EASTERN SHORE CHIROPRACTIC & SPORTS CLINIC

PEDIATRIC HISTORY FORM

PATIENT DEMOGRAPHICS

Childs Name_____ Today's Date _____/_____/____

Date of Birth _____/_____/_____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____

Address _____

City _____ State _____ Zip _____ Phone (Home) _____

Mothers Name: _____Mother's Mobile _____DOB____/____/____

Fathers name: _____Father's Mobile_____DOB ____/____/____

Pediatrician/Family MD _____City & State _____

Last Visit: ____/____/____ Reason for visit:_____

Who is responsible for this bill? _____

☐ Father's Social Security # _____-_____-_____☐ Mother's Social Security # _____-_____-_____

☐ Other *(please explain):*

CHILD'S CURRENT PROBLEM:

Purpose of this visit: _____Wellness Check-up _____Injury or Accident _____Other

Please explain: _____

If your child is experiencing ***Pain/Discomfort please identify where and for how long*** _____

_____

1. **When did the** Problem first begin? Date ____/____/_____ _____Unknown _____Gradual _____Sudden
2. **Ever had** this problem **before**? No_____Yes_____ If yes when? _____
3. Any **bowel or bladder** problems since this problem began?: If yes, *(Describe)*:_____
4. Have you seen any **other doctors** for this problem? No Yes If yes who? _____
5. How long ago? _____Days _____ Weeks _____ Months _____Years
6. What were the results of past treatment? _____
7. How is this problem **NOW:** ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off

   Please list any **medication taken** for this problem: _____
8. Has your child ever sustained an injury playing organized sports? _____ If yes; please explain

   _____

   _____
9. Has your child ever sustained an injury in an auto accident? _____ if yes, please explain

   _____

   _____

HAS YOUR CHILD EVER SUFFERED FROM: *mark a* **Y for** *YES OR* ***N*** *No*

☐ Headaches ☐ Orthopedic Problems ☐ Digestive Disorders ☐ Behavioral Problems

☐ Dizziness ☐ Neck Problems ☐ Poor Appetite ☐ ADD/ADHD

☐ Fainting ☐ Arm Problems ☐ Stomach Aches ☐ Ruptures/Hernia

☐ Leg Problems ☐ Reflux ☐ Muscle Pain ☐ Seizures/Convulsions ☐ Heart Trouble ☐ Joint Problems ☐ Constipation ☐ Growing Pains

☐ Chronic Earaches ☐ Backaches ☐ Diarrhea ☐ Sinus Trouble ☐ Poor Posture

☐ Hypertension ☐ Asthma ☐ Scoliosis ☐ Anemia ☐ Colds/Flu

☐ Walking Trouble ☐ Bed Wetting ☐ Colic ☐ Broken Bones ☐ Sleeping Problems

☐ Fall in baby walker ☐ Fall from bed or couch ☐ Fall from crib ☐ Fall off swing

☐ Fall off bicycle ☐ Fall from high chair ☐ Fall off slide ☐ Fall down stairs

☐ Fall from changing table ☐ Fall off monkey bars ☐ Fall off skateboard/skates

☐ Other: _____ ☐ Allergies to: _____

I understand that I am directly and fully responsible to Eastern Shore Chiropractic and Sports Clinic for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

☐ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____

Parent or Legal Guardian's Signature Date

_____ _____

Doctor Signature Date

Eastern Shore Chiropractic and Sports Clinic
Informed Consent for Chiropractic Treatment

You have the right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give your consent to treatment.
I request and consent to chiropractic adjustments and other chiropractic procedures, including but not limited to various modes of physical therapy and diagnostic x-rays, laser and acupuncture/dry needling. The chiropractic treatment may be performed by any of the Doctors of Chiropractic or chiropractic assistants working at Eastern Shore chiropractic and Sports Clinic. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a back up for the doctors at Eastern Shore Chiropractic and Sports Clinic.
I have had the opportunity to discuss with the doctor my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.
I understand that there are some risks to chiropractic treatment including but not limited to:

- Broken bones
- Dislocations
- Sprains/strains
- Burns or frostbite (physical therapy)
- Worsening/aggravation of spinal conditions
- Increased symptoms/pain
- No improvement of symptoms or pain
- Infection (acupuncture/dry needling)
- Punctured lung (acupuncture/dry needling)
- Other _____

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.
I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment.

Patient name: _____

Patient signature or representative: _____

Date: _____

Witness to patient signature: _____

EASTERN SHORE CHIROPRACTIC AND SPORTS CLINIC

Authorization for Verbal Communication, to Leave Voicemail Messages, and/or Receive Emails Regarding My Personal Health Information

This does not authorize release of medical records without a signed authorization to release medical records by patient or guardian

PATIENT INFORMATION:

Patient Name: _____ Birth Date: _____-_____-_____

INFORMATION TO BE DISCLOSED: Verbal communication only regarding patients care-no copies of medical records provided

PLEASE PROVIDE YOUR CURRENT TELEPHONE NUMBERS WHERE WE HAVE PERMISSION TO CALL AND/OR LEAVE A CONFIDENTIAL VOICEMAIL:

Home Phone: _____ Cell phone: _____

Work Phone: _____ Other Phone: _____

We normally contact our patients between 8 a.m. and 5 p.m. Monday through Friday. Please check below where you would prefer to be contacted during these hours:

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

If we need to contact you after hours, please check below where you prefer to be called:

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

YOUR PROTECTED HEALTH INFORMATION DESIGNEES:

If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your medical information. This person (designee) will also be able to call the office on your behalf.

PLEASE PRINT THE NAME AND RELATIONSHIP TO YOU/PATIENT OF EACH DESIGNEE BELOW:

Designee Name: _____ Relationship to patient: _____

Designee Name: _____ Relationship to patient: _____

_____ **CHECK HERE IF YOU *DO NOT* WANT YOU HEALTH CARE INFORMATION DISCUSSED WITH ANYONE OTHER THAN YOURSELF.**

APPOINTMENT REMINDERS:

If you would like to be set up for appointment reminders, please list a cell phone number and provider OR email address.

(Cell phone provider required for text reminders!)

Cell phone number: _____ Cell phone provider: _____

OR Email address: _____

CONFIDENTIAL EMAIL:

PLEASE WRITE BELOW AN EMAIL ADDRESS THAT WE CAN SEND EDUCATIONAL INFORMATION PERTAINING TO YOUR TREATMENT PLAN/GOALS (STRETCHES, EXCERSICES, ETC.):

_____

YOUR SIGNATURE BELOW CONFIRMS YOUR APPROVAL OF THESE UPDATED HIPAA COMMUNICATIONS PREFERENCES. YOU MAY CHANGE YOUR SELECTIONS AT ANY TIME, BUT MUST DO SO IN WRITING BY COMPLETEING AN UPDATED FORM.

Patient Signature: _____ Date: _____-_____-_____

Witness: _____ Date: _____-_____-_____

OFFICE POLICY

We believe that a clear definition of our office policies will allow YOU, the patient, and Us, the doctor, to concentrate on the big issue – **REGAINING AND MAINTAINING YOUR HEALTH.**

APPOINTMENT POLICY

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service.
This office reserves the right to charge $70 for no call/no show appointments, as there are other patients that may need those appointment times. If, for any reason, you are unable to keep an appointment and can't reschedule with 24 hours' notice, we require that you telephone immediately to reschedule that visit; we typically can fill your appointment time within at least 1 hours' notice. If it is after office hours you may leave a message on our voicemail at 251-990-8383. If there are 3 missed appointments/no call no shows in a row you could be dismissed from care.
When entering the office on any given visit, please go directly to the front desk and "sign in". We sincerely attempt to honor all appointments at the scheduled time. If you are more than 10 minutes late for your appointment, you may be asked to wait for the next available appointment; we cannot guarantee how long you may have to wait to be seen or which doctor will be able to see you.

FINANCIAL POLICY

1. It is our policy that all services rendered in this office are charged directly to you, the patient, and that you are personally responsible for all payments whether or not the office accepts insurance assignment.
2. All payments are expected at the time of services or at the end of the week. Patient balances may not exceed $150.00 at any time.
3. All insurance assignment patients must pay their deductible in full and the co-pay/co-insurance at the time of service or at the end of the week.
4. There will be a $35.00 fee imposed for all checks returned to this office.
5. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and those, cancelled without a 24-hour notice.

A detailed policy manual has been given to me. I have read and understand all the policies.

Signature _____ Date_____

Eastern Shore Chiropractic & Sports Clinic
22806 US HWY 98
Fairhope, AL 36532
251-990-8383

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize the Doctors of Eastern Shore Chiropractic and whomever they may designate as their assistants to administer Chiropractic Care as they deem necessary to my child:

_____
(child's full legal name)

Signed: _____ Relationship to child: _____ Date:_____
(Parent or Guardian)

Witnessed: _____ Date: _____

EASTERNSHORE CHIROPRACTIC AND SPORTS CLINIC
22806 US HWY 98
FAIRHOPE, AL 36532
251-990-8383

OFFICE POLICIES FOR PATIENTS

Patient copy to keep

APPOINTMENT POLICY

Office visits are scheduled according to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. Since your condition requires numerous appointments over the next few weeks or months, we have designed a multiple appointment program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results for you.

We also run a no wait clinic (we don't like to make our patients wait); in order for us to continue with this benefit you need to arrive for your appointments on time.

Missed/Rescheduled Appointments

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that count, not the days on which you receive the service. **This office reserves the right to charge $70 for no call/no show appointments, as there are other patients that may need those appointment times.** If, for any reason, you are unable to keep an appointment and can't reschedule with 24 hours' notice, we require that you telephone immediately to reschedule that visit; we typically can fill your appointment time within at least 1 hours' notice. If it is after office hours you may leave a message on our voicemail at 251-990-8383. If there are 3 missed appointments/no call no shows in a row you could be dismissed from care.

When entering the office on any given visit, please go directly to the front desk and "sign in". We sincerely attempt to honor all appointments at the scheduled time. **If you are more than 10 minutes late for your appointment, you may be asked to wait for the next available appointment; we cannot guarantee how long you may have to wait to be seen or which doctor will be able to see you.** The doctors are often requested for speaking engagements and corporate ART work and very commonly have to leave the office quickly in the afternoon. If you are running late, please contact the office immediately. We cannot ensure the doctors will be here after your scheduled appointment time. If we are unexpectedly running behind, we will try to contact you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

EMERGENCY NUMBERS

In case of non-life threatening emergencies such as flare ups, falls, or injuries, please call the office at 251-990-8383. The doctors may not be able to see you right away, but the doctor can give you recommendations until they can. Please call if any of the above occurs to you or your family.

CELL PHONES

Some of our patients experience migraines and/or other problems provoked by the tone of a cellphone. For this reason, we ask that you turn your cell phone to silent upon entering the office. There is **no talking** on cell phones while in the office, especially in treatment areas, as this may interfere with our equipment and is disrespectful to the doctor treating you.

KIDS

We are a family oriented office, but due to the conditions we commonly treat (headaches, migraines, etc.) we ask that if your child in under 10 years of age, they are not left in the treatment areas unsupervised.

FINANCIAL POLICY

Patients must understand that ultimately they are financially responsible for professional services rendered. We do not bill patients. If we are forced to bill you, a $15 bookkeeping service fee will be added.

- It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services including those not reimbursed by third party payers.
- All payments are expected at the time of service. Patient balances are not to exceed $150.00 at any time.
- All insurance assignment patients must pay their deductibles in full and the copayments at the time of service.
- Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month. Charges may also be made for missed appointments and those cancelled without 24 hours' notice.
- All accounts not paid within 90 days will automatically be put through collections.

CASH POLICY

This policy is very simple-all services must be paid at the time they are rendered.

INSURANCE POLICY

- The privilege of insurance assignment begins when out office receives your insurance forms.
- All deductible payments MUST be made prior to insurance submittal.
- You are considered to be a cash patient until our office qualifies your coverage to determine the extent of benefits under your policy.
- All copayments are payable when the services are rendered. A $150.00 balance must not be exceeded by any patient. **Services may be declined if balance has been exceeded.**
- All patients whose visitation schedule is once per month will not be eligible for insurance assignment. Charges for services will again be due as they are received.

- Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted.
- This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.
- Since we do not own your policy and occasionally will experience difficulty in collection from the carrier, we may ask for your active assistance in rectifying this situation.