PEDIATRIC PATIENT INTAKE FORM

Child's Name:_____

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

Phone:_____ Email: _____

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

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

Mother's Name:_____ DOB:_____

Father's Name:_____ DOB:_____

Insurance: □ Excellus □ MVP □ United Healthcare □ Cigna □ Aetna □ Other

Third Trimester Presentation: Vertex_____ Breech_____ Transverse_____ Face/Brow_____

Type of Birth: Normal Vaginal_____ Forceps _____ Suction cap or Vacuum _____ Cesarean_____

Location: Hospital _____ Home_____ Birthing Center_____

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 6 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: _____

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). I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND I AGREE TO PAY FOR ALL SERVICES PROVIDED.

SIGNED: _____ WITNESSED: _____ DATE: _____

PEDIATRIC CASE HISTORY

Delivery/Birth History: _____

_____

At what age did the child:

Respond to sound _____ Follow an object with eyes _____ Hold head up _____

Sit Alone _____ Crawl _____ Stand _____ Walk Alone _____

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

Chicken Pox _____ Mumps _____ Measles _____

Rubella _____ Whooping Cough _____ Other _____

Has the child ever suffered from?

□ Headaches	□ Orthopedic Problems	□ Digestive Problems	□ Behavioral Problems
□ Dizziness	□ Neck Problems	□ Poor Appetite	□ ADD/ADHD
□ Fainting	□ Arm Problems	□ Stomachaches	□ 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 the 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 of bicycle
□ Fall from highchair	□ Fall off slide	□ Fall down stairs
□ Fall from changing table	□ Fall off monkey bars	□ Other

Has the child ever sustained injuries when playing organized sports? _____ If yes, please explain _____

_____

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

_____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

Derleth Chiropractic

Financial Policy

SCHEDULING

- All appointments during regular hours must be scheduled so as to reduce waiting time for you and others
- You are free to stop in at any time, but you will have to wait until all scheduled appointments are seen. You will be fit in as soon as possible.
- Cancellations require 24 hour notice. THERE IS A $20.00 FEE OTHERWISE.

PAYMENT

- Payment is expected in full at the time services are rendered. This includes all co-payments.
- For your convenience we accept Cash, Checks, MasterCard and Visa.
- Payments on your deductible will be made by paying our per visit charge until it is met.
- Should you discontinue care for any reason other than discharge by the doctor; any outstanding balances will become immediately due and payable in full by you.

INSURANCE

- Our office will verify your insurance coverage in effort to help you determine exactly what chiropractic coverage is available under your policy.
- It is your responsibility to provide us with all the appropriate insurance forms, addresses, and information so that proper filing can be done.
- We are not obligated to accept your insurance payment on assignment although for your convenience, we may, based on our experience with your insurance carrier.
- You are always responsible for the portion of your bill that the insurance may not cover and for your annual deductible.
- Remember that your insurance coverage is a contract between you, your employer and the insurance company. We do not bill any secondary insurance carriers.

FEES

- Our fees generally fall between what is considered reasonable and customary for this area.
- Many insurers pay a percentage of the reasonable and customary rate, called the Co-Pay.

LASTLY

- You are responsible for all charges incurred as a patient of this office.
- We will do all we can with your insurance claims, but ultimately, you are responsible for payment.
- Past due statements for unpaid balances will be mailed. Statements unpaid for more than 30 days may be subject to an interest charge. In the effort to avoid expensive collection agency fees we hold the right to automatically bill any unpaid and outstanding balances, including interest payments to any credit card account on file in our office.

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

I, the undersigned, have read and agree to the guidelines of this financial/insurance policy. I also fully acknowledge that I have insurance coverage with _____Insurance Company and assign directly to Derleth Chiropractic, PLLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby, authorize the doctor to release all information necessary to secure the payment of benefits. I authorize that use of this signature on all my insurance submissions whether manual or electronic.

Patient/ Guardian Signature: _____ **Date:** _____

Derleth Chiropractic PLLC
625 Ayrault Road
Fairport, NY 14450
585-598-3535

HIPPA-PATIENT CONSENT

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCAREOPERATIONS

(Name)_____hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing the consent. 1. The Privacy Notice includes a complete description of the use and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for the treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. 2. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice. In accordance with applicable law.[5]

3. I understand that, and Consent to, the following appointment reminders that will be used by the Practice: a) an e-mail mailed to me at the address provided by me; and b) telephoning my home and/or cell phone and leaving a message on my answering machine or with the individual answering the phone.[6]

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care information.[7]

5. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations.[8] However, the Practice is not required to agree to any restrictions that I have requested.[9] However, if the Practice agrees to a requested restriction, then the restriction is binding on the Practice.[10]

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation will not apply to the extent that the Practice has already taken action in reliance on this Consent.[11]

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.[12]

8. I understand that if I do not sign this Consent evidencing my Consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.[13]

I have read and understand the foregoing notice, and all of questions have been answered to my full satisfaction in a way that I can understand.

_____ _____

Name of Individual (Printed) **Signature of Individual**

_____ _____

Signature of Legal Representative (e.g., Attorney-in-Fact, Guardian, Parent): **Relationship**

_____

Date Signed/Witness:

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INFORMED CONSENT TO CHIROPRACTIC CARE

Patient Name_____ Birth date_____

Please discuss any questions or concerns with the Doctor before signing this consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities, physical therapy stretches, and diagnostic x-rays by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with another office or clinic personnel the purpose and benefits of the chiropractic adjustment and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustment and treatments are usually beneficial and seldom cause any problems, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatments: Chiropractic care as stated above.

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Please Print Name of Patient, Parent or Guardian **Relationship to Patient**

Doctor Signature_____