

PEDIATRIC HISTORY FORM

Dear New Patient,

Welcome to Montgomery Chiropractic Wellness Center! Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Birth Date: ____/____/____

Sex: Male Female How did you hear about our office? _____

Name of Parents/Guardians: _____ Work Phone: _____

Purpose for contacting us? _____

Other Doctors seen for this condition: No Yes If yes, Doctor's names and Prior Treatments: _____

Other Health Problems? _____

Check any of the following conditions your child has suffered from during the past six months:

- | | | | | |
|---|---|---------------------------------------|---|--|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Other: _____ |

Family History: _____

Previous Chiropractic Care: No Yes Chiropractor name: _____

Date of last visit: ____/____/____ Reason: _____

Are you satisfied with the care your child has received there? No Yes

Pediatrician: _____ Date of last visit: _____

Reason for Pediatrician visit: _____

Number of doses of Antibiotics your child has taken in past six months? _____ Total during lifetime? _____

Number of doses of Other Prescription Medications in past six months? _____ Total during lifetime? _____

Vaccination History: _____ Adverse Reaction(s) to Vaccination? No Yes

Were you told that you had a choice in vaccinating your child? No Yes

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during pregnancy? No Yes List: _____

Ultrasounds during pregnancy? No Yes Number: _____

Medications during pregnancy/delivery? No Yes List: _____

Location of birth: Hospital Birthing Center Home

Birth Intervention: Forceps Vacuum Extraction Caesarian Section: Emergency or Planned?

Complications during delivery? No Yes List: _____

Genetic Disorders or Disabilities? No Yes List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: ____/____

Feeding History:

Breast Fed: No Yes How long: _____

Formula Fed: No Yes How long: _____ Type: _____

Introduced to solids at: _____ months, Cow's milk at _____ months.

Food/Juice Allergies or Intolerance: No Yes List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to Sound: _____

Cross Crawl: _____

Respond to Visual Stimuli: _____

Stand Alone: _____

Hold Head Up: _____

Walk Alone: _____

Sit Up: _____

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

Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, martial arts, etc.)? No Yes List: _____

Has your child ever been involved in a car accident? No Yes List: _____

Has your child been seen on an emergency basis? No Yes List: _____

Other traumas not described above? No Yes List: _____

Prior surgery? No Yes List: _____

Menarche? No Yes Age: _____

Childhood Diseases:

Chicken Pox: No Yes Age: _____

Mumps: No Yes Age: _____

Rubella: No Yes Age: _____

Rubeola: No Yes Age: _____

Whooping Cough: No Yes Age: _____

Other: No Yes Age: _____

**We are here to serve you and encourage you to ask questions.
Your participation is vital and will help determine your results.**

I hereby certify that all information is correct to the best of my knowledge and authorize this office and the Doctor to administer care to my Son/Daughter as is deemed necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Parent signature: _____

Date: _____

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

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

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractor's objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ **Date:** _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree sign below.

Signature: _____ **Date:** _____



OFFICE FINANCIAL POLICY

CASH

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE

1. If you have insurance, we will gladly accept assignment with the following exceptions and regulations, provided we have prior certification from your insurance company.
2. We accept assignment for the initial treatment plan only. Any follow-up visits will be payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we will continue to file your insurance but require full payment per visit.
3. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with the same, as your contract is between you and your insurance company.
4. Whenever you receive any worksheets from your insurance company or explanation of benefits, please bring this information into this office as soon as possible. We must have a copy of this to determine whether proper payment has been made. If you should receive a check from your insurance company during our billing, you must bring it into the office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue you an overpayment check - it will not come from your insurance company. All insurance payments, regardless of which company issues a check, first, are applied to your account as long as any balance is due.

5. Any services not covered or coverage reductions by your insurance will be the patient's responsibility.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.
7. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payment in full immediately; regardless of any claims submitted. If patient has a credit on his or her account, refunds are processed at the beginning of the next month and are dependant on insurance reimbursement if applicable. Any refund given from a credit card payment will be charged a 3% processing fee.
8. If you have questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the Doctor.
9. I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process Insurance claims by provider or agent. I designate this provider, practice and Agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.
10. I hereby authorize and direct my insurer to issue payment for services rendered by Montgomery Chiropractic Wellness Center, LLC. Regardless of my benefit, I understand that I am financially responsible for the fees for services rendered, that finance charges may accrue on past due balances, and that failure to pay will result in the account being turned over to an outside collection agency. I agree to pay all attorney fees and court costs incurred in collecting any unpaid balances for services rendered.

Thank you.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient's Signature

Date

**AUTHORIZATION, ASSIGNMENT & RELEASE FORM
AUTHORIZATION AND ASSIGNMENT**

In consideration of your undertaking to care from me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges you incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you, by my attorney out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or you, based in whole or in part upon the charges made for your services.
3. In the event any insurance company is obligated, by contractual agreement, to make payment to me or to you for the charges made for your services, refuses to make such payment upon demand by you. I herby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent date) and authorize you to prosecute and take action in my name as you see fit and further authorize you to compromise, settle or otherwise receive and claim as you see fit. However, it is understood that until a reasonable effort has been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from collecting the amounts owed directly from me. I understand that whatever amounts you do not collect from the insurance companies' proceeds, whether it is all or part of what is due, I personally owe and agree to pay to you.
4. In addition to the above, I herby waive the statute of limitations on collection and/or recovery in this State of Indiana.
5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.
6. This Authorization and Assignment will be in continual effort until revoked by both parties.

Patient/Insured Signature

Date

RECORDS RELEASE

To _____, I herby authorize you to release to _____ any information including the diagnosis and records of treatment or examination rendered to me or all care during the period from _____ to _____.

Date

Patient/Insured Signature

Date

Staff Signature

RELEASE FROM CARE

I, _____ hereby understand that Dr. _____ is releasing me from care, for my accident dated _____, and that I have reached [] pre-accident status or [] maximum medical improvement. I further understand that all expenses incurred from this accident are my responsibility or the insurance company's and that all expenses incurred after the date below will be my personal responsibility. I will make financial arrangements for payment directly.

Parent Signature _____

Date _____

Staff Signature _____