Pediatric New Patient Information

Patient Information

Date:_______________

Child's Name:____ Child's Nickname:_______________________________

Reason for Visit:____

Sex: M / F Date of Birth:_______________ Age:_________ Child's SS#______________________________

Child's Home Phone #:_______________________________________

Child's Home Address:____

Who may we thank for referring you?____

Family Information

Mother's Name___________________________________ Father's Name:_____________________________________

Home Phone #:___________________________________ Home Phone Number:______________________________

Work Phone #:___________________________________ Work Phone Number:______________________________

Parent's Marital Status: ❍Married ❍Single ❍Divorced ❍Widowed

List Ages of other Children in Family:____

Payment Information:

Please read and sign our Financial Agreement. Does your health insurance cover chiropractic? Y / N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for the child's health insurance coverage.

Insured's Name____________________________________ Birth date:________________ SS#________________

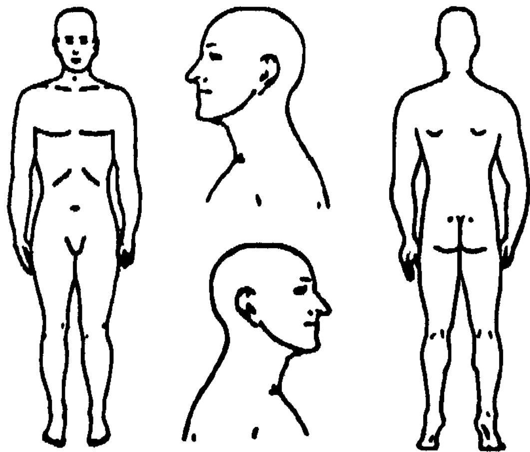
Insurance Company Name:____ Phone #______________________

Insurance Company Address to send claims:____

Employer:_______________________________________ Group#_____________ Insured's ID#_______________

Complaint Form

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM BELOW



Has the child ever had chiropractic care? No Yes

When? ____________Why? ___________________

Where? _____________________________________

What is the **MAIN** complaint? _________________________________Date problem began? ____________________

How did this problem begin? ____

How is the condition changing? GETTING BETTER GETTING WORSE NOT CHANGING

Have the child had this condition in the past? YES NO

How often does he/she experience symptoms? ____

IF APPLICABLE:

Describe the nature of the symptoms:

Burning	Dull	Numb	Radiating pain	Sharp	Shooting	Stabbing	Throbbing	Tightness	Tingling

Other: ____

Please rate the pain on a scale of 0 to 10 (0= no pain and 10= excruciating pain) Check one.

	1		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**

If the condition is improving, how much has it improved since it began? (0%= no improvement; 100%=pain is completely gone)

	10%		**20%**		**30%**		**40%**		**50%**		**60%**		**70%**		**80%**		**90%**		**100%**

What activities aggravate the condition? ____

What makes the pain better? ____

Consent to Treat

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named ____ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent/Guardian Name (Printed):____

Parent/Guardian Signature:____

Date:____________________________

Authorization of Appointment Reminders

It is our desire for our staff to use your name, address and/or telephone number, and/or e-mail address for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from Dr. Donna Cray or on your relationship with our staff.

Your signature indicates your authorization of this activity.

____ ______________

Parent/Guardian Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

Financial & Record Policy

The following is information you should know to help you have a more satisfying relationship with our office staff and chiropractor. Please review this information as well as the enclosed financial policy.

PLEASE NOTE:

If you are late, you may be asked to reschedule your appointment. Our doctor makes every effort to stay on schedule and late arrivals will not allow us to do so.

CHECK-IN:

All patients must sign in at the front desk. After you check-in, new patients will be asked to turn in the paperwork. Patients will be asked to verify current information such as your address and insurance. You will be asked to present a photo ID for us to photocopy to verify your identity. You may be asked to update our patient information form if we do not have a current one on file. If you have brought with you any MRI'S or other X-rays, they should be given to the front desk.

- **Payment is expected at the time of service unless other arrangements are made in advance.** Payments may be made with cash, check, Visa or MasterCard. We will file all claims with the insurance company. You are responsible for payment of all co-insurance, deductibles, and co-pays. **If a dispute with the insurance company arises, you are responsible for settling the dispute with your insurance company.**

- There will be a twenty-five dollar ($25) fee for all returned checks.

- **There is a twenty-five dollar ($25) charge for all missed appointments. You can leave a message on our voice mail 24 hours a day.** Your insurance company will not pay this charge. It is your responsibility.

- There is a **$20 service fee** for accounts that are sent to the collection agency or that are **over 60 days** past due. I guarantee payment in full of the patients account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs. Accounts that are not settled within 30 days of being sent to the collection agency will incur additional collection agency fees.

- Frederick Family Chiropractic, LLC is responsible for all records and x-rays in accordance with policy WAC 246-808-650. In keeping with this policy, **the patient may check out x-rays for 60 days. If the x-rays are not returned within 60 days, a fee of $75.00 will be assessed to the patient.**

- A copy of your medical records may be provided for a fee (Indiana Title 16-39-9-3). The fee structure is as follows:
  - Fifteen dollar ($15) copying fee for each medical record request
  - Twenty-five cent ($0.25) per page charge after the first ten (10) pages
  - Actual postage costs

I have read and understand the above financial policy.

________________________________ ____________________

Patient/Guardian signature Date

Patient Acknowledgement and Receipt of

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

Name__________________________________ Date_______________

Print Patient's Name

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______________________________________

Signature of Parent/Guardian