PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____

PATIENT INFORMATION

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

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: _____

NEWBORN HISTORY

(BIRTH TO 3 YEARS)

Today's Date: _____

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

Reason for today's visit: _____

When did this problem first occur?_____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

How many hours does your child sleep between feeds? During day _____ at night _____

	YES	NO	COMMENTS
Does your baby go to sleep easily?	□	□	_____
Does baby have a preferred sleeping position?	□	□	_____
Does baby cry if you change this sleeping position?	□	□	_____
Does baby have any feeding difficulties?	□	□	_____
Is baby breast fed?	□	□	_____
If no, for how long was baby breast fed?_____Weeks/Months			
Does baby have a one sided breast-feeding preference?	□	□	_____
Preferred breast?	Left/Right		
Is baby formula fed?	□	□	_____
Which formula or other milk source?_____			
Does baby frequently spit-up after feeding?	□	□	_____
Does baby cry a lot?	□	□	_____
For how many hours each day?_____			
Does baby pass a lot of intestinal gas?	□	□	_____
Does baby have a preferred head position?	□	□	_____
Does baby frequently arch his/her head and neck backwards?	□	□	_____
Does baby cry or become irritable during diaper change?	□	□	_____
Has baby ever had a fever?	□	□	_____
Has baby had any falls?	□	□	_____
Has baby been in a car accident or near-miss?	□	□	_____
Has baby had any other trauma?	□	□	_____
Do you have any other concerns you wish to discuss?	□	□	_____

THIS SECTION FOR CLINIC USE ONLY

_____

_____

PREGNANCY HISTORY

Today's Date: _____ Child's Name:_____

How many children do you have?_____ What was the term of your pregnancy? _____weeks.

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING?

	YES	NO	EXPLAIN
Falls	☐	☐	_____
Motor Vehicle Accident(s)	☐	☐	_____
Near-Miss MVA	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Anemia	☐	☐	_____
Morning Sickness	☐	☐	_____
Indigestion	☐	☐	_____
Seizures	☐	☐	_____
Swollen Ankles	☐	☐	_____
Thyroid Problems	☐	☐	_____
Heart Problems	☐	☐	_____
Back Pain	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Were you hospitalized	☐	☐	_____
Any other illness	☐	☐	_____

Any other information you wish to add about your pregnancy:

_____

_____

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to birth?_____hours

How long was the 2nd stage (the pushing phase) of the labor?___mins

PLEASE ANSWER THE FOLLOWING QUESTIONS AND GIVE EXPLANATION WHERE NECESSARY.

	YES	NO	
Hospital Birth	☐	☐	_____
Home Birth	☐	☐	_____
Midwife assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-Section	☐	☐	_____
Emergency C-Section	☐	☐	_____
Induced birth (Pitocin)	☐	☐	_____
Forceps delivery	☐	☐	_____
Vacuum extraction	☐	☐	_____
Head presentation	☐	☐	_____
Face presentation	☐	☐	_____
Breech presentation	☐	☐	_____

THIS SECTION FOR CLINIC USE ONLY

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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
Effective 5/1/24

***PLEASE INITIAL* to confirm you understand and agree with the following:**

All Patients:

_____Payment is due at the time of service or within 30 days of monthly billing.
If you can't pay your balance within 30 days, you must contact our office to make other arrangements. We accept cash, check, HSA, debit and credit cards (Visa, Master Card, Discover and American Express).

_____An Administrative Fee of $3 is added to each visit and cannot be submitted to your insurance. This includes Medicare, Medicaid, VA, Motor Vehicle Personal Injury & Workers Compensation *(This fee is included in the $55 cash rate for an adjustment and $65 cash rate for acupuncture.)*

_____**Past Due Balance** is any amount owed where we have not received the full patient balance within 30 days of monthly billing. Late fees and collections are used if necessary. We offer a variety of re-payment options so don't hesitate to contact us.

Patients Using Insurance:

_____As a courtesy to our patients, we bill patient primary insurance (and secondary if applicable) and make every effort to ensure claims are promptly and correctly processed. We highly recommend you also contact your insurance carrier and check into your coverage for chiropractic care. **Do not assume that you will not owe anything if your insurance "covers" chiropractic care or you have more than one insurance policy.**

_____If a problem arises, we will inform you as soon as possible and expect you to call your insurance carrier to clear up any problems. 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.

_____Accepting your insurance does not place financial responsibility onto this practice. A**ll charges regardless of the insurance coverage are the patient's responsibility** and the patient is ultimately responsible for any unpaid balances. Benefits are subject to all contract limits and the member's status on the date of service.

_____We have to limit the number of visits we submit to your insurance company due to contracting requirements we must adhere to. The number of visits allowed varies by insurance company and policy.

I consent that I understand and agree with the above information.
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.

Patient Name:_____

Signature:_____ Date:_____