



WELCOME TO OUR OFFICE

We realize that this is your first visit to our office, and our past experience has shown us that new patients have many unanswered questions on their minds. Our staff will attempt to do everything possible to make you feel at ease, and to answer any questions that you may have.

To ensure your first visit with us is a pleasant one, here are the procedures you can expect during this visit.

1. VIDEO: To acquaint you with our office and explain how we help our patients regain their health, most patients see a short 8-minute video.
2. CONSULTATION: Your doctor will talk to you, review your health history, and determine if yours is a chiropractic case. You will have time to discuss your health concerns with him.
3. EXAMINATION: Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your problem.
5. CHIROPRACTIC DIAGNOSTICS: A computerized scan of your spine will indicate abnormal muscle and nerve activity. A scanner will be placed on your back at precise locations to determine the amount of irritation to your nervous system.
4. X-RAY: Necessary views may be taken to visualize the location of any spinal problem, reveal any pathology, and make your chiropractic care more precise. Before proper care can be rendered, your doctor will study your examination findings. On your follow-up visit the doctor will review with you the findings, and give his specific care recommendations.
5. FUTURE VISITS: Your first visit is complete. Plan to spend about 30 minutes on your next visit to receive the doctor's report of findings and a chiropractic adjustment. Details regarding treatment, expectations, prognosis, health coverage, financial issues, etc. will be discussed in detail before your case is accepted for treatment.

Business Arrangement Policy

We are committed to providing you with the best possible care. If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. Many times the expenses incurred by an individual for health care are paid by insurance companies. Recognizing

this, it is our policy to accept assignment for health care rendered to our patients under the following circumstances:

1. Personal or group health insurance: (partial credit) It is the office policy to ask you to pay the portion of the bill that your insurance company does not pay.
2. Auto accident/insurance coverage: Partial to complete credit with chiropractic insurance coverage.
3. Work injury/compensation coverage: With the employer authorization partial to complete credit.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a service that we perform for our patients, all charges are your responsibility from the date the services are rendered. If there is no health insurance coverage which reimburses you for our services, arrangements will be made with you that will allow you to receive the needed care and take care of expenses on a daily, weekly, or monthly basis. We hope this serves as an introduction that explains and answers some of your questions. We sincerely believe that the best doctor/patient relationship exists when there is complete understanding of treatment and financial responsibilities between the doctor and the patient.

Pediatric Questionnaire

Name _____ SS# _____ DOB ___/___/___ Age _____
Home Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work Phone _____ Your E-Mail _____
Fax Number (To Which Your Confidential Medical Information Can Be Sent) _____
Present Occupation _____ Previous Occupation? _____
Name of Parent or Guardian _____
How Did You Hear About Our Office: _____
Name, Address, and Specialty of Your Referring Health Professional _____

Referring Health Professional Phone# _____ Fax Number# _____
Name and Address of Your Primary Care Physician _____

Primary Care Physician Phone# _____ Fax# _____
Have You or Any of Your Family Members Seen or Received Treatment from a Chiropractor? _____

Chief Health Concerns: _____
Reason for Contacting Us: _____
How Did the Problem Start? ___ Suddenly? ___ Gradually? Post-Injury? ___ Yes ___ No
Have You Ever Been Check For VERTEBRAL SUBLUXATIONS? ___ Yes ___ No
List Other Care Undergone for this Complaint (Including Medications) _____

Duration of Problem (episode) _____ minutes / hours / days / months / years
Pattern of Problem: Constant / Intermittent / Occasional / Cyclical

Initiating Factors: _____
Relieving Factors: _____

Effects of Problem on Body Function and Daily Activities: _____

HISTORY OF BIRTH (please circle appropriate answer)

Hospital / Birthing Center: Home Medical Midwife
Assisted With ___No ___Yes If Yes: Forceps Vacuum Extraction C-Section Induced
Medications Delivered to mother at birth? ___No ___Yes If Yes What? _____
Complications at birth: ___No ___Yes Explain; _____
APGAR at Birth _____ After 5 Minutes _____ Birth Weight _____ Length _____

GROWTH AND DEVELOPMENT

Was the infant alert and responsive within 12 hours of delivery? ___No ___Yes Explain _____
At What age did the child: Respond to Sound _____ Follow an Object _____
Hold up Head _____ Vocalize _____ Sit alone _____ Teethe _____
Crawl _____ Walk _____
Do Sleeping patterns seem normal to you ___No ___Yes

CHEMICAL STRESSORS:

Was your child breast-fed? ___No ___Yes How long _____ Formula introduced at age _____
Type of formula used _____ Introduction of cow's milk at age _____ Began Solid
foods at age _____ Type _____ Age & type of commercial baby food
introduced _____ Food / Juice intolerance ___No ___Yes
(explain) _____
During pregnancy did the mother smoke? ___No ___Yes
Did the mother drink alcohol? ___No ___Yes Any illness during pregnancy: _____
Any supplements of mother during pregnancy: _____
Any drugs taken during pregnancy _____
Any exposures to ultrasound ___No ___Yes If so, how many and what was the medical
reason? _____
Any invasive procedures (amniocentesis, CVS): ___No ___Yes What? _____
Any Pets at home? ___No ___Yes Any Smokers at home ___No ___Yes
Any Vaccinations? Which Ones and any reactions _____

Any antibiotics? ___No ___Yes Explain: _____

PSYCHOSOCIAL STRESSORS.

Any difficulty with lactation? ___No ___Yes Any problems with bonding? ___No ___Yes
Any behavioral problems? ___No ___Yes Onset: _____ Any night terrors, sleepwalking,
difficulty sleeping _____ No _____ Yes Specify _____ Age of child when began
daycare? _____ Average number of hours of television/week? _____ Does
your child seem normal for their age? ___No ___Yes

FAMILY HISTORY

(Check off those involving immediate family and add identification as to:

Mother= (M) Father= (F) Siblings= (S) Grandparents= (G)

- | | | |
|--|--|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Cancer (Type) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Rheumatoid |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Arthritis |

INSURANCE INFORMATION

Primary Insurer _____ Secondary Insurer _____
 Insurer Address _____ Sec. Insurer Address _____
 City _____ State _____ Zip _____ City _____ State _____ Zip _____
 Policy/ ID# _____ Policy/ ID# _____
 Group# _____ Effective Date _____ Group# _____ Effective Date _____
 Policy Holder _____ DOB _____ Policy Holder _____ DOB _____
 Your Employer's Name _____ Phone _____ Fax _____

Is a Referral Required for You to be Seen in Our Clinic? ___Yes ___No

NOTE: If Your Insurance Requires a Referral, and if Such is Not Provided, You Will be Responsible for the Payment of All Charges. All Co-payments are Due at the Time of the Appointment.

AUTHORIZATION AND RELEASE: 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 payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%.

The patient understands and agrees to allow this chiropractic office to use their 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. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____
 Guardian's Signature Authorizing Care _____ Date _____

CONSENT TO TREATMENT OF MINOR CHILD

I authorize the licensed doctor and whomever he/she may designate as his/her assistants to administer chiropractic care as he/she so deems necessary to my (relationship):

_____ (name): _____

Signature: _____ Date: _____

FEMALE PATIENTS

This is to certify that to the best of my knowledge I am NOT pregnant and that X-rays may be ordered. Beginning date of your last menstrual period (date): _____

Signature: _____ 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.

Signature: _____ Date: _____

Understand, and Confirm, That the Above Information is Accurate

Patient Signature	Date