# Welcome to Our Office

Pediatric Patient Intake

**This Patient Intake will serve as the pediatric patient paperwork and Legal Release for all providers within our Practice Management Group: Beyond Wellness LLC, Loudoun Family Chiropractic LLC, Dee Chiropractic PLLC, Natural Health Therapies LLC, Araya Holistic Pain Management LLC, Elite Performance Chiropractic and Wellness LLC and Core Health Chiropractic**

| | | |
|---|---|---|
| Patient Full Name: | | |
| Patient Preferred Name: | | |
| Parents'/Guardian's Names: | | |
| Home Phone #: | Parent's Cell #s: | |
| Home Address: | | |
| City: | State: | Zip Code: |
| Child's Birth Date: Age: | Gender: Male □ Female □ | SS#: |
| Parent's Email Address: | | |
| How Did You Hear About Us? | | |
| Previous Chiropractic Care? Yes ☐ No ☐ | Approximate Date of Last Visit: | |

**Please check reasons for pursuing chiropractic care for your child**:

- □ He/She is continuing ongoing care from another chiropractor.
- □ I recently had my spine checked and see the value in getting my child checked.
- □ I'm concerned about his/her health and I'm looking for answers.
- □ He/She has a specific condition that concerns me.
- □ I want to improve my child's immune function.
- □ I have no idea why we're here. Please take the time to explain to me what you do for children.
- □ Other (Brief Description): ______________________________________________
______________________________________________

**In order for us to better understand your child's current level of health, please check any of the following body signals which he/she has or has had previously**:

| | | | |
|---|---|---|---|
| □ Headaches/Migraines | □ Asthma | □ Sleep Problems | □ Weight Problems |
| □ Postural Imbalance | □ PPD/Autism | □ ADD/ADHD | □ Seizures |
| □ Bedwetting | □ Ear Infection | □ Frequent Colds | □ Allergy/Sinus Problems |
| □ Scoliosis | □ Growing/Back Problems | □ Digestive Problems | □ Colic |

- □ Car Accident (Brief Description): ______________________________________________
______________________________________________
- □ Other (Brief Description): ______________________________________________
______________________________________________

**Number of times your child has taken antibiotics**:

During the past 6 months: ______________________________

Total during his/her lifetime: ______________________________

List reasons: ______________________________________________________________________________

**Number of doses of other prescription medications your child has taken**:

During the past 6 months: ______________________________

Total during his/her lifetime: ______________________________

List reasons: ______________________________________________________________________________________________

**Prenatal History**:

Adopted: Yes □ No □

Complications during pregnancy: Yes □ No □

List reasons: ______________________________________________________________________________________________

Ultrasounds during pregnancy: Yes □ No □

Medications/drugs/caffeine use during pregnancy? Yes □ No □

List: ______________________________________________________________________________________________________

Cigarette/Alcohol use during pregnancy? Yes □ No □

Location of birth: □ Hospital □ Birthing Center □ Home □ Other: ____________________________

**Birth Intervention**:

| | | |
|---|---|---|
| □ Mother Induced | □ Mother Medicated (Pitocin, etc.) | □ Caesarian Section |
| □ Forceps | □ Vacuum Extracted | □ Baby Given Medication After Delivery |

Complications during delivery? Yes □ No □ List: ____________________________________________________________

Genetic disorders or disabilities? Yes □ No □ List: ____________________________________________________________

Breast Fed? Yes □ No □ How long? ______________ Formula Fed? Yes □ No □ How long? ______________

Food or Other Allergies? Yes □ No □ List: _________________________________________________________________

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (ex. bed, changing table, down stairs, etc.) Was this the case with your child? Yes □ No □

__________________________________________________________________________________________________________________________
_______________________________________________________________________________________________

Is/Has your child been involved in any high-impact or contact-type sports (ex. soccer, football, gymnastics, hockey, basketball, cheerleading, martial arts, etc.)? Yes □ No □

__________________________________________________________________________________________________________________________
_______________________________________________________________________________________________

Has your child been seen in an emergency room? Yes □ No □

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Prior surgery? Yes □ No □

__________________________________________________________________________________________________________________________
_______________________________________________________________________________________________

Office Use Only:

## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

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.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Our only practice objective is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

## Consent to Evaluate and Adjust a Minor

I, [print name] ___________________________________, being the parent or guardian of ___________________________________ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_________________________________ _________________________________ _________________________________

Name of Patient (Print) Parent/Guardian Signature Date

## HIPPA Notice of Privacy Practices and Acknowledgement

I understand that under the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

Conduct, plan, and direct my treatment and follow-up among healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment, and health care operations. I also understand that *Beyond Wellness LLC* is not required to agree to my requested restrictions, but if agreed upon, *Beyond Wellness LLC* is then bound to abide by such restrictions.

_________________________________ _________________________________ _________________________________

Name of Patient (Print) Parent/Guardian Signature Date

## Authorization Form for Other Uses of Protected Health Information

Our notice of privacy practices provides information about how we may use and disclose *Protected Health Information* (PHI) about you, pursuant to the above acknowledgement form. The patient may desire other individuals such as family members to have access to their PHI. Use the spaces below to specify those individuals, their relationship to you, and any limitations (if any) on the extent of their access to your PHI (e.g. billing issues only) and any expiration date to that access.

Name Relationship Limitations/Expiration Date

____________________________________________________________________________________________________

____________________________________________________________________________________________________

The above-mentioned Protected Health Information (PHI) may be subject to re-disclosure by the party receiving the information and may no longer be protected by privacy rules. By signing this form, you authorize Beyond Wellness LLC to the use and disclosure of PHI about you for the reasons stated above. You have the right to revoke this authorization at any time in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of Beyond Wellness LLC.

_________________________________ _________________________________ _________________________________

Name of Patient/Guardian (Print) Patient/Guardian Signature Date

**Patient Financial Policy**

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer, and the insurance company. Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. As a courtesy to you, we will file a claim with your insurance on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

If we do not participate in your insurance plan or you opt to not use your insurance benefits, you will be seen by the practice as a cash paying patient. By accepting this status, you agree that we will assume no responsibility for communicating with your insurer nor will we accept their fee schedule. Payment for your care and treatment will be due at the time of the service. Upon request, we will issue you a super bill so that you may independently submit to your insurance plan for reimbursement.

Due to current federal and insurance regulations, **all** co-payments/co-insurances are collected at time of service, unless prior arrangements have been made. We accept cash, check, Visa®, and MasterCard®. A fee of $30 will be charged for checks returned for insufficient funds. Patient agrees that if account is sent to collections he or she will be responsible for Beyond Wellness Practice Management's costs of collection up to and including attorney's fees. We encourage you to contact us promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or account.

**$50.00 may be charged for not canceling the appointment at least 24 hours prior to the time of the visit.**

**Patient Financial Agreement**

I hereby authorize Beyond Wellness Practice Management and its contracted providers to apply for benefits on my behalf for all services rendered. I certify that the information I have provided in regards to my insurance coverage is correct. I further authorize the release of any information necessary to my insurance company to determine benefits for services rendered. I request that payment of authorized benefits be made payable directly to my rendering provider on my behalf.

I understand and agree that regardless of my insurance status, I am financially responsible for the balance on my account. I understand that if Medicare and/or my insurance provider deny services, then it will be my responsibility to pay for these charges. I have read and understand the above Patient Financial Policy and have provided the practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

A copy of this agreement may be used in place of original.

________________________________________ ________________________

Signature of Patient, Policy Holder, or Legal Guardian Date

________________________________________

Printed Name