PEDIATRIC PATIENT INTRODUCTION

Child's Name:_____ Mother's Name:_____ DOB:_____

Case Number:_____ Father's Name:_____ DOB:_____

Address:_____ City/Town:_____ State:_____ Zip:_____

Home Phone:_____ Mother's Work Phone:_____ Mother's Cell Phone:_____

Email:_____ Father's Work Phone:_____ Father's Cell Phone:_____

Birth Date:_____ _____ _____ Age:_____ Sex:_____ Number of Siblings:_____ Referred by:_____

Birth Weight:_____ Birth Length:_____ Current Weight:_____ Current Length:_____

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps_____ Cesarean_____ Suction Cap or Vacuum_____

Location: Home_____ Birthing Center_____ Hospital_____

Problems During Pregnancy:_____

Problems During Labor/Delivery:_____

Apgar Scores:_____ _____ Was there presence at birth of: Jaundice (Yellow)? _____ Cyanosis (Blue)? _____

Congenital Anomalies/Defects?_____ If Yes, Please Explain?_____

Infant Feeding: Breast_____ Bottle_____ If Bottle, Which Formula? _____

Number of Hours Sleeping per Night:_____ Quality of Sleep: Good_____ Fair_____ Poor _____

Obstetrician/Midwife:_____

Pediatrician/Family MD:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Immunization History:_____

Number of doses of antibiotics your child has taken: During the past six months_____ During his/her lifetime_____

Previous Chiropractor:_____

Date of Last Visit:_____ _____ _____ Purpose:_____

Has your child ever been treated on an emergency basis?_____ If yes, please explain:_____

Purpose of this Appointment:_____

Insurance/Billing Information:_____ Policy #:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED:_____ WITNESSED:_____ DATE_____ _____ _____

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-rays remain the property of this office.

SIGNED:_____ DATE_____ _____ _____

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PEDIATRIC CASE HISTORY

Delivery/Birth History:_____

_____

_____

_____

At what age did the child:

Respond to Sound_____ Follow an Object with His/Her Eyes_____ Hold Head Up _____

Sit Alone_____ Crawl_____ Stand_____ Walk Alone_____

At what age, if ever, did this child suffer from the following childhood diseases?

Chickenpox_____ Mumps_____ Measles_____ Rubella_____

Rubeola_____ Whooping Cough_____ Other_____

Has this child ever suffered from:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to_____
☐ Sinus Trouble	☐ Poor Posture	☐ Diabetes	☐ Allergies to_____
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Allergies to_____
☐ Colds/Flu	☐ Walking Trouble	☐ Anemia	☐ Other_____
☐ Colic	☐ Broken Bones	☐ Bed Wetting	☐ Other_____

Has this child ever suffered the following spinal traumas?

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from highchair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other_____

Has this child ever sustained an injury playing organized sports?_____ If yes, please explain:_____

_____

Has this child ever sustained injuries in an auto accident?_____ If yes, please explain:_____

_____

Present History:_____

_____

_____

_____

Surgery:_____

Medications:_____

Accidents:_____

Family History:_____

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Patient Financial Policy

In the interest of good communication and our continued commitment to provide high quality chiropractic care, we have established a Patient Financial Policy.

We are committed to supporting you in understanding your spinal health and will always present you with the best recommendations to treat your personal situation. To make these services affordable we are pleased to offer you the following payment options:

1. Cash
2. Check
3. Visa, MasterCard, Discover, American Express

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

MEDICAID and MEDICARE do not cover exams or x-rays. The cost of these services will be the patient's responsibility, which is due at time of service.
EXAMS ARE $80, INFANT EXAMS ARE $100.
X-ray cost depends on which region of the spine is x-rayed as well as how many views are taken.

Missed or cancelled appointments may be subject to a $25 "**no show fee**" if our office does not receive 24 hour notice.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered.

Most out of network insurance policies will be billed for you. However, patients will be responsible for payment for services rendered, and your insurance will reimburse you depending on your out of network benefits.

Signature _____ Date _____

THRIVE Chiropractic
Advanced | Wellness Solutions

Late Appointment Policy

If you are an established patient and arrive late to your appointment, you will likely be asked to reschedule unless the doctor's schedule can still accommodate you. Priority will be given to the patients who arrive on time. One or two late patients cause the entire daily schedule to fall behind, which is an inconvenience for other patients. We strive to see each patient as close to their scheduled appointment time as possible.

The same terms apply if you arrive late to a massage appointment. You may be asked to reschedule at the discretion of the massage therapist.

Cancellation Policy

We ask that if you need to reschedule or cancel your appointment, you notify our office at least **24 hours** in advance. When a patient does not call in advance, they may be preventing another patient from getting much needed treatment due to a seemingly full schedule.

Missed Appointment or "No-Show" Policy

While we make every effort to provide reminder text alerts and e-mails, it is your responsibility to remember your appointment. We charge a $25 missed appointment fee to patients who do not keep their scheduled appointment or who cancel less than 24 hours in advance. This fee is not covered by your insurance company.

A $50 no show fee will be charged for a missed massage appointment.

Signature _____ Date _____

Consent to treat / Assignment of Benefits

I hereby authorize Jeffrey Pearson D.C., and/or Chelsea Pearson D.C., to examine and treat me. I hereby request and consent to the performance of procedures, which may include but is not limited to various modes of physical therapy, diagnostic x-rays, and/or chiropractic adjustments on me (or the patient named below, for whom I am legally responsible) by the doctor named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back up for the above mentioned doctors and Thrive Chiropractic.

I understand and am informed that in the practice of medicine and in the practice of chiropractic there are some risks to treatments including, but not limited to, fractures, disk 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 rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I request that payment of authorized benefits be made either to me or on my behalf to the above mentioned doctors for any services furnished me by that doctor. I authorize any insurance company or any government agency and its agents any information needed to determine these benefits or the benefits payable for related services. I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that verification of insurance benefits is not a guarantee of payment. I understand that I am financially responsible for all charges, whether or not paid by said insurance company. I hereby authorize said assignee to release all medical information necessary to secure payment, including copies of chart notes.

This Assignment will remain in effect until revoked by me in writing. A photocopy of this Assignment is to be considered as valid as an original. If patient is a minor, who is the responsible party? _____

Patient's Name:_____ Signature of Patient:_____

Date Signed:_____ Witness or Patient's Guardian Signature

_____

To be completed by patients representative if patient is a minor or physically or legally incapacitated

Patient's Name:_____ Signature of Patient:_____

Date Signed:_____ Representative's Signature:_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operation, 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 HIPPA 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 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 request 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 affect 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 officer 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 the health care operations our office has the right to refuse to give care.

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Patient Health Information Consent Form Acknowledgement of Receipt

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

Print Name:_____

Patient Signature_____Date:_____