

CONFIDENTIAL PEDIATRIC HISTORY - Age 6 or younger

Date _____

Name (including middle initial) _____

Male Female Preferred Language _____

Address _____

City _____ ST _____ Zip _____ Social Security Number _____

Age _____ Birth Date _____ Age of Siblings _____

Home Phone _____

Ethnicity: *Hispanic or Latino* *Not Hispanic or Latino* *Decline to Answer*

Race: *Black or African American* *White (Caucasian)* *Other* *Decline to Answer*

Parent/Guardian _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Responsible Party's Employer _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Chief Complaint _____

Previous Doctor of Chiropractic _____ Date of last visit _____

Reason _____

Present M.D. and Address _____

Date of last visit _____ Reason _____

Birth History (c-section, forceps, other difficulties, normal, etc.) _____

Accidents _____

Illness/Hospitalization _____

Family History (Health problems with parents or siblings) _____

Sleep Patterns _____

Exercise Routine _____

Temperament and Social Interactions _____

Does anyone in the household smoke? _____

Patient Name _____ Date: _____

Child's Daily Dietary Habits *Please Circle*

Fruits Vegetables Protein Sugar Milk

Grains: refined unrefined

Frequency of eating _____

Types of snacks _____

Infant Milk: Human Formula Cow: 2% Whole Goat

Is there anyone you would like us to keep informed regarding your child's treatment at this office?

e.g. family physician, referring doctor, etc. Yes No.

Please specify name and address, if known _____

What Supplements are they taking? _____

What **non-prescription** medication are they taking? Tylenol Ibuprofen Aspirin Other

What **prescription** medications or Drugs are they taking?

****** If they take more than 4 prescription medications, please provide us with a medications list******

Medication Name _____ Dosage & Frequency _____

Medication Name _____ Dosage & Frequency _____

Medication Name _____ Dosage & Frequency _____

Medication Name _____ Dosage & Frequency _____

Do they have any medication allergies? If so, please list medication name, reaction & onset date.

I hereby authorize Mt. Lookout Chiropractic and whomever they may designate as their clinicians to administer care as they so deem necessary to my child/ward (listed above). I accept responsibility for payment for services rendered.

Signature of Parent/Guardian

Witness

Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC EXAMINATION AND TREATMENT On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, the Doctor of Chiropractic may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to, or refuse, certain aspects of care once therapeutic options have been presented.

RISKS OF CHIROPRACTIC CARE AND TREATMENT I understand and have been informed that there are risks of side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications from chiropractic treatment are rare and unlikely, events ranging from soreness, sprains and strains, to fracture or dislocation, to injuries of the spinal discs, nerves and cord have occurred. Cerebrovascular accidents, such as a stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.8 -5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke,). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand and I do not expect the Doctor of Chiropractic to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor of Chiropractic to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

I will immediately notify a member of the office staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if, for some reason, I am unable to reach or contact the practice, that I should telephone my personal primary care doctor or present myself to the nearest hospital emergency room.

ALTERNATIVE TREATMENTS AVAILABLE I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, non-treatment, treatment and evaluation by another provider, and surgery. Each is associated with their own benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting condition(s) at any time.

CONSENT By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

I, the undersigned, hereby request, consent to, and authorize Mt. Lookout Chiropractic & Sport Injury Center to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the scope of the practice of chiropractic care. I attest that the information provided in regards to my, or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, nor omission. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from any treatment rendered.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

Signature (Patient, Parent, or Legal Guardian)

Print Name (Patient, Parent, or Legal Guardian)

ERISA AUTHORIZATION (EMPLOYEE RETIREMENT INCOME SECURITY ACT)

I hereby designate, authorize, and convey to Mt. Lookout Chiropractic & Sport Injury Center to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. (2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Mt. Lookout Chiropractic & Sport Injury Center and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

PATIENT COMMUNICATIONS POLICY

It is the policy of Mt. Lookout Chiropractic & Sport Injury Center to not leave messages via voicemail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this office or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, often requesting a return phone call to discuss pertinent information. However, with your consent, detailed information can be left via the following methods:

I hereby authorize that Mt. Lookout Chiropractic & Sport Injury Center can leave detailed messages regarding my healthcare via voicemail at the following phone numbers that I have provided:

Cell Home Work

I hereby authorize that Mt. Lookout Chiropractic & Sport Injury Center can leave detailed messages regarding my healthcare via another person reached at the following phone numbers that I have provided:

Cell Home

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorization pertaining to myself or my dependent. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

Signature (Patient or Responsible Party)

Print Name (Patient or Responsible Party)

Date

CONSENT TO TREAT A MINOR WITHOUT PARENT OR GUARDIAN PRESENT

I do hereby authorize and give my consent to Mt. Lookout Chiropractic & Sport Injury Center to provide evaluation and treatment as needed and necessary to my minor child in my absence following initial consultation.

Yes No

My child will be accompanied by (check all that apply):

Himself or Herself

Other: _____

Other: _____

Signature (Patient or Responsible Party)

PRIVACY PROTECTION AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider.

I hereby authorize Mt. Lookout Chiropractic & Sport Injury Center to release a complete report of services rendered including diagnosis, findings and details of treatment, and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, attorney, or other intermediaries responsible for payment of my charges and hereby release Mt. Lookout Chiropractic & Sport Injury Center from any consequences thereof. I understand that I may revoke this consent at any time by giving written notice.

Please list below the names of and your relationship to individuals whom you authorize Mt. Lookout Chiropractic & Sport Injury Center to release your protected health information.

Name and Relationship

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Mt. Lookout Chiropractic & Sport Injury Center to ensure the privacy of my protected health information. I understand that this acknowledgement will be placed in my electronic file and maintained for six years. A copy of this notice is available at any time upon request.

AUTHORIZATION TO ACQUIRE HEALTHCARE INFORMATION

I hereby authorize Mt. Lookout Chiropractic & Sport Injury Center to obtain details regarding my current and/or prior care health status from my primary care provider, referring

provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that are held regarding my medical and health management are applicable for release. This release does NOT allow information pertaining to drug and/or alcohol abuse, or mental health information to be included. I understand that I may revoke this consent at any time, except to the extent that action has already been taken, with written notice.

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL POLICY

In consideration of all services provided, I hereby assign and transfer to Mt. Lookout Chiropractic & Sport Injury Center all of my rights, title, and interest to healthcare reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered, including Medicare Part B. I certify that the health insurance information that I have provided is accurate and that I am responsible for keeping it updated.

I understand that I will be fully responsible for payment of any and all charges not paid by health insurance. I understand that the balance of my account is due in full within 30 days of notice, unless a payment plan arrangement has been made in advance. In the event that a bill is disputed, notification must be made within 30 days. If I do not notify Mt. Lookout Chiropractic & Sport Injury Center within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days may be reported to a collection agency, and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

I hereby authorize Mt. Lookout Chiropractic & Sport Injury Center to submit claims, on my or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I have provided, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Mt. Lookout Chiropractic & Sport Injury Center directly for services rendered to me or my dependent.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Mt. Lookout Chiropractic & Sport Injury Center are paid in full. I also understand that I am responsible for all amounts not paid by my health insurance, including co-payments, co-insurances, and deductibles.

Mt. Lookout Chiropractic & Sport Injury Center accepts cash, personal check, Visa, Discover, and MasterCard. I understand that I will have to pay a \$30.00 fee for each check that is returned to Mt. Lookout Chiropractic & Sport Injury Center for non-sufficient funds.

Prior balances considered delinquent must be paid prior to being seen for any further scheduled visits. Charges added to your account will be due in full when stated on the invoice.

EXTENDED FINANCIAL POLICY

Please read our financial policy in its entirety. If you have any questions or concerns please feel free to ask any questions that you may have. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

INSURANCE It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will copy for our records. We will request a copy at each annual office visit, or if you have not been seen in the past twelve months. If your insurance information changes at any time during your treatment, it is ultimately your responsibility to provide us with the new information as soon as it becomes active. If current information is not obtained at the time of service it will be the patient's responsibility to pay the entire balance until current information is provided to our office. It is the patient's responsibility to know their benefits and coverage.

Your insurance policy is a contract between you and the insurance company. As a courtesy and pursuant to contractual obligations we will file all your claims for you. However, we will not become involved in any disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copays, and non-covered charges.

REFERRALS Some insurance policies require you as the policy holder to obtain a referral from your primary care physician, or student health center prior to receiving treatment at our office. It is your responsibility to obtain this documentation and present it to our office at the time of service. If this information is not obtained, you will be responsible for the entire balance of your account.

COPAYS Copays are due at the time of service. Copays are usually collected PRIOR to you seeing the doctor but may sometimes be collected after you have received treatment.

MEDICARE If you are a Chiropractic Medicare patient you will be responsible to pay for your exam on your first visit, at the time of service. While Medicare requires an exam they do not cover it. Exams are typically \$110-\$125. Xrays are also not covered by Medicare and the cost would be your responsibility and would also be due at the time of service.

CASH PLANS Cash plans are available for patients who do not have insurance or wish to not bill to insurance. These plans differ and can be discussed with your doctor. Cash plan payments are due at the time of service.

SUPPLEMENTS/MERCHANDISE Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's

responsibility and are not covered by any insurance carrier. These items include but are not limited to, supplements, pillows, back packs, braces, heel lifts, orthotics, and cold packs.

UNPAID/OUTSTANDING BALANCES We ask that full payment be made at the time of service unless prior arrangements have been made, either with your doctor or our billing office. If you have a deductible plan, once insurance has paid you will be mailed a statement: Prompt and timely payment is appreciated. You may call our billing office to set up a payment plan if necessary. Any overdue balances will be considered for collections.

RETURNED CHECKS The charge for a returned check is \$30. This can be paid by cash, money order, or charge. This will be applied to your account in addition to the original amount owed.

MISSED APPOINTMENTS We ask that you keep all scheduled appointments. In the event you are unable to keep your appointment we ask that you provide a:

- Chiropractic- 4 hours notice
- Physical Therapy- 24 hour notice or a \$35 missed appointment fee may apply

CREDIT BALANCES From time to time you may accrue a credit balance. Credit balances will be refunded at the patient's request. Refunds are made by check. After the request for a refund has been made, please allow time for review of your entire account and processing through our accounting department. Once approved please allow 30-45 days for your refund check to arrive.

ADMINISTRATIVE FEE With the increased cost of providing healthcare services, we are implementing a \$2 admin fee per date of service, per provider to continue to offer our excellent & high standard of care.

Patient Initials _____ CA Initials _____

I have read Mt. lookout Chiropractic and Sports Injury Center's Patient Financial Policy and acknowledge my responsibility with my signature below.

Signature (Patient, Parent, or Legal Guardian)

Print Name (Patient, Parent, or Legal Guardian)

MLC Staff Witness

Date

A photo copy of this document will be treated as an original