Pediatric Patient Questionnaire

CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City: State: Zip:

Cell Phone: - - Home Phone: - - Work Phone: - -

Email: Child's SS #: - - Birthdate: / / Age:

How did you hear about us? Height: ft. in. Weight: lbs.

Who is your primary care physician?

Is your child receiving care from any other health professionals? ◯ Yes ◯ No
- If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ◯ Suddenly ◯ Gradually ◯ Post-Injury

Has your child ever received care for this condition before? ◯ Yes ◯ No
- If yes, please explain:

Is this condition: ◯ Getting worse ◯ Improving ◯ Intermittent ◯ Constant ◯ Unsure

What makes the problem better? What makes the problem worse?

HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

◯ Resolve existing condition
◯ Overall wellness
◯ Both

Have you ever visited a chiropractor? ◯ Yes ◯ No If yes, what is their name?

What is their specialty? ◯ Pain Relief ◯ Physical Therapy & Rehab ◯ Nutritional ◯ Subluxation-based ◯ Other:

PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ◯ Yes ◯ No If yes, please explain: _____

Did mother smoke? ◯ Yes ◯ No If yes, how many per week? _____

Did mother drink? ◯ Yes ◯ No If yes, how many per week? _____

Did mother exercise? ◯ Yes ◯ No If yes, please explain: _____

Was mother ill? ◯ Yes ◯ No If yes, please explain: _____

Any ultrasounds? ◯ Yes ◯ No If yes, please explain: _____

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: lbs. oz. Child's birth height: in. APGAR score at birth: APGAR score after 5 minutes:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____ Teethe: _____
Sit alone: _____ Crawl: _____ Walk: _____ Begin cow's milk: _____ Begin solid foods: _____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: / /

Gem City Chiropractic
5812 Wilmington Pike
Centerville, OH 4545□

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Gem City Chiropractic
Effective Date: 03/13/2017

Our HIPAA Notice of Privacy Practices describes the privacy practices of Gem City Chiropractic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights – You may…

- Request to inspect any copy of your records
- Request to amend incomplete or inaccurate information in your records
- Receive an accounting of certain disclosures of your health information
- Ask for additional privacy protections (although your request may be declined)
- Ask for confidential communications in a particular manner
- Receive a paper copy of this Notice
- File a complaint without penalty

Use and Disclosure – We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so . We use and disclose your information:

- For treatment, payment, and health care operations
- Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and services.
- As permitted or required by the law
- For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; national security
- With your authorization

Changes to this Notice – We reserve the right to change this Notice at any time as allowed by law. Updated Notice will be in our office and paper copies will be available upon request.

Complaints - If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (937) 886-7474, sending a letter to our office address, or by e-mailing drnathanbaxter@gmail.com

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Please Indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

Spouse: _____ Yes, Health info ____ Yes, Billing Info ____ Yes, Scheduling ____

Parent/s or Guardian: _____ Yes, Health Info ____ Yes, Billing Info ____ Yes, scheduling ____

Relative/Friend/ Other: _____ Yes, Health Info ___ Yes, Billing Ingo ___ Yes, scheduling ____

Acknowledgement of Receipt of this Notice As a patient of Gem City Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practice for additional information. I understand that Gem City Chiropractic respects their legal obligation to keep health information private unless require by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient: _____ Date: _____

Gem City Chiropractic Financial Policy

If you have insurance that we are in network with, we will make a copy of your card and collect any co-pay or coinsurance that is due. Once we receive an EOB (Explanation of Benefits) from your insurance company, we will send you a statement if there is a balance remaining for us to collect.

If you have insurance that we are *not* in network with, you may contact your insurance company to see if they will reimburse you for visiting an out of network provider. You will be responsible for providing payment at the time of service. We will assist you by providing receipt of your treatment in our office, or that you may seek reimbursement form your insurance company.

Common Insurance Terms:

Allowed amount: For the insurance companies that we are in-network with, there is an amount that we have agreed to receive as payment for our services. This contracted amount is sometimes less than our standard fee schedule. This "allowed amount" will be made by a combination of the patient and the insurance company, sometimes wholly by one party or the other. How much of this amount the insurance will pay is determined by the patient's deductible, co-pay, coinsurance, and out of pocket limit amounts with their insurance company.

Deductible: Most insurance policies are written with a deductible. The deductible is amount that the patient must pay before the insurance company is responsible. Sometimes the deductible is figured on a per-person basis with a maximum amount per year for the family. The deductible may apply to all charges, or it may apply only to office visit charges and exclude x-rays, exams, and diagnostic procedures. The services that are subject to the deductible are decided by the insurance contract or policy. The amount of the deductible will differ from one company and one contract to another.

Copay and Coinsurance amounts: a ***copay*** is a **set dollar amount** that the patient is responsible for. With **coinsurance**, the patient is responsible for **a percentage of the allowed amount** on a service. Some insurance contracts will have the patient responsible for a combination of a copay and coinsurance on charges, or may utilize a copay for certain services and a co-insurance for others.

To help you understand your payment responsibility, our staff will be happy to check your benefits**. However, a quote of benefits by our staff does not guarantee payment by your insurance company or verify eligibility**. Should your health insurance company deny payment, you are personally and fully responsible for your charges. It is for this reason that **we highly** recommend that you contact your insurance company to discuss your benefit coverage for chiropractic services when provided by our practitioners.

Gem City Chiropractic is pleased to offer **EVERYONE** a **time of service (TOS) discount**.

A **Time of Service Discount** is a discount off our standard fee schedule. This discount is available when making payment at the time that service is rendered. Payment can be made via cash, check, or credit card.

By signing below, I agree to the following: " I have read, understand and agree with the described financial policies on this page. By signing, I agree that I also understand that as the patient, or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Gem City Chiropractic. Failure to pay all costs associated with my care as agreed may result in collection activity on my account as well as reporting of my payment history to credit reporting bureaus."

_____ _____

Patient Name (please print) Date

_____

Signature of Patient or Authorized representative

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient 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 patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of 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 disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of 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 a health care provider who specializes in that area.

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 expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

Gem City Chiropractic

5812 Wilmington Pike

Centerville, OH 45459

937-886-7474

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary diagnostic x-rays on me (or on patient named below, for whom I am legally responsible: _____ by W. Nathan Baxter, D.C. And/or working in this office authorized by above referenced doctor of chiropractic.

I further understand that such chiropractic services may be performed by Gem City Chiropractic office and/or other licensed Doctors of Chiropractic who may treat me now, or in the future at this office. I have had an opportunity to discuss with W. Nathan Baxter, D.C., and/or his staff the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

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

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent for to cover the entire course of treatment for my present condition(s) for which I seek treatment at this facility.

Printed Name of Patient

Signature of Patient

Signature of Patient's representative if patient is a minor

DATE: _____