ABUNDANT HEALTH
CHIROPRACTIC

Pediatric Patient Information **Date: _____**

Name: _____ Nickname**:** _____

Street Address: _____

City:_____ State: _____ Zip code: _____

Female: ____ Male: ____ Date of Birth: _____

SSN: _____-____-_____ Referred by:_____

Name of Parent:_____Phone_____Cell Phone Carrier_____

Purpose for Contacting Us?

_____

_____

_____

Other Doctors Seen for this Condition:_____N_____Y Doctors' Names and Prior Treatments:_____

_____

Please check conditions your child currently has or has had in the past 6 months:

___Allergies
___Asthma
___Attention Problems/ADD/ADHD
___Back Pain
___Bed Wetting
___Bronchitis/Upper Respiratory Infections
___Chronic Colds
___Colic
___Constipation/Diarrhea
___Digestive Problems
___Ear Infections
___Ear Infections
___Eczema/Skin Problems
___Growing Pains
___Headaches
___Recurring Fevers
___Car Accident
___Scoliosis
___Seizures
___Sinus Trouble
___Temper Tantrums
___Other

_____

_____

Previous Chiropractor:_____

Date of Last Visit: ___/___/____ Reason:_____

Name of Pediatrician:_____

Date of Last Visit:___/___/____

Are you satisfied with the Care your Child has Received There? ____N ____Y

Vaccination
History:_____
_____
_____

Please list any medications or vitamins/supplements your child may be taking:

Medications	Vitamins/Supplements
_____	_____
_____	_____

 # Of doses of antibiotics your child has taken: _____6 months _____ during lifetime

Were there any complications in pregnancy or birth of this child?
_____

Ultrasounds During Pregnancy?____N____Y, Number: _____
Medications During Pregnancy/Delivery? _____ N____Y, List:_____
Cigarette/Alcohol Use During Pregnancy: _____N____Y

Location of Birth_____ Hospital_____Birthing Center_____ Home
Birth Intervention_____Forceps_____ Vacuum Extraction____
_____Caesarian Section, Emergency or Planned?
Complications During Delivery?____N_____Y, List:_____
Genetic Disorders or Disabilities:____N____Y, List:_____

Birth Weight:_____ Birth Length:_____ APGAR Scores:_____

Feeding History:

Breast Fed:_____N_____Y, How long:_____

Formula Fed:____N_____Y, How long:_____

Introduced to Solids at:___Months, Cows' Milk at _____ Months

Food Intolerances_____N_____Y, List:_____

Any other dietary preferences/restrictions your child may have:
_____
_____

Does your child consume any of the following? Please check:

___Juice	___glasses/day	___Sugar	___/day
___Soda	___/week	___Processed Food	___/week
___Milk	___glasses/day	___Sweeteners	
___Fast Food	___/week	___Other _____	

Developmental History:

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

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

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child ? _____N _____Y

Is / has your child been involved in any high impact or contact type sport (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Marital Arts, etc.)? _____ N _____Y, List:

_____

Has your child ever been involved in a Car Accident? _____ N _____ Y, List:

_____

Has your child been seen on an Emergency Basis? _____ N _____ Y, List:

_____

Other Traumas Not Described Above? _____ N _____ Y, List:

_____

Prior Surgery: _____ N _____ Y, List:

_____

Menarche: _____ N _____ Y, Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

ABUNDANT HEALTH
CHIROPRACTIC

Consent to Chiropractic Services for a Minor-

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

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment. The objective of chiropractic health care in this office is ***to improve and optimize the health and wellbeing of the spine and nerve system through the correction of Vertebral Subluxations***.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Our chiropractic method of correction of a vertebral subluxation is by specific adjustments of the spine. An adjustment is the specific application of forces made by hand or with an adjusting instrument.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I, _____ have read and fully understand the above (print name).

Outcomes and options relative to care have been discussed and noted. All questions regarding the doctor's objectives pertaining to my child's care in this office have been answered to my complete satisfaction.

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary:

_____ _____

(signature) (date)

Financial Policy

Payment in full is expected in all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. **The cash fee for a new pediatric patient should not exceed $128, which includes the initial consult, a chiropractic exam, x-rays and if applicable the first adjustment.**

If your insurance company covers Chiropractic care and you would like us to assist you in the billing process please fill out the "insurance permission" section below.

Returned checks and balances over 30 days will be subject to additional collections fees and interest charges. (Past due account will be sent to collections after 60 days). I understand that I am responsible for any charges and fees from the collections agency.

Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regards to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

I have read, understand & agree to financial policies for Abundant Health Chiropractic.

Signed_____ Date_____

Witness_____ Date_____

Insurance Permission

As a courtesy to you we will bill your insurance company. If payment is not received after 30 days, you should contact your insurance company and have them make payment. If, after 60 days, payment is still not received, you will be responsible for payment. We need your permission with respect to the following two statements or we cannot make claims directly to your insurance company:
"I authorize Abundant Health Chiropractic to release to my insurance company any medical or other information necessary to process my insurance claims."
"I authorize payment be made directly to Abundant Health Chiropractic. I permit a copy of this authorization to be used in place of the original."

Signature: _____ Date _____

Also, if you are <u>not</u> the subscriber on your health insurance policy, please provide the following subscriber information which is important for looking up medical benefits information and in the claims submission process. Thank you.

Subscriber's name: _____ Subscriber's date of birth: _____

ABUNDANT HEALTH
CHIROPRACTIC

Appointment Reminders and Health Care Information Authorization

The following office procedures allow Abundant Health Chiropractic to operate in an efficient manner and allow us to support our practice members/patients with their care. By signing below you are giving us authorization to follow through with these procedures. Should you desire something not be done, place a line through anything you refuse and initial.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We require 24 hour notice to cancel an appointment. Any missed appointments without notice will result in a $10 fee.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including postcards) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care. We would like to directly thank the person who referred you and use your name.
- When you refer anyone to us, we would like to directly thank you and publicly thank you on our office announcement board.
- We would like to be able to refer others to speak with you about your experience at Abundant Health Chiropractic.
- We often take and post photos of our practice members/patients in the office and in our newsletters.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Abundant Health Chiropractic.

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.

We at Abundant Health Chiropractic are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a practice member/patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have received a copy of Abundant Health Chiropractic's *Notice of Privacy Practices for Protected Health Information.* Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

_____ _____

Patient name printed Date

_____	_____
Patient Signature	ABC representative