WELCOME TO FETZER FAMILY CHIROPRACTIC

Patient Information

*Thank you for choosing **Fetzer Family Chiropractic** for your health care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

Today's Date: _____ Parent's e-mail address:_____

Child's Name: _____ Birth Date: _____

Address:_____

City:_____ State: _____ Zip Code :_____ Home Phone #: _____

Mother's Name: _____Cell/Work Phone #:_____/_____

Father's Name: _____Cell/Work Phone #:_____/_____

Preferred contact number: Mother's Home / Cell / Work Father's Home / Cell / Work

Would you like to receive a text message / email reminding you of an upcoming appointment? **Y** or **N**

Emergency Contact_____ Phone #_____

Whom can we thank for referring you? _____

Child's Race, Ethnicity and Primary Language

Race – Please check one

__American Indian or Alaska Native
__Asian
__Black or African American
__Native Hawaiian or other Pacific Islander
__White
__Other _____
__Declined __Unknown/Unavailable

Ethnicity – Please check one

__Hispanic or Latino
__Not Hispanic or Latino
__Declined
__Unknown/Unavailable

Is English your primary language? **Y** or **N** If no, please list_____

PHI – Personal Health Information

Personal Health Information regarding your child may be communicated in the following way (please select one or more):

__No preference
__In person only
__Preference specified below:
__Mailing address may be used for written communication
__Messages may be left on answering machine at primary phone number listed
__Voice mail message may be left on primary phone number or cell phone listed
__Text message may be sent to cell phone

Payment/Insurance Information

Please read/sign the *Fetzer Family Chiropractic* Financial Policy and give the front desk a copy of your child's insurance card.

Health Questionnaire

Reason for today's visit: _____

When did these symptoms begin? _____

How frequent are the symptoms? Constant Frequent Intermittent Occasional

When are the symptoms worse? Morning Afternoon Evening No Change Other _____

What relieves the symptoms? _____

What activities are limited by the symptoms? _____

Other doctors seen for this condition: _____

Has your child ever been to a chiropractor before? **Y** or **N**

Is this condition due to an accident? **Y** or **N** If yes, date: _____ Auto Other

Current height _____ Weight_____

Previous Surgeries (please list procedure and year): _____
_____

List all Prescription and Over-the-Counter Medications that your child is taking: _____
_____

List all Nutritional and Herbal Supplements that your child is taking: _____
_____

What do you hope to get from your child's visit/treatment?

_____Reduce symptoms
_____Improve sleep
_____Improve behavior
_____Explanation of condition/treatment
_____Diet and Nutritional Advice
_____Preventing symptoms in the future

Pregnancy History (Mother): Did you experience any of the following during pregnancy?

__Severe viral infection during 1st trimester
__Breech position
__Accident or Injury
__Severe stress
__Pre-eclampsia
__Alcohol or drug use
__Radiation Exposure
__Hypertension (high blood pressure)
__Diabetes
__Back pain

Labor and Delivery History: Did you and/or the child experience any of the following during birth?

__Hospital birth
__Home birth
__Long and/or difficult labor
__Rapid delivery
__Induced labor
__Elective c-section
__Emergency c-section
__Breech birth
__Forceps or vacuum
__Fetal distress
__Cord around the neck
__Antibiotics
__Premature delivery
__Positional issues ("sunny-side up")

Newborn History: Did the child experience any of the following as a newborn?

__Required resuscitation/oxygen
__Prolonged jaundice
__Poor sleeper
__Immunizations in hospital
If yes, specifiy vaccine:
__Uneven skull (cone-head or flat spots)
__Colic
__Formula fed
__Breast fed
__Difficulty latching/sucking

Length at Birth: _____ Weight at Birth: _____

Health History: Has your child experienced any of the following?

__Illness accompanied by high fever
__Headaches
__Seizure/convulsions
__Chronic ear infections or fluid
__Head injury
__Falls, clumsiness, or poor coordination
__Neck or back problems
__Joint problems
__Scoliosis
__Adverse reaction to vaccination
__Diabetes
__Hypoglycemia (low blood sugar)
__Heart condition
__Trouble with bladder control (enuresis)
__Digestive disorders (diarrhea / constipation)
__Asthma
__Sinus problems
__Eczema
__Allergies (food / environmental / chemical)
__Other: _____

Neurological History: Had your child been diagnosed with any of the following?

__Hearing loss
__Vision impairment
__ADD or ADHD
__Dyslexia
__Anxiety/Depression
__Obsessive/Compulsive Disorder
__Autism/Autism Spectrum Disorder
__Other:_____

Did your child crawl (on all fours)? **Y N** At what age did your child walk unassisted? _____

AUTHORIZATION FOR CARE OF A MINOR

I authorize the Doctors of Chiropractic at Fetzer Family Chiropractic to evaluate and treat my son/daughter as they deem necessary.

Parent/Guardian Signature: _____ Date:_____

I have read and understand the payment policy of Fetzer Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Fetzer Family Chiropractic and my insurance company. I request that Fetzer Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Fetzer Family Chiropractic that all charges will be due and payable immediately.

_____

Patient's signature (or guardian if patient is a minor) Date

CREDIT CARD GUARANTEE

By having health insurance it is designed to keep *your* out of pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance and wait up to 60 days for payment. Please remember, that you are ultimately responsible for payment. If you have a co-pay, these will be collected at time of service. As a pre-requisite, we ask that you leave a credit card to guarantee payment of any additional fees. These fees will be charged on your designated credit card on file for the remaining balance after insurance has paid their portion on or around the 15th of the month.

Credit Card: Visa Mastercard Discover Flex Card/HSA

Card # _____

Cardholder Name_____ Vin #_____ Exp.Date_____

Zip Code _____ (The zip code that the card billing goes to)

I agree to the above terms and authorize you to bill the designated credit card. I understand that should payment not be received within 60 days of submission of my claim, I will be charged the amount due.

Patient's signature Date

Fetzer Family Chiropractic

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Non Insured Patients

We request that 100% of the first visit be paid at the time of the visit. We are happy to accept your check, Discover, Master Card, or Visa. We do offer a Time of Service discount of 20%.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card or your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for the following companies: Blue Cross Blue Shield, Medica, United Healthcare, Healthpartners, Noridian, Cigna, UMR, etc.

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you once your deductible is met.

2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____co-pay. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

FLEX PLANS / HEALTH SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.