FAMILY FIRST CHIROPRACTIC PC

PATIENT CASE HISTORY CHILDREN BIRTH – 15 YEARS OLD

Dear Parent:

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe your child's condition will respond satisfactorily, we will not accept your child's case.

Patient Information:

Child's Name: _____ Age: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Parent's Information:

Mother's Name: _____ Contact Phone: _____

Father's Name: _____ Contact Phone: _____

Which parent do we contact regarding your child's care? ☐Mother ☐Father ☐Either **Birth History:**

Delivery: ☐Vaginal ☐Forceps ☐Vacuum Extraction ☐C-Section ☐Breech

Place of Birth: ☐Home ☐Birthing Center ☐Hospital Infant Feeding: ☐Breast ☐Bottle ☐Formula

Any problems during pregnancy? ☐Yes ☐No If yes, please explain: _____

Any problems during labor/delivery? ☐Yes ☐No If yes, please explain: _____

Was there presence at birth of: ☐ Jaundice (yellow) ☐ Cyanosis (blue)

Were there any Congenital Anomalies/Defects: ☐Yes ☐No If yes, please explain: _____

Health Information:

Is your child here for: ☐ Wellness Checkup ☐ Specific Complaint

If a specific complaint, please explain: _____

How long has your child had this condition? _____ Has your child had this condition in the past? ☐Yes ☐No

Which activities aggravate your child's condition? _____

Is their condition getting progressively: ☐ Worse ☐ Better ☐ Staying the Same

Is their condition interfering with their: ☐ School ☐ Sleep ☐ Daily Routine ☐ Other, please explain: _____

Obstetrician/Midwife's Name: _____ Date of last visit: _____

Pediatrician's Name: _____ Date of last visit: _____

List all surgeries (include year performed): _____

Medications your child currently takes: ☐OTC pain/fever reducer ☐Allergy Medicine ☐Vitamins ☐Other: _____

Has your child ever suffered from: ☐Colic ☐Ear Infection ☐Asthma ☐Recurrent Cold ☐Chronic Cough ☐Other: _____

Do you feel that your child is sick often? ☐Yes ☐No If yes, explain: _____

Has your child been in an auto accident, even a minor "fender bender"? ☐Yes ☐No If yes, when? _____

Has your child had any other injuries or accidents? ☐Yes ☐No If yes, list: _____

Immunization History:

☐DPT ☐MMR ☐Chicken Pox ☐Polio ☐Flu Shot ☐Hep B ☐ Pertussis/Whooping Cough ☐Other: _____

Childhood Diseses:

☐ Chicken Pox ☐Rubella ☐Mumps ☐Measles ☐Whooping Cough ☐Other: _____

I understand that it is my responsibility to complete these clinic forms accurately. The above information is correct to the best of my knowledge. It is my responsibility to notify the doctor if any of this information has changed or requires an update.

_____ _____ _____

Parent/Legal Guardian's Name (PRINTED) Parent/Legal Guardian's Signature Date

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APPOINTMENT POLICY

In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. **Be on time for your appointments.** We strive to see all of our patients at their scheduled time, running late for your appointment will either push back our subsequent patients or cause you to have to wait until the doctor is able to see you. Please remember that we have reserved appointment times especially for you. Therefore, **we request at least 24 hour notice in order to reschedule your appointment**. This will allow us to offer that cancelled time to another patient. When you cancel your appointment at the last minute, everyone loses- you, the doctor and other patients that would have utilized your appointment time. Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time.

_____ _____ _____

Patient's Name (PRINTED) Patient/Parent/Guardian's Signature Date

FINANCIAL POLICY

I clearly understand and agree that all serviced rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Cash Patients

All payments are due at the time of service, unless prior arrangements have been made. Any balance left over 30 days may be subject to a 5% interest charge. **CHECKS ARE NOT ACCEPTED.**

Medicare Patients and Insurance Patients

We are a **NON-PARTICIPATING PROVIDER WITH MEDICARE**. We MUST have a copy of your Medicare Card and Driver's License to file your claims on your behalf. Medicare will only cover and reimburse for a limited number of ACUTE chiropractic care visits. Maintenance care is not covered and no reimbursement will be offered to the patient from Medicare.

We **DO NOT** process any other insurance in our office. We are an **OUT-OF-NETWORK PROVIDER** according to your plan description. We can print you an itemized Superbill for **YOU** to submit for **POSSIBLE** reimbursement.

Product Purchases

All products must be paid for at the time they are received (in stock items) or ordered (custom products, such as orthotics).

The above mentioned policies were designed to make things easier for all of us. Thank you for your cooperation. By signing below, the patient agrees to abide by the policies listed above.

_____ _____ _____

Patient's Name (PRINTED) Patient/Parent/Guardian's Signature Date

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including, but not limited, to examination tests, diagnostic x-Ray(s) and physical therapy techniques (including Rock Tape application), on me (or on the patient named below, for whom I am legally responsible) which are recommended by Dr. Ryan Gutierrez and/or other licensed Doctors of Chiropractic who will now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Family First Chiropractic.

The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms. While rare, in the practice of chiropractic there are some risks to treatment including, but not limited to: sprains/strains, increased symptoms or pain, no improvement of symptoms or pain, fractures, disc injuries, strokes, dislocations, and serious neurological impairment.

We do not offer to diagnose or treat any disease or condition other than 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 advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care 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 eliminate a major interference to the body's nerve system. Our only method is specific adjusting to correct subluxations (misalignments).

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read and fully understand the above statement. I have also had an opportunity to ask questions and all of my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek care.

CONSENT TO EVALUATE AND TREAT A MINOR (TREATMENT OF A CHILD UNDER 18 YRS)

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. I understand and agree that all services rendered to my child are charged directly to me and that I remain personally responsible for payment.

_____ _____

Parent/Legal Guardian's Signature Date

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HIPAA CONSENT AND ACKNOWLEDGEMENT

I acknowledge that Family First Chiropractic's HIPAA (Notice of Privacy Practices) has been provided to me.

The Notice of Privacy Practices describes the uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Family First Chiropractic. The Notice of Privacy Practices also describes my rights and Family First Chiropractic's duties with respect to my protected health information.

Family First Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

The undersigned does hereby consent to the use of his/her health information in a manner consistent with the Notice of Privacy Practices pursuant to HIPAA.

If patient is a minor or under a guardianship order as defined by State Law:

_____	_____	_____
Patient's Name (PRINTED)	Parent/ Legal Guardian's Signature	Date