Pediatric History Form

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ SS#: _____
Address: _____ City: _____
State: _____ Zip: _____ Birth Date: _____ Sex: _____
Home Phone: _____ Business: _____
Weight: _____ Height: _____ Referred By: _____
Names of Parents/Guardians: _____

Purpose for Contacting Us _____
Other Doctors seen for this condition: Yes: _____ No: _____
Doctor's Names/Prior Treatments: _____

Check any of the following conditions your child has suffered from during the past 6 months:

☐	Ear Infections	☐	Scoliosis	☐	Seizures	☐	Chronic Colds
☐	Asthma/Allergies	☐	Digestive Problems	☐	ADHD	☐	Recurring Fevers
☐	Colic	☐	Bed Wetting	☐	Car Accident	☐	Temper Tantrums
☐	Headaches	☐	Growing/Back Pains	☐	Other:	☐	Other

Family History: _____
Previous Chiropractor: _____ Date of last visit: _____
Reason: _____
Name of Pediatrician: _____ Date of last visit: _____
Reason: _____
Are you satisfied with the care your child received? Yes: _____ No: _____

Antibiotics--Number of doses your child has taken:
In last 6 months: _____ Total during lifetime: _____
Prescription Medications--Number of doses your child has taken:
In last 6 months: _____ Total during lifetime: _____ List: _____
Vaccination History: _____

PRENATAL HISTORY
Name of Obstetrician/Midwife: _____
Complications during pregnancy Yes: _____ No: _____ List: _____
Ultrasounds during pregnancy Yes: _____ No: _____ #: _____
Medications during pregnancy/delivery Yes: _____ No: _____ List: _____
Cigarette/Alcohol use during pregnancy Yes: _____ No: _____
Location of Birth: Hospital _____ Birthing Center _____ Home _____

BIRTH INTERVENTION
Forceps _____ Vacuum Extraction _____ Caesarian Section: Planned Emergency
Complications during Delivery? Yes: _____ No: _____ List: _____
Genetic disorders or disabilities? Yes: _____ No: _____ List: _____

FEEDING HISTORY
Breast Fed Yes: _____ No: _____ How Long: _____
Formula Fed Yes: _____ No: _____ How Long: _____
Introduced to solids at Month: _____ Cows Milk at Month: _____

Allergies/Intolerance Yes:_____ No: _____ List: _____

DEVELOPMENTAL HISTORY

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor or chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to sound _____ Hold Head Up _____ Cross Crawl _____ Walk Alone
_____ Respond to Visual Stimuli _____ Sit Up _____ Stand Alone _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie, bed, changing table, down stairs, etc).
Was this the case with your child? Yes: _____ No: _____ List: _____
Is/has your child been involved in any high impact or contact type sports (ie, soccer, football, gymnastics, baseball, cheerleading, martial arts, etc?
Yes: _____ No: _____ List: _____

Has your child ever been involved in a car accident? Yes: _____ No: _____ List: _____
Have your child been seen on an emergency basis? Yes: _____ No: _____ List: _____
Other traumas not described above? Yes: _____ No: _____ List: _____
Prior surgery? Yes: _____ No: _____ _____
Menarche? Yes: _____ No: _____ List: _____

CHILDHOOD DISEASES

Chicken Pox Yes: _____ No: _____ Age: _____ *Rubeola* Yes: _____ No: _____ Age: _____
Rubella Yes: _____ No: _____ List: _____ *Mumps* Yes: _____ No: _____ Age: _____
Whooping Cough Yes: _____ No: _____ List: _____ *Other* Yes: _____ No: _____ Age: _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS. YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS. AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

Advanced Health Chiropractic
FINANCIAL POLICY

CASH PATIENTS: Patients without the benefit of chiropractic coverage on their insurance are **responsible to pay 100%** of their charges as services are rendered. If care becomes extensive, a **payment agreement** can be provided which will spell out a monthly amount.

GENERAL INSURANCE: As a courtesy to you we will bill your insurance company and wait for payment. The insured is responsible for knowing their insurance benefit coverage. Every attempt will be made to determine an estimate of the insured's coverage, but because the insurance policy is a unique agreement between your employer and the insurance company, **we can make no guarantees**. **We cannot become involved in disputes between you and your insurance company** regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, coinsurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc., other than to supply factual information when necessary. Each guest is ultimately responsible for the timely payment of their account.

Your obligation is to pay any and all deductibles and co-payments as you go. **You are also responsible for any "non-covered" services. If your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and after 90 days you will be responsible for payment in full for any outstanding balance. Remember, the care and services were provided to *you* and not your insurance company. You are responsible for all cost incurred in this office.**

MEDICARE: As a participating provider with Medicare, we will accept what Medicare approves for your adjustments. Please be aware that **Medicare covers only chiropractic adjustments**. Medicare does not pay for any other services performed at our office, including but not limited to the New Patient Exam.

WORKERS COMPENSATION: It is your responsibility to provide all necessary billing information to this office before or the day of your initial visit. If you have retained an attorney, you are also further required to provide this office with all attorney information. If you are a Missouri Workers Compensation patient, the laws require you, to get your employer's approval to come to this office. Without this approval, Missouri Workers Compensation will not pay for your care.

PERSONAL INJURY: All patients involved in a personal injury, such as a motor vehicle accident, are required to provide all necessary billing information and attorney information to this office before or the day of your initial visit. If you have retained an attorney you will be asked to sign a lien to protect any outstanding balance in this office at the time of settlement. **Any outstanding balance not paid at the time of settlement is YOUR responsibility.**

CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS: We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
First No Call/No Show - $0
Second (and beyond) No Call/No Show - $25 fee; this will not be covered by your insurance company.

COLLECTIONS FEE: If your account goes 90 days + with no payment and payment arrangements are not made your account will be sent to collections and a $25 fee will be added to cover costs.

I understand the information above and agree to the financial policy

PATIENT SIGNATURE: _____
PRINTED NAME: _____
DATE: _____

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