CAPITAL CHIROPRACTIC & REHABILITATION CENTER
In pursuit of your best life

Confidential Patient Information

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PEDIATRIC PATIENT INTRODUCTION

Child's Name:____

Mother's Name:______________________ Father's Name:______________________

Address:______________________ City:______________ State:________ Zip:________

Best Cell Phone:______________ Best Email:______________________

Birth Date:_____ _____ _____ Age:______ Sex:______ Number of Siblings:______ Referred By:______________

Birth Weight:__________ Birth Length:__________ Current Weight:__________ Current Length:______________

Obstetrician/Midwife:____

Pediatrician/Family MD:____

Date of Last Visit:_____ _____ _____ Purpose:______________________

Immunization History (Circle One): Current Delayed Schedule None

Did your child react to them? □Y □N If yes, how so?______________________

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:____

Type of Birth: Normal Vaginal______ Forceps______ Cesarean______ Suction/Vacuum______ Induced Labor__________

Location: Home_______ Birthing Center_______ Hospital_______ Duration of Gestation:______________

Problems during pregnancy:____

Problems during labor/delivery:____

Apgar Scores:______ ______ Was there presence at birth of: Jaundice (yellow)?________ Cynosis (blue)?__________

Congenital anomalies/defect?______ If yes, please explain?______________________

Has this child ever suffered any major traumas?

____

Do the child's siblings have any health problems? □Y □N If yes, please explain? ______________________

Questions about chemical environmental concerns:

During pregnancy, did the mother:

1. Smoke □Y □N
2. Drink alcohol? □Y □N
3. Take supplements/ vitamins? □Y □N
4. Use Medications or other drugs? □Y □N If yes, what?______________
5. Become ill? If so, How?______________
6. Receive invasive procedures? (ie. Amniocentesis, CVS) □Y □N If yes, explain:______________________

Was your child breast fed? □Y □N If yes, for how long?__________ (weeks months years)

At what month/yr was: 1. Formula introduced?________ 2. Cow's milk?__________ 3. Solid foods?______________

Has your child had antibiotics? □Y □N If yes, how many and why?______________________

Any pets at home? □Y □N Any smokers at home? □Y □N If yes, how much?______________________

Psychological Considerations:

Any difficulties with lactation? □Y □N Any problems bonding? □Y □N

Does your child seem normal to you? □Y □N

Does your child have any behavior problems? □Y □N If yes, what?______________________________

Does your child have difficulties sleeping (e.g. night terrors, sleepwalking, etc.)? __________________

Number of hours sleeping per night:_____________ Quality of Sleep: Good____ Fair____ Poor_____

Did your child go to daycare? □Y □N From what age?________

Average number of hours of TV/Computer per week?________

Traumas and Injuries:

Any evidence of trauma at birth? □Bruises □Odd shaped head □Stuck in birth canal □Fast/Long birth

□Respiratory Depression □Cord around neck □Other____

Any falls/accidents during pregnancy? □Y □N If yes, please explain:____

Any hospitalizations? □Y □N If yes, Please explain:____

Does your child play sports? □Y □N Number of hours per week?_______________

Has the child ever sustained injuries in an auto accident? □Y □N If yes, explain:_____________________________________

Approx. hours spent at play per week?____________ hrs

At what age did the child:

Sit alone___________ Crawl___________ Stand___________ Walk Alone___________ Vocalize___________

Did this child suffer from the following childhood diseases?

Chickenpox___________ Mumps____________ Measles__________ Rubella__________

Rubeola__________ Whooping Cough___________ Other___________________________

Allergies:____

Other____

Does your child experience any of these other symptoms?

Headaches	Digestive issues	Behavioral Problems	Dizziness	Neck Problems	Poor Appetite
ADD/ADHD	Fainting	Arm/Leg Problems	Stomach Aches	Hernias	Reflux
Seizures	Cardiac Issues	Constipation	Diarrhea	Growing Pains	Chronic Earaches
Backaches	Sinus Issues	Poor Posture	Diabetes	Asthma	Scoliosis
Asthma	Hypertension	Colds/Flu	Difficulty Walking	Anemia	Colic
Broken Bones	Bed Wetting	Other:			

Anything else you would like to share?

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that, like exercise, it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases, underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. To put these occurrences in perspective, once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

PhysioTherapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Chiropractic Acupuncture adverse reactions include bruising, numbness or tingling near the needling sites, dizziness, or fainting. More rare events include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is a possible risk, though the clinic uses sterile disposable needles and maintains a clean and safe environment.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises, physical therapy and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:____ Date:___________________________________

Signature of Parent or Guardian:____________________________________ Date:_____________________________________
(if a minor)

Signature of Treating Clinician after any questions have been answered:____________________________ Date:______________

Financial/Privacy Policy and Disclaimer

Returned Checks: It is our policy to collect $25.00 for returned checks. This is to cover any fees that apply from the transaction.

Financial Policy Questions: We are happy to address questions regarding your account at any time. Please direct account questions to our billing administrator.

HIPAA Privacy Policy: Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you**.** By signing below, you acknowledge that you have received the HIPAA Privacy Policy and that you understand and will comply with our financial policies.

Collection of Patient Balance

*****Please initial the following to acknowledge that you have read each statement**.

______**Payment is expected at the time of service.**

______Your insurance company can and will be billed, determined by your preference and our current status as in-network or out-of-network with that company. **We cannot guarantee your coverage**, even if our office attempts to confirm your benefits and eligibility. Final approval of coverage is based on the explanation of benefits after the claim has been filed.

______Any balance remaining after insurance benefits are obtained is the responsibility of the patient. Any non-covered services are the responsibility of the patient at the rate determined by in-network or out-of network rates as determined by the insurance company's explanation of benefits.

______If payment is not rendered at the time of service, the patient is expected to remit payment within 30 days of the patient visit.

______All balances remaining unpaid after 30 days may be turned over to a collection agency.

______ **It is the patient's responsibility to understand his/her insurance policy and the intricacies of coverage**. Capital Chiropractic cannot guarantee exact details at any given time.

______ If unable to make your appointment, please notify our office at least 24 hours' notice out of respect and courtesy to other patients. **After two (2) missed/cancelled visits without 24 hours' notice, you will be charged $50.00 for each visit that is missed.** You will be responsible for this payment.

Designation of Authorized Representative

- I do hereby designate Capital Chiropractic and Rehabilitation Center to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Capital Chiropractic and Rehabilitation Center. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any other applicable remedies.

- I do hereby authorize Capital Chiropractic and Rehabilitation Center to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Capital Chiropractic and Rehabilitation Center.

Signature of Patient:____ Date:______________________________

Release of Protected Health Information

I, ____________________________, give my consent to allow the transfer and/or discussion of my protected health information to be released to this office. I understand that as a patient, my health information is confidential, and will be treated as such by this office, Capital Chiropractic and Rehabilitation Center, PLLC. I understand that any information collected by this office will be for the benefit of care provided, and will remain confidential between this office and the providing practitioner.

To attest to my consent to the release of my information, I hereby affix my signature to this authorization.
RPHI expires 3 years after date of signature below.

Signature of Patient:____ Date:______________________________

Signature of Parent or Guardian (if a minor):_____________________________________ Date:_____________________