PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____

Birth date _____

SS#_____

Age _____ Gender _____ Weight_____

ABOUT THE PARENT

Name_____

Employer_____

Work address _____

Work phone _____

Type of work _____

Marital Status _____

Social Security # _____

Driver's License # _____

E-mail address_____

Payment method ❑ Cash ❑ Check ❑ Credit card

VACCINATIONS

Have you chosen to vaccinate your child? ❑ Yes ❑ No

If yes, check all that your child has received.

❑ DPT ❑ MMR ❑ Chicken Pox ❑ Hepatitis ❑ Other

Describe any and all reactions to vaccine(s).

_____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:
❑ Sports ❑ Auto ❑ Fall ❑ Home Injury
❑ Other

Please explain _____

When did this condition begin? _____

Has this condition
❑ gotten worse ❑ stayed constant ❑ comes and goes

Does this condition interfere with
❑ Sleep ❑ Daily routine ❑ Other activities

Please explain _____

Has this condition occurred before? ❑ Yes ❑ No

Please explain _____

Have you seen other doctors for this condition?
❑ Yes ❑ No

Doctor's Name(s) _____

Type of treatment _____

Results _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that	Yes	No
• Doctors of Chiropractic work with the nervous system?	❑	❑
• The nervous system controls all bodily functions and systems?	❑	❑
• Chiropractic is the largest natural healing profession in the world?	❑	❑
• If Chiropractic care starts at birth, you can achieve a higher level of health throughout life?	❑	❑

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? ❑ Yes ❑ No

Reason for those visits? _____

Doctor's name_____

Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? ❑ Yes ❑ No

Has any child in your family seen a Chiropractor? ❑ Yes ❑ No

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

❑ Drugs / Medicine ❑ Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy?_____

_____

How was your delivery?

❑ Labor chemically induced ❑ Labor was Dr. assisted
❑ C-section delivery ❑ Forceps/Vacuum extraction?
❑ Did Dr. pull or twist baby? ❑ Premature delivery

Please explain _____

Did you nurse the baby? ❑ Yes ❑ No

Did your baby have colic? ❑ Yes ❑ No?
Feeding problems? ❑ Yes ❑ No
Vaccinations? ❑ Yes ❑ No?

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

❑ Allergies
❑ Asthma
❑ Attention problems
❑ Bed wetting
❑ Breathing problems
❑ Colic
❑ Constipation
❑ Digestive problems
❑ Ear problems
❑ Frequent colds
❑ Headaches
❑ Hyperactivity
❑ Irritability
❑ Skin problems
❑ Sleeping disorders
❑ Tubes in the ears
❑ Vision problems
❑ Other _____

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever: …taken antibiotics?	❑	❑	_____
…been hospitalized?	❑	❑	_____
…had a severe fall?	❑	❑	_____
…been in a car accident?	❑	❑	_____
Is your child …accident prone?	❑	❑	_____
Had Surgery? Please Explain…			_____
…currently taking any medication(s)?	❑	❑	_____
…having difficulty interacting with others?	❑	❑	_____

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?

_____

What changes (if any) in your child's health or behavior would you like accomplished?

GOALS FOR MY CHILD'S CARE

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❑ **Relief care** – Symptomatic relief of pain or discomfort

❑ **Corrective care** – Correcting and relieving the cause of the problem as well as the symptoms

❑ **Comprehensive care** – Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care

❑ I want the Doctor to select the type of care appropriate for my condition.

Parent or guardians signature:_____Date:_____

Childs name:_____

AUTHORIZATION FOR CARE OF A MINOR

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill of service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of parent or guardian: Date:

PRIVACY PRACTICES ACKNOWLEDGEMENT
PATIENT RECORD OF DISCLOSURES

Acknowledgement Form

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone**: _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Written Communication**: _____

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ **Work Telephone** _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ **Other:** _____

_____

_____

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to linit the use or disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below if competed properly, will constitute an adequate health record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Back to Health Family Chiropractic

Payment for Services and Supplies Rendered

This is the fun part about our Financial Policy. We work hard to keep the cost of chiropractic care down and affordable. You, our wonderful patients, can help us accomplish this by paying your co-pay and any outstanding balances owed at the time of service. The following is a summary of our payment policy.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Yes, this is true. We require payment at the time we provide services unless other arrangements have been made in advance. This includes applicable deductibles, co-insurances (your percentage of the balance due) and co-pays for participating insurance companies. We accept cash, local checks, debit cards and credit cards; Visa, Mastercard and Discover. There is a $25.00 service charge for returned checks, and we reserve the right to charge a $5.00 processing/administrative statement fee for non-payment of co-pays at the time of service.

We do understand extenuating circumstances may occasionally cause financial hardship. Please call or speak personally with our Billing Specialist to discuss a reasonable payment agreement.

INSURANCE COVERAGE

At the time of your visit, you will be asked to provide your medical insurance card for correct claim processing. As a courtesy to our patients, we process claims for any insurance group in which we are considered participating providers. (This means we have reached a contractual agreement with them for payment of services Back to Health Chiropractic provides to their members.) You are expected to pay your deductible and co-payments or co-insurance ***at the time of service*** whether we are a participating provider or not. If we have not received payment from your insurance company within 45 days, (2 billing cycles), you will be expected to pay the balance in full. You are ultimately responsible for all charges incurred. If your insurance company denies payment for any reason other than an error on our part, it is ***your*** responsibility to follow up with them to appeal. We will not research denials for you unless it is caused by an error within our office. We will be happy to resubmit charges, once you have researched a solution with a representative from your insurance company.

We will gladly bill secondary insurances if we are on their list of participating providers and you notify us that you have a secondary insurance at the time of service.

If we do not participate with your company, or you cannot provide proof of medical insurance coverage, it is expected you will make payment at the time of service.

REFERRALS

If Dr. Molly determines you need to be seen by a specialist, it is your responsibility to check with your insurance carrier to determine if a Referral or Prior Authorization is required. There are numerous levels of coverage and policy requirements within each carrier/company. Our staff is not responsible for knowing whether or not your policy has these requirements, however; they will help you and your provider process the referral.

MISSED OR "NO SHOW" APPOINTMENTS OR LATE CANCELLATIONS

When you miss a scheduled appointment, or cancel it close to the appointed time, it represents a cost to you, to us and to the other patients. Please try to give a 24 hour notice if you can not make an appointment. We reserve the right to charge a $25.00 fee for missed or late cancelled appointments. Excessive missed or "no-show" appointments will sadly result in discharge from the Back to Health practice.

CUSTODIAL PARENTS

By law, you are responsible for payment of your child's medical bills, even if you are not the subscriber of the insurance policy that covers your child's medical services.

SIGNATURE

I have read and understand Back to Health Family Chiropractic's Financial Policy. I agree I am responsible for the balance of my account for any professional chiropractic services rendered. I certify the patient information given is true and accurate to the best of my knowledge. I also agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any fees incurred by the collection agency, in addition to any amount owed for services.

_____ _____

Signature of insured / responsible representative Date

_____ _____

Witness Date

Back to Health Family Chiropractic

Instruction: Fill in Your Name and Name of all Drugs and Vitamins/Supplements you take. Hand in

Name: ______________________________

For Office Use Only (italic categories)

NAME OF DRUG	*DEPLETES/INTERFERES WITH*	*pg.*	*COST*	*Ordered* *Yes*	*No*

SUPPLEMENTS/VITAMINS	Helpful	Somewhat	Not at all	Patient Notes/Comments

For Office Use Only:
Notes:

______________________ /

Physician's Signature/DATE

Back to Health Family Chiropractic
Dr. Molly Keefe
128 North Main Street
St Albans, Vermont 05478
(802) 527-BACK

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CONSENT TO TREATMENT OF A MINOR

I hereby authorize BACK TO HEALTH FAMILY CHIROPRACTIC to evaluate and treat, as they deem necessary, my **daughter/son**(circle one)**,** _____(child's name).

I further attest that I have the legal ability to make medical decisions on my child's behalf.

Date: _____

Signed: _____

Witness: _____

****

r

AUTOMOBILE ACCIDENT HISTORY

AUTOMOBILE ACCIDENT:

Name _____ Sex M / F Age: _____

Address _____ Driver's License # _____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example, head on the dash, chest on steering wheel ? Y / N

If Yes, which part and how? _____

Where you taken after the accident? _____

Were you hospitalized? Y / N When did you go? _____ If yes, how did you get there? _____

If by ambulance, did the ambulance attendants place you in a ____ neck brace ____ back brace ___ other_____

Any medications or medical supplies given? _____

Did you have x-rays, CT, MRI taken? Y / N When? _____ Where? _____

How long were you there? _____

Did you receive care from any other health care specialist? Y / N ? If yes , who? _____

What type of care were you given and for how long? _____

Immediately after the accident were you ____conscious ____ dazed/confused ___unconscious
If unconscious for how long? _____

Where did you feel the pain initially? _____ 72 hours later?_____

What are your current symptoms? _____

Have you ever been injured in a similar manner? Y / N If yes, how and when? _____

_____

ACCIDENT HISTORY:

Date and Time: _____

State How Accident Happened in your own words_____

_____

_____

Were you driving? Y / N Passenger? Y/ N Pediatrian? Y / N
Was it your car? Y / N If not who's car was it? _____

Passenger? Y / N Were you in the Front? Back? right middle or left side? _____

At the time of impact were you: ____looking straight ahead ____ looking to the right ____ looking to the left
___ looking down ____ looking up

AUTOMOBILE ACCIDENT HISTORY(cont.)

Was your vehicle shoved: ___ forward ____ backward ___sideways

Did your vehicle hit: _____another car ____ a sign __ guard rails ___ bridge ___other _____

Were you shoved: ____ forward ___backward ___sideways

Did your seat have a head restraint(headrest?) Y / N If yes, what position: ____low _____midposition _____high

Did your head ride over the headrest? Y / N Did your hat/glasses end up in the back seat or rear window? Y / N

Did any other part of your body hit the interior of the vehicle? Y/ N if yes please specify: ____ seatbelt restraints

___ steering wheel ___ dashboard ___ windshield ___side door ___ side window ___ other _____

Were you holding the steering wheel? Y / N Did you brace your arms Y/ N ____steering wheel ___ dash

Were you surprised by the impact? Y / N

Did you brace your legs against the floorboard? Y /N Was your ankle turned? Y / N

Did the vehicle go into a spin or roll as a result of the impact? Y / N
How much damage to the outside of your vehicle? _____ none _____ some ___ a lot ___ totaled
How much damage to the other vehicle? _____ none _____ some ___ a lot ___ totaled
Other people in car: Name and Address: _____
_____
_____

Other vehicle ? __ car ___ truck __ motorcycle ___ other _____

Who was ticketed? _____ why? _____

Seat Belt On? Y / N Shoulder harness on? Y / N Did the seat belt break? Y/ N Did it contribute to your pain? Y/N

Was it daylight, night, dusk or dawn? _____

Were you tired? Y / N Were you awake? Y / N How long had you been in the car? _____

Where were you prior to the accident? _____ What was the weather conditions? _____

_____ Traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____ The other car? _____

Was your vehicle in: ___ park ___ neutral ___ in gear ___ moving ___ stopped

Were your brakes being applied? Y / N

Type of Road: Two Lane _____ Four Lane ____ Gravel _____ Tar ____ One Way _____ Divided _____

Did it happen at: _____ a stop sign? _____ traffic light? _____ at an intersection? ___ other? _____

Was your car hit? ___Front __ Back __Left side front ___Left side Back ___Right side front ___Right side back

What damage was done to your car? Inside _____

Outside_____

Other_____

AUTOMOBILE ACCIDENT HISTORY(cont.)

If you struck another car, did you strike it: ____Front ____ Back ___Side

What was the damage to the other car? Inside _____

Outside _____

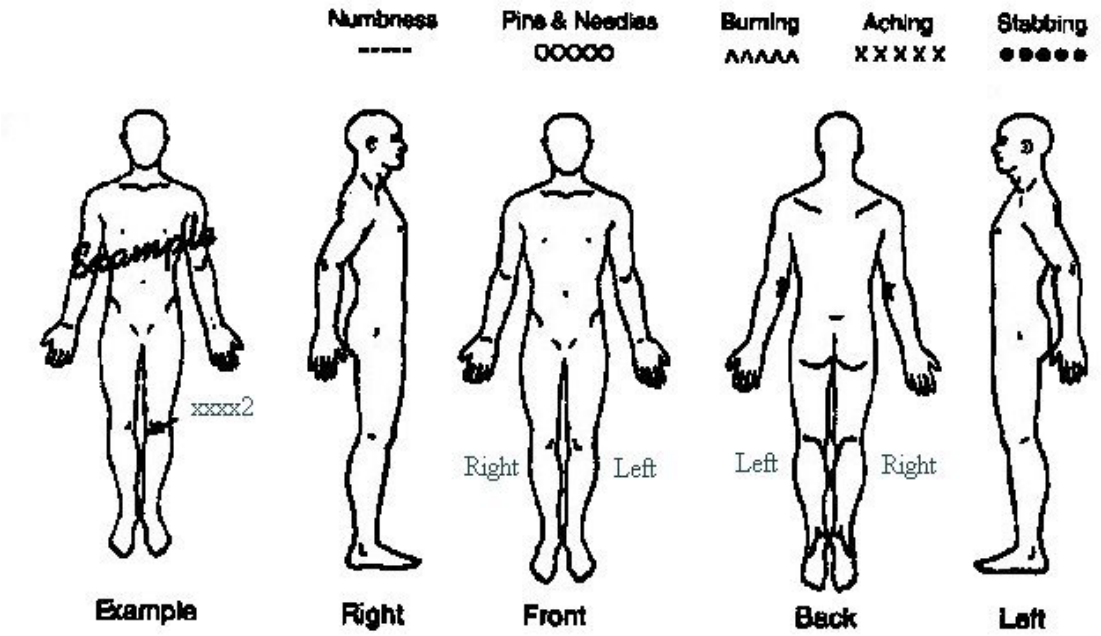
Have you lost time from work? Y / N If yes how long? _____ Does it bother you to ride in a car now? Y/ N

ATTORNEY INFORMATION

Do you have an attorney: Y / N If yes: Name, address and phone number: _____

_____

Please fill out the diagram as you feel currently



Patient Signature: _____ Date: _____

Print Name : _____

Witness: _____ Date: _____