PEDIATRIC CONSULTATION

Name ______________________________ Date ____________

The vast majority of our patients have experienced literally dozens of impacts that could cause subluxated vertebra. What I want to do now is discover several of yours.

What was your child's birth like? ______________________________

How long entire labor? ____________ How long did you actually push? ____________

Were you induced? Yes No Nerve block? Yes No C-section? Yes No

Was there any pulling on the head? Yes No Forceps or vacuum extraction used? Yes No

47% of all children fall on their head by the age of one and they have at least 200 more major falls by the age of 5 years old.

When was (name)'s most recent fall? ______________________________

Was any care given? ____________ Was s/he checked by a chiropractor? ____________

And the fall before that? ____________ Any care given? ____________

What sports or recreational activities does s/he do? ______________________________

When was (name)'s most recent stress, strain, or injury while doing these activities? ____________

Care given? ______________________________

Has (name) been involved in a motor vehicle accident as a passenger? Yes No

Briefly describe: ______________________________

Any treatment received? ____________ Chiropractic? ____________

These sound important. Thank you for explaining your (son/daughter)'s history of accidents and traumas. This will help the doctor better understand the case. What I want to do now is ask you a few questions regarding (name)'s current health concerns.

Does s/he have any health concerns? ______________________________

If so, how long? ______________________________

Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future.

Are there any other conditions s/he is or was experiencing? ______________________________

How long? ______________________________

Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. How often does (name) have this condition? ____________

Any medications? ______________________________

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NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions.

Name:	Date:
Address:	City/State/ZIP:
Home Phone:	Work Phone:
Birth date: Age:	Social Security #:
Marital Status: M W D S	
Your Employer:	Occupation:
Spouse's Name:	Spouse's Employer:
Children's Names and Ages:	
Favorite Hobbies or Interests:	
Method of Payment for First Visit: Cash Check Credit Card	

Current health complaints/reasons for consulting our office:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Who may we thank for referring you? ______________________________

Have you had same or similar problem(s) before? ______________________________

If so, for how long? ______________________________

Is this the result of an auto or work injury? ______ If so, when? ______________________________

Father, mother, brother, sister, children with similar problems? ______ If so, who? ________________

Other doctors you have seen for this problem: ______________________________

Surgeries you have had: ______________________________

Medications you currently take: ______________________________

Is there any chance you are pregnant? ______________________________

Have you ever been diagnosed with cancer? ______ If so, what kind? ______________________________

Do you have health insurance? ______ Name of company: ______________________________

Who is your primary care physician?______________________________ Phone:________________

May we contact them and keep them updated on your status? YES / NO

****The above information is true and accurate to the best of my knowledge****

Patient or Guardian Signature______________________________ Date:________________

Financial Policy / HIPPA / Release of Records

Health Insurance: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductibles, co-insurance and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my insurance is a contract between me and my insurance company and that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. Our most common codes (charges) are:

99203 (Exam - $97)98943/98940/98941 (Manipulation - $25/$35/$45) 97012 (traction - $22)
97110 (therapeutic exercises - $30)

If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred. I also understand that *I AM RESPONSIBLE FOR GETTING ANY REFERRAL NEEDED FOR TREATMENT IN THIS OFFICE . IF A REFERRAL IS NEEDED AND IS NOT RECEIVED IN THIS OFFICE, THEN I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES.*

Workman's Compensation- you need to notify the receptionist NOW! Ohio State law is specific on how we must bill your charges and what specific paperwork needs to be filled out.

Automobile Accidents- you need to notify the receptionist NOW if you are here for treatment related to an automobile accident. We require on file your car insurance, the person's at fault car insurance, your driver's license, your health insurance, and a copy of the accident report. I also give any insurance carrier and/or attorney authorization to directly pay Polaris Family & Sport Chiropractic for the treatment rendered at our office. I authorize & direct payment to Polaris Family & Sport Chiropractic of any sum I owe now or hereafter owe to him by my attorney &/or by any insurance obligated to reimburse.

ACKNOWLEDGMENT & UNDERSTANDING:

I understand that if it is determined: a) That there is no insurance coverage, b) If your insurance company refuses to acknowledge & assign payment directly to the doctor, c) If your insurance company notifies us that you are responsible for additional payment to our office, d) If I stop care for any reason, or e) If a liability claim exists, & my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney... THEN PAYMENT FOR SERVICES RENDERED BY THE DOCTOR AT POLARIS FAMILY & SPORT CHIROPRACTIC WILL BE MADE ON A CURRENT BASIS & MY PORTION OF THE CHARGES WILL BE PAID IN FULL AND DUE IMMEDIATELY. I further understand should collection of my account be referred to an attorney for payment or collection agency, I am personally responsible for all collection fees, interest, & attorney fees that may occur.

I acknowledge I have read all eight pages of the "Notice of Privacy Practice," and I understand and agree to its terms (Please ask the office assistant if you want a copy of the Privacy Policy). Furthermore, I authorize Polaris Family & Sport Chiropractic, Inc. to release any information deemed necessary concerning my condition to any doctor, insurance company, attorney, collections, adjustor, or other business necessary regarding my case in this office.

______________________________ __________________________________ __________

Patient Name (Please Print) Signature (Patient or Guardian) Date