
Address:_____ City:_____ State:_____ Zip code:_____
Date of Birth:_____ Age:_____ Gender:_____
Mother's Name:_____ Mother's Cell:_____ Work Phone:_____
Father's Name:_____ Father's Cell:_____ Work Phone:_____
List Ages of Other Children in Family:_____
Pediatrician's Name:_____ Clinic Name:_____
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your child's care here? Y N

Demographics: Language _____(Primary)
Race: Unspecified_____ American Indian or Alaska Native _____ Black or African American _____ Other_____ White_____
Ethnicity: Not Hispanic or Latino _____ Hispanic or Latino _____ Unspecified_____
Would you like reminders for future appointments? If so, ☐ TEXT, ☐ EMAIL, or ☐ NONE? (Circle One) * **Phone Carrier**_____

History of Present Illness

Is your visit for wellness care? Y N If yes, skip to **Past & Current Health History**
Specific Concern:_____
When did this begin?_____ How did it originally occur?_____
Is the concern: Getting Better ☐ Same ☐ Getting Worse ☐
If able, describe the concern: Sharp ☐ Dull ☐ Numb ☐ Tingling ☐ Achy ☐ Other:_____
Is this concern: Constant ☐ Frequent ☐ Intermediate ☐ Occasional ☐
Does anything relieve the problem? Y N If yes, what?_____
Does anything make it worse? Y N If yes, what? _____
Previous doctors & treatments: _____
Please rate the pain of the problem if relevant,

Past & Current Health History

Please check each of the following your child has currently, or has had in the past:

☐ Measles, Mumps	☐ Headaches	☐ Stomach Aches
☐ Chicken Pox	☐ Dizziness	☐ Reflux
☐ Eczema/Skin problems	☐ Fainting	☐ Diabetes
☐ Pneumonia	☐ Seizures/Convulsions	☐ Hypertension
☐ Asthma/Wheezing	☐ Heart Trouble	☐ Anemia
☐ Cancer	☐ Orthopedic Problems	☐ Bed Wetting
☐ Hepatitis	☐ Neck Problems	☐ Behavioral Problems
☐ Allergies	☐ Joint Problems	☐ ADD/ADHD
☐ Frequent Colds/Sore throat	☐ Scoliosis	☐ Ruptures/Hernia
☐ Diarrhea	☐ Back Pain	☐ Growing Pains
☐ Constipation	☐ Poor Appetite	☐ Sleep Problems
☐ Ear Infections	☐ Digestive Disorder	☐ Speech Problems

Please list any medications or supplements your child is currently on: _____

Number of doses of antibiotics your child has taken in his/her history: _____

Has your child ever suffered the following spinal traumas?

N Been in car accident	N Fall from bed or couch	N Fall of skateboard or skates
N Broken bones	N Fall off swing	N Fall off bicycle
N Concussion	N Fall off slide	N Fall down stairs
N Sports Injuries	N Fall of monkey bars	N Other: _____

Date of last visit to pediatrician: _____ Purpose of visit: _____

Y N Has your child ever been treated on an emergency basis? _____

Y N Did you choose to vaccinate your child? If yes, which vaccines? _____

Please list any hospitalizations, surgeries, or traumas: _____

Lifestyle & Diet

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours of sleep do you get each night? _____

Do any of your friends or family smoke? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you sometimes get headaches when you read? _____

Do you have trouble paying attention in school? _____

What do you usually eat for breakfast? _____

What do you usually eat for lunch? _____

What do you usually eat for dinner? _____

What kind of snacks do you usually eat? _____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or coffee do you drink each day? _____

How often do you eat fast food? _____

I certify the information provided is accurate to the best of my knowledge. I authorize the doctor to examine and treat my condition as she deems appropriate through the use of chiropractic care.

Child's Name: _____

Guardian Signature: _____ Date: _____

Informed Consent:

CHIROPRACTIC: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the name of the patient below, for whom I am legally responsible for) by Dr. Yost and/or other licensed doctors of chiropractic who now or in the future with at Yost Family Chiropractic Inc.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to reply upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts that known to him or her, is in my best interest. I understand that results are not guaranteed. I have read the above consent. I understand I have the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I have received the Chiropractic Clinic's Notice of Privacy Practices for protected health information. *(Request a copy if needed.)*

ACUPUNCTURE: Acupuncture is the insertion of a thin needle into the surface of the body. A patient may feel a slight pricking sensation near the needle. Patients usually report little or no pain during an acupuncture treatment.
Side Effects: The following side effects may occur and are not limited to the following:

a. Some pain following treatment in the insertion location (uncommon).
b. Minor bleeding from insertion location (occasionally).
c. Minor bruising (occasionally).
d. Infection (rare).
e. Needle sickness (feeling faint or dizzy, rare).
f. Broken needle (almost unheard of).

(Not to mention are many other potential side effects of treatment which are much more common: acquisition of a deeply relaxed state, drugless relief of your condition, enhanced well being, improved immunity and increased mental clarity and insight.)

Although no outcome of treatment can be guaranteed, it is understood that every patient is unique and that each treatment is designed specifically for the conditions of the patient.

MASSAGE: I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massageon anyone whom she deems to have a condition for which massage is contraindicated.

With this knowledge, I give my informed and voluntarily consent to the above procedures:

Print Patient Name: _____ Date:_____

Patient or Guardian Signature: _____

Authorization, Release & Financial Polices:

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of my insurance coverage.

I understand and agree to allow this chiropractic office to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. The following person(s) have my permission to receive my personal health information:

_____ _____

I do understand that insurance companies do not pay for services that they determine to be not "medically necessary" and therefore, may deny payment for services provided to me by the chiropractor. However, I clearly understand and agree that all services rendered to me are my personal responsibility and I am securing my account with the credit card given at time of check in. If payment hasn't been received in 10 days from terminating any care, I authorize deduction from my credit card. PLEASE NOTE: Insurance companies do not pay for care that is not medically-necessary. If your child does not have a musculoskeletal complaint, he/she does not qualify for insurance coverage. I agree to allow Yost Family Chiropractic to use my picture/my child's picture for publication in printed advertisement and/or website.

Print Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

Using Health Insurance?

Because your insurance policy is an agreement between you and that particular company, we ask that you call and determine what your benefits are. Please use this form to assist you in getting your questions answered and helping you understand your chiropractic benefits. Feel free to ask your insurance representative any additional questions you may have.

1. Call the Customer Service/Member # on your insurance card. Follow the automated steps to receive your member benefits.

2. What is Insurance Representatives name: _____

   a. Date: _____ Time: _____

3. My name is _____; I am calling to see what my chiropractic benefits are.

4. I will be seeing Dr. Heather Yost with Yost Family Chiropractic. Is she in or out of network?

5. Is there a deductible? ○{YES} ⊙{NO} (circle one)

   a. If YES, what is my deductible amount? _____

   b. How much has been applied to my deductible? _____

6. What are my chiropractic benefits?

   a. Co-Insurance: _____

   b. Copay: _____

7. Are there any policy limitations such as a dollar amount or number of office visits? _____

_____

   a. If YES, has anything been already applied to these limitations? _____

8. What is my policy period? (example: calendar year) _____

9. Is authorization and/or referral required for my plan? _____

10. Are my covered benefits based on medical necessity? ○{YES} ○{NO} (circle one)

11. Provide your insurance representative with the following codes. Find out if they have the same chiropractic benefit quoted above or if they have a separate benefit.

   a. Are x-rays covered, if done in the office? _____

   b. CPT Code 99202 (Exam): _____

   c. CPT Code 97014 (Muscle Stimulation Therapy,): _____

   d. CPT Code 97112 (ART, Muscle Therapy): _____

   e. CPT Code 29200 (Kinesotape Strapping): _____

Consultations are free of charge and all fees will be discussed before any services are rendered

PS – Have an HSA or FLEX account? Great news! Take advantage of reduced fees *(sometimes even better than your insurance benefits!)* by using these tax savings accounts.

Patient Print Name: _____

Patient Sign: _____ Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20_____

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)

Missed Appointment Policy

Thank you for choosing Yost Family Chiropractic for your health & wellness care. As a client of this practice, please know that we will strive to give you the best care. To accomplish our goal and meet your needs, the following policy applies:

You are responsible for providing a valid credit card number in order to schedule any appointment, including chiropractic, massage, and acupuncture, with Yost Family Chiropractic. This credit card guarantees your appointments with YFC and you will not be charged unless you fail to attend your appointment or do not give us at least 24-hour notice to reschedule. A failure to comply with this policy will result in your card being charged for a $30 appointment fee. For your convenience, we accept all major credit cards.

I understand and agree to the above policy. By signing below I authorize deduction from my credit card on file if I fail to follow this policy.

Printed Name: _____ Date: _____

Signature: _____