



CUPP CHIROPRACTIC CLINIC

DR. REE ANN CUPP



Acct # _____

PEDIATRIC PATIENT INFORMATION

Child's Name: _____

Social Security Number: _____

Male Female

Birthdate: Mo _____ Day _____ Year _____ Age: _____

Mother's Name: _____ Father's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Emergency Phone Number: _____

Type of Birth: Vaginal _____ Forceps _____ Breech _____ Cesarean _____

Birth Weight: _____ lbs. _____ oz. Present Weight: _____

Problems during Pregnancy or Delivery: _____

Congenital Anomalies / Defects: _____

Hours of Sleep per Night: _____ Quality of Sleep: _____

Date of Last Visit to M.D. _____ Purpose: _____

Immunization History: _____

Purpose of this visit: _____

Has Your Child Been Treated on an Emergency Basis? Yes No

Explain: _____

Other: _____



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Has Your Child Ever Suffered From?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Colds / Flu | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Rubeola |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Measles | <input type="checkbox"/> Ruptures/Hernias |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Sugar Concentration |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> "Growing Pains" | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Walking Problem |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Paralysis | |

Present History: _____

Surgery: _____

Medications: _____

Accidents: _____

Family History: _____

I Hereby Acknowledge This Clinic and its Doctor(s) to Administer Care as they Deem Necessary to my Child.

Parent's Name: _____

Parent's Signature: _____ Date: _____



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CONSENT TO TREAT A MINOR CHILD

I hereby authorize Dr. Ree Ann Cupp, D.C. and whomever she may designate as her assistants to administer treatment as she so deems necessary to my _____, _____.

Dated at Metairie, Louisiana this _____ day of _____ 20_____.

Signed _____

Address _____

Witness _____

Address _____

Signature _____



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Patient Disclosures and Authorizations

Please read the following information and initial in the appropriate sections.

Insurance Coverage

Welcome to Cupp Chiropractic Clinic. We will be more than happy to submit all insurance forms for you and help you recover the most from your benefits. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Most insurance policies require the policy holder to pay co-insurance, co-payment and/or a deductible. If we are a participating provider for your specific insurance company, then we will abide by our contract fees, which include your co pay and/or deductible responsibility. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations.

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

Patient Initials _____

Assignment of Benefits

I hereby authorize my insurance company and/or any third party payee to direct any payment to Cupp Chiropractic Clinic for services rendered to me. If my current policy prohibits direct payment to the Doctor, then I hereby instruct and direct my insurance company and/or third party payee to make out the check to me and mail it as follows:

C/O: Cupp Chiropractic Clinic
3544 West Esplanade Ave.
Suite 1
Metairie, LA 70002

Furthermore, if I have an attorney representing me in this case, I authorize him/her to direct payment to you out of the proceeds of any settlement of my case.

I also grant you the right to request from my insurance company, attorney, and/or third party payee any information regarding the status of my claim and/or information on any payments made for my treatment at this clinic.

Patient Initials _____

Missed Appointments

It is the policy of Cupp Chiropractic Clinic to assess a **\$15.00** missed visit fee to patients who cancel appointments with less than a 24-hour notice. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

Patient Initials _____

Payment for Services

It is the policy of Cupp Chiropractic Clinic to have our patients make any and all payments due on their account upon arrival unless otherwise agreed upon.

Patient Initials _____

Consent for Use or Disclosure of Health Information

Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us give you this disclosure, please understand that we have and always will, respect the privacy of your health care information.

Medical Release

There are several circumstances in which we may have to use or disclose your health care information:

- ~ To another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- ~ To another party if they are potentially responsible for the payment of your services.
- ~ To an insurance company, adjuster or attorney in order to process any claims for reimbursement of charges incurred by me.
- ~ Within our practice for quality control or other operational services such as sending the following products to you: Appointment reminders, Birthday cards, Newsletters, Thank you cards, and any and all correspondence with Dr. Cupp. You have the right to refuse authorization to use or disclose your health information for mailings. It will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
- ~ To the Chiropractic Association of Louisiana if we need the CAL's assistance to receive reimbursement for your services or because the party responsible for reimbursing your services has improperly processed your claim. By signing this form you are giving CAL authorization to re-disclose your information to the party responsible for the payment of your services, the CAL's legal counsel and state or federal agencies that may be asked to intercede on your behalf. You have the right to refuse authorization to use or disclose your health information to CAL. It will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health care information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You may inspect or copy the information that we disclose at any time (§ 164.524).

This authorization will expire seven years after the date on which you last receive services from us.

I hereby authorize you to release any of my health information you deem appropriate in the manner described above.

Patient Initials _____

I understand that all health services rendered to me and charged to me are my personal financial responsibility.

I understand and agree to the conditions of this policy.

I have received a copy of this agreement. **Patient Initials** _____

Patient Name Printed

Patient Signature

Patient Account Number

Dr. Ree Ann Cupp D.C.
Authorized Provider Representative

Kristina Mercier
Personal Representative Signature

Date