PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

Child's Name:_____ M/F Date of Birth: _____

Child's Nickname:_____

FAMILY INFORMATION

Mother's Name: _____ Mother's DOB:_____

Address: _____ City _____ State____Zip_____

Home Phone: _____ Cell: _____ Work: _____

Father's Name: _____ Father's DOB: _____

Address: _____ City _____ State____ Zip_____

Home Phone: _____Cell: _____ Work:_____

Preferred Email:_____

Billing Statement Delivery Preference: ☐Email ☐Mail

INSURANCE INFORMATION

Primary Insurance:_____ Name of Insured: _____

Date of birth of insured: _____

Secondary Insurance: _____ Name of Insured: _____

Date of birth of insured: _____

CONSENT TO TREAT

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named above as the examining/treating doctor deems necessary.

I understand and agree that I am personally responsible for payment of all fees charged by this office for such care regardless of what my insurance company covers. I hereby authorize Perreault Chiropractic & Acupuncture to seek payment and authorize/assign payment directly to them from my insurance company.

PARENT GUARDIAN SIGNATURE: _____

PRE-SCHOOL CHILD HISTORY

(3 YEARS TO 5 YEARS)

Today's Date: _____

Child's Name:_____ Sex: M/F Date of Birth: _____

Reason for today's visit :

_____

PLEASE ANSWER THE FOLLOWING	YES	NO	COMMENTS
Does your child complain of pain or discomfort?	□	□	_____
If yes when did it start?_____			
Onset was: □Sudden □Gradual			
Problem is: □Constant □Intermittent			
Has your child ever had this problem before?	□	□	_____
Has your child been treated for this problem previously?	□	□	_____
By whom?_____			
Has your child had chiropractic care before?	□	□	
Previous chiropractor _____			
HEALTH HISTORY			
Does your child ever complain of back or neck pain?	□	□	_____
Does your child ever complain of leg or arm pain?	□	□	_____
Does your child ever complain of headaches?	□	□	_____
Has your child had asthma?	□	□	_____
Does your child have allergies?	□	□	_____
Are there any smokers in the home?	□	□	_____
Has your child had earaches?	□	□	_____
At what age did they first occur?_____			
How frequently do the earaches occur?_____		□Right □Left □Both	
Is your child presently taking any medication?	□	□	_____
Please list any other illness which has been a concern for your child:			
_____			
Has your child ever had surgery?	□	□	_____
If so what type?_____			
TRAUMA			
Has your child had any recent falls or trauma? When?	□	□	_____
Has your child ever fallen from a significant height?	□	□	_____
Has your child ever had a bone fracture?	□	□	_____
Does your child every bang his/her head repeatedly?	□	□	_____
NUTRITION			
Do you have any concerns about your child's nutrition?	□	□	_____
Does your child have food allergies?	□	□	_____
Does your child have a persistent or recurring rash?	□	□	_____
Does your child take vitamins?	□	□	_____
Does your child eliminate stools every day?	□	□	_____

CHIROPRACTIC & ACPUNCTURE INFORMED CONSENT

PATIENT NAME: _____

TO THE PATIENT: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT

As a part of the analysis, examination and treatment, you are consenting to the following procedures:

Initial each procedure you are consenting to.

___**Chiropractic:** Including but not limited to spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, and radiographic studies.

___**Acupuncture:** I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named for whom I am legally responsible) by the Doctor.

POSSIBLE RISKS IN CHIROPRACTIC ADJUSTMENT

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor.

THE PROBABILITY OF THOSE RISKS OCCURRING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

THE RISKS AND DANGERS OF REMAINING UNTREATED

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

POSSIBLE RISKS IN ACUPUNCTURE TREATMENT

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

PATIENT PLEASE REVIEW, PRINT & SIGN NAME

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment, including acupuncture. I have discussed it with the Doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name _____ Signature_____

Signature of Parent or Guardian (if a minor)_____

Date:_____

Consent to the Use and Disclosure of Health Information for treatment, payment or healthcare operations.

I understand that as part of my healthcare, Perreault Chiropractic & Acupuncture originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses treatment, and any future plans for care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that a "Notice of Privacy Practices" is available at my request which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Perreault Chiropractic & Acupuncture reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Perreault Chiropractic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Perreault Chiropractic & Acupuncture has already taken action in reliance thereon.

Signature:_____Date:_____

Patient Financial Responsibility Policy/Authorization & Assignment of Benefits

General

The patient's insurance policy is a contract between the patient and his or her insurance company. However, **all charges regardless of the insurance coverage are the patient's responsibility** and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, PC & A bills the patients' insurance and makes every effort to ensure that claims are promptly and correctly processed. PC & A also bills patients' secondary insurance when patients provide complete insurance information.

Patient co-pays are expected at the time of service, and any remaining payment is due within 30 days of receiving the first bill from PC & A. We accept cash, checks, money orders, debit cards and credit cards (Visa, Master Card, Discover and American Express).

If you can't pay your balance within 30 days, please contact our office and we will work with you to find a monthly payment amount that will work with your financial needs.

If no insurance information is provided, or the correct information is not provided within the allowed amount of time set by the insurance company, the patient will be fully responsible for charges incurred.

Past Due Balances

A past due balance is any amount owed after the insurance company has paid its portion, but where PC &A has not received the full patient balance within ninety (90) days. ***Patients who have a previous collection agency balance and wish to receive services are required to pay any new charges at the time of service.***

I hereby authorize Perreault Chiropractic & Acupuncture to release to my insurance company information necessary for them to process my claims for care. I also assign insurance benefits to Perreault Chiropractic & Acupuncture as may be allowed by my insurance company. I further understand that I am fully responsible for all the charges incurred at Perreault Chiropractic & Acupuncture, regardless of my insurance coverage. Please note: We will do all we can to ensure your care is covered by your insurance carrier. However, benefits quoted to us are not a guarantee of payment but a general outline of your coverage. If a problem arises, we will appraise you as soon as possible and will expect you to call your insurance carrier to clear up any problems. Please keep in mind your contract is between you and your insurance carrier. We do not have any legal rights to your insurance contract – you do. Please be aware that many insurance carriers can take up to 3 months or more to process a claim.

Patient Name:_____

Signature:_____ Date:_____