CHILD PATIENT INFORMATION SHEET

ABOUT YOUR CHILD

Today's Date ___/___/___

Child's Name ______________________________

Nickname ________________ Sex M F (circle one)

Reason for Visit ______________________________

____

____

Birth date ___/___/___ Age _____ Grade _____

School ______________________________

SS# ______________________________

Child's Address ______________________________

____

Child's Phone # ______________________________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name ______________________________

Relationship to child ______________________________

Are you the child's legal guardian? ______________

CHILD'S MEDICAL HISTORY

List any allergies ______________________________

____

List medications ______________________________

____

Vitamin supplements ______________________________

____

Has your child had any of the following?

Measles ___/___ German Measles ___/___

Chicken Pox ___/___ Mumps ___/___

Pneumonia ___/___

List any diseases (Ex: diabetes, asthma, heart, etc.)

____

____

____

Birth weight ___________ Length ___________

Age sat up ___________ Stood up ___________

Age walked ___________ 1st spoke ___________

1st tooth ___________ Toilet trained ___________

Formula Y N Breast fed Y N

Vitamins Y N Floride Y N

FAMILY INFORMATION

Parent's marital status (please circle)

Single Married Divorced Widow Separated

Mother's name ______________________________

Biological Stepmother Guardian Adopted

Mother's health Good Fair Poor

Birth date ___/___/___

Home Phone # ______________________________

Employer ______________________________

Work Phone # ______________________________

SS# ______________________________

Father's Name ______________________________

Biological Stepmother Guardian Adopted

Father's health Good Fair Poor

Birth date ___/___/___

Home Phone # ______________________________

Employer ______________________________

Work Phone # ______________________________

SS# ______________________________

Who is responsible for making child's appointments?

Mother Father Child

Please list any other children, with birth dates and genders

____

____

CONSENT TO TREATMENT OF A MINOR

As my child's parent and/or legal guardian, I hereby authorize Chase Chiropractic and its professional staff to administer treatment as they deem necessary to my __________ (son/daughter), ____________________ (minor's name).

In the event that diagnostic x-rays are advisable in this case, so that a complete analysis can be made of the present musculoskeletal problem or illness, authorization is granted for such radiographic examination to be performed in order to treat this case.

This authorization will permit administration of treatment as deemed necessary to treat the present problem as well as any problem or illness that may occur in the future.

Parent/guardian signature ______________________________ Date ___/___/___

Witness ______________________________ Date ___/___/___

INSURANCE INFORMATION

<u>Primary insurance Company</u>

Company name ______________________________

Address ______________________________

Customer Service Phone # ______________________________

ID # ____________________ Group # ____________________

Policy holder's name ______________________________ Birth date ___/___/___

<u>In the event of an emergency, who should we contact?</u>

Name ____________________ Relationship ____________________

Home phone# ____________________ Work phone # ____________________

ACCOUNT INFORMATION

<u>Person ultimately responsible for account</u>

Name ____________________ Relationship ____________________

Billing address ______________________________

We invite you to discuss frankly with us any questions regarding our services.

Our office policy requires payment at time of visit unless services are billed to your insurance company. If your company rejects the claim, you must pay for the service and settle any dispute with your insurance company yourself. Unless other arrangements are made, the person bringing the patient to this office is responsible for the charges. Accounts 90 days past due, with no financial arrangement with this office, will be sent to collection.

I hereby authorize payment of benefits directly to provider. I further authorize the physician to release any information required to process insurance claims.

I understand the above information and guarantee this form is completely correct.

Signature of responsible party ______________________________ Date ___/___/___

Chase Chiropractic Center

(586) 774-0091
FAX: (586) 774-6045
29050 Harper Ave.
St. Clair Shores, MI 48081

DR. PATRICK CHASE
Chiropractor

Informed Consent to Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures, and diagnostic x-rays, on me (or on the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with or serving as backup for the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Signature of Patient: ____________________________________
Date: ________________

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.

Signature of Patient's Representative: ______________________
Date: ________________

Chase Chiropractic Center
29050 Harper Ave., St. Clair Shores, MI 48081
Phone: (586)774-0091 Fax: (586)774-6045

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, ______________________________, have received a copy of this office's Notice of Privacy Practices. 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:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

____
Patient

____
Signature

____
Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** ______________________________

____

____
Staff signature **Date**

Form Copyright © 2013 by InstaCode Institute.
Form may only be copied and/or customized by the owner of this book for use in his/her own office.

Financial Agreement

We, the staff at Chase Chiropractic thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship. Our goal is to inform you of the provisional aspects of that financial policy.

Please understand that payment for services is an important aspect of the provider-patient relationship. We try to make payment as convenient as possible by accepting cash, check, MasterCard and Visa. Please note, a $35.00 service fee will be charged for all returned checks.

Please know that depending on your insurance carrier it may be necessary for you to become involved in the claims process to obtain accurate information to be successful in receiving any payable toward your care.

It is your responsibility to provide all necessary insurance eligibility, identification, and authorization as well as notifying our office of any information changes when they occur. Photo identification is required when accepting insurance information.

It is the patient's responsibility to know if our office is participating or non-participating provider of their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier.

Payment is due at time of service.

Signed____

Date____

Chase Chiropractic Center

29050 Harper
St. Clair Shores, MI 48081

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:________________________ **Last Name:**________________________

Email address: ________________@________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ________________

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (__________)	Offspring: (__________)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: ______________

For office use only

Height:________ Weight:__________ Blood Pressure:______/______

MISSED APPOINTMENT POLICY

We ask for your assistance and cooperation in keeping your scheduled appointment date and time. It is our policy that if a patient misses or cancels an appointment *with less than 24 hours notice*, that patient will be charged a **$25.00 fee** (subject to change) for that time slot. This policy is necessary to avoid the numerous scheduling problems that last-minute cancellations and missed appointments create. If a need arises to cancel or change your appointment, please give us a minimum of 24 hours notice.

We thank you for your cooperation and look forward to being a vital part of your recovery and maintenance.

Signature______________________________ Date__________