PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Child's Name: _____

Child's Nickname: _____

Reason for Visit: _____

Sex: M / F Date of Birth: _____ Age: _____ Child's SS #: _____

Child's Home Phone #: _____

Child's Home Address: _____

_____

Who may we thank for referring you? _____

FAMILY INFORMATION

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Home Phone: _____

Cell Phone:_____ Cell Phone:_____

Work Phone: _____ Work Phone: _____

Parent's Marital Status: Married Single Divorced Widowed

List Ages of Other Children in Family: _____

Predominant language used at home: _____

PRIMARY INSURED

Full Name: _____ Social Security Number: _____

Date of Birth: _____ Driver License Number: _____

PAYMENT INFORMATION

Please read and sign our Financial Agreement.

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office, Opp Family Chiropractic P.A., and its doctors to examine and administer care to my son / daughter named, _____ as the examining / treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care.

Parent's Name: _____ Signature: _____

Date: _____ Witnessed by: _____

Pediatric Pre-Exam Information

Patient: _____ Date: _____

I. Family Medical History

Please check if any blood relatives to the patient had any of the following illnesses and mark accordingly by noting M (mother); F (father); S (sibling); PGM (paternal grandmother); MGM (maternal grandmother); PGF (paternal grandfather); or MGF (maternal grandfather).

_____Allergy, Asthma or Eczema
_____Cancer
_____Diabetes or Low Blood Sugar
_____Heart Trouble
_____High Blood Pressure / Stroke
_____Kidney Disease
_____Liver Disease
_____Mental Retardation
_____Mental Illness
_____Scoliosis
_____Ulcers
_____Other: _____

II. Pregnancy

Please check any areas that applied to the patient's mother during her pregnancy:

____Complications
____Medications
____Recreational Drugs
____Smoking
____Alcohol
____Caffeine: Cola
____Caffeine: Coffee
____Caffeine: Tea
____Caffeine: Chocolate
____Caffeine: Other
____Vitamins / Minerals
____Any diagnosed illnesses
____Hospitalization
____Immunization
____Bleeding
____Premature Contractions
____Back Pain
____Other Pain
____Excessive Weight Loss
____Excessive Weight Gain
____Toxic Exposures
____Allergic Reactions
____Mental Trauma
____Physical Injury
____Prenatal Classes
____Chiropractic Care
____Prenatal Care
____Carried to Full Term
____Attitude – Mostly Happy
____Attitude – Mostly Depressed

III. Labor and Delivery

____Greater than 12 Hours
____Complications
____Fetal Monitor Used
____Medications
____Forceps
____Other: _____
____Caesarian
____Hospital
____Home Birth
____Premature Delivery
____Vacuum Extraction

Prenatal History – *if known please indicate*

The duration of the pregnancy was _____ weeks

The apgar score at birth was _____

The apgar score at five minutes was _____

The length at birth was _____

The birth weight was _____

Please check any problems the patient had at birth:

____Breathing ____Nursing

____Coloring ____Sleeping

____Crying ____Jaundice

____Choking ____Other (Please explain) _____

Please check if any item(s) applied to the patient at birth:

____Medication ____Surgery

____Artificial Feeding ____Erythromyocin

____Vitamin K ____Circumcision

____Other (Please explain) _____

IV. Nutrition

Please check if the patient has received any of the following items:

____Breast Milk ____Sweets

____Commercial Formula ____Juice: Fruit

____Cow's Milk ____Juice: Vegetable

____Goat's Milk ____Vitamins

____Solid Foods ____Medications

____Other (Please explain) _____

V. Immunization

Please list any immunizations the patient has received along with the date it was received and any reactions observed:_____

_____

_____

_____

Note foreign travel: _____

_____

_____

VI. Illnesses

Please list any illness(es) the patient has had along with the date(s) of the illness(es) and any treatments received: _____

_____

_____

Family Physician

Name of pediatrician and date of last exam:_____

_____

_____

VII. General System Review

A. Has your child ever been unconscious or had a convulsion? _____

_____

_____

B. Any problems with the eyes, including vision? _____

_____

_____

C. Has your child ever been cyanotic? (turned blue) _____

_____

_____

D. Does your child tolerate exercise? _____

_____

_____

E. Any recurring problem with vomiting, diarrhea, constipation or stomach pain? _____

_____

_____

F. Do the stools look or smell abnormal? _____

_____

_____

G. Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance of urine?_____

_____

_____

H. Does your child complain of any extremity or back pain? Do you notice a limp or unusual gait pattern?_____

_____

_____

I. Any allergies, eczema, hay fever, hives, asthma, or drug reactions?_____

_____

_____

J. Other Problem?_____

_____

VIII. Additional Information

Use this section for further information concerning specific items previously checked:

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I agree to allow Opp Family Chiropractic to leave voice messages on my phone containing personal information. ☐ YES ☐ NO

Check all phone numbers that apply:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Other:_____

I agree to allow Opp Family Chiropractic to send me emails containing personal information.
☐ YES ☐ NO

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Name and Signature Date

PATIENT FINANCIAL RESPONSIBILITY
POLICY & ACKNOWLEDGEMENT

Opp Family Chiropractic appreciates your confidence in choosing us to provide for your health care needs. We are committed to providing you with the best possible care for your total body wellness. The treatment you have elected to participate in includes a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. Contact your insurance company to determine what is covered and what is not. You are ultimately responsible for payment of any services and care received at Opp Family Chiropractic whether they are covered by your insurance company or not. Be sure to bring your insurance card to each visit. Always notify our office of any changes to your insurance. And last, be prepared to pay any portions your insurance company does not cover.

Co-Pays & Deductibles

If your insurer requires you to pay a co-pay or a deductible, please be aware of the amount of your co-pay or deductible at the time of services. You will be asked to pay all co-pays or deductibles at the time of service. If you do not pay your co-pay or deductible at the time of service, we will bill you and may charge you a reasonable service fee to offset the cost of sending you a statement. All bills are due within seven (7) days of the date it was mailed or e-mailed to you.

Cancellation/No Show Policy

When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or re-schedule, you are asked to notify us as soon as possible, but no later than 24 hours in advance. Appointment cancelled without 24 hours notice may be assessed a cancellation fee of $25. Habitually cancelling appointments may cause us to ask you to seek another chiropractor for your healthcare needs.

Failure to Meet Financial Responsibility

If you fail to meet the financial obligations agreed upon in this financial policy and acknowledgement, your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. Your future status with this office will be considered at that time and may lead to being discharged from care at Opp Family Chiropractic. If you have any questions, please contact the billing department.

Patient Acknowledgment

I have read and understand Opp Family Chiropractic's Patient Financial Responsibility Policy. I agree to assign insurance benefits to Opp Family Chiropractic whenever necessary. I authorize Opp Family Chiropractic to release information to a collection agency or attorney in the event I don't fulfill my financial responsibilities. I understand that if I fail to meet my financial obligations to Opp Family Chiropractic then I will be responsible for all costs and reasonable collection and/or attorney fees. I expressly authorize Opp Family Chiropractic to charge any outstanding balance, due to co-pays, deductibles or non-covered services, on my credit card pursuant to the terms I agreed to in this Acknowledgement and the *Patient Payment Authorization* I signed.

I would like Opp Family Chiropractic to (check all that apply):

☐ Mail my billing statements to:

☐ E-mail my billing statements to:

Signature of Patient/Responsible Party Date

Printed Name of Patient

PATIENT PAYMENT AUTHORIZATION

EXPLANATION OF AUTOMATED RECURRING PAYMENT OPTION

Opp Family Chiropractic ("OPP") offers an automated payment option to our patients for their convenience. If you (a patient or a payer on behalf of a patient) return this completed Patient Payment Authorization, OPP will automatically charge your credit/debit card for any outstanding balance due to co-pays, deductibles or non-covered services.

Name on Card																		
Billing Street Address																		
Billing City, State, Zip																		
Type of Card					-					-					-			
Credit Card Number	☐ Visa ☐ MasterCard ☐ Discover																	
Expiration Date										CVV Code								

BY MY SIGNATURE BELOW, I AUTHORIZE OPP FAMILY CHIROPRACTIC P.A. TO PROCESS MY DEBIT/CREDIT CARD FOR 100% OF THE PATIENT'S OUTSTANDING BALANCE IN FULL IF AFTER SEVEN (7) DAYS OF THE RECEIPT OF AN E-MAILED OR MAILED BILLING STATEMENT A BALANCE REMAINS OWING FOR CO-PAYS, DEDUCTIBLES OR NON-COVERED SERVICES. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION BY GIVING MY NOTICE IN WRITING TO OPP FAMILY CHIROPRACTIC P.A.

THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL ALL AMOUNTS OWED RELATED TO THE TREATMENT RENDERED TO PATIENT ARE PAID IN FULL, OR UNTIL I CANCEL THIS AUTHORIZATION. TO CANCEL, I MUST NOTIFY OPP IN WRITING AND GIVE REASONABLE OPPORTUNITY TO ACT.

I AGREE THAT OPP, IN ITS SOLE DISCRETION, MAY TERMINATE THIS AGREEMENT IF MY ACCOUNT SHOULD LACK SUFFICIENT FUNDS FOR PAYMENT. IN THE EVENT OPP IS UNABLE TO SECURE FUNDS FROM MY BANK ACCOUNT OR CREDIT CARD FOR ANY REASON, I MAY BE CHARGED FOR FURTHER COLLECTION ACTION THAT MAY BE UNDERTAKEN TO THE FULL EXTEND PROVIDED BY LAW.

☐ **CHECK HERE IF YOU WOULD LIKE A PHONE CALL BEFORE WE CHARGE YOUR ACCOUNT**

☐ **CHECK HERE IF YOU WOULD LIKE US TO CHARGE YOUR ACCOUNT WITHOUT A PHONE CALL**

Patient Name	
Cardholder Name	
Cardholder Signature	