PEDIATRIC HISTORY FORM

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ S.S.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Work Phone: _____

Sex: _____ Weight: _____ Height: _____ Referred By: _____

Names of Parents / Guardians: _____

Purpose For Contacting Us ? _____

Other Doctors Seen for this Condition: _____ N _____ Y , Doctors' Names and Prior Treatments: _____

_____

Other Health Problems ? _____

Check any of the Following Conditions Your Child has Suffered from During the Past Six Months:

☐ Ear Infections	☐ Scoliosis	☐ Seizures	☐ Chronic Colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive Problems	☐ ADHD	☐ Recurring Fevers	☐ Growing / Back Pains
☐ Colic	☐ Bed Wetting	☐ Car Accident	☐ Temper Tantrums	☐ Other _____

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Are You Satisfied with the Care Your Child has Received There ? _____ N _____ Y

Number of Doses of Antibiotics Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____

Number of Doses of Other Prescription Medications Your Child has Taken:

During the Past Six Months: _____ , Total During His / Her Lifetime: _____ List: _____

Vaccination History: _____

Prenatal History:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy ? _____ N _____ Y , List: _____

Ultrasounds During Pregnancy ? _____ N _____ Y , Number: _____

Medications During Pregnancy / Delivery ? _____ N _____ Y , List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction

_____ Ceasarian Section , Emergency or Planned ?

Complications During Delivery ? _____ N _____ Y , List: _____

Genetic Disorders or Disabilities: _____ N _____ Y , List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____ , _____

Feeding History:

Breast Fed: _____ N _____ Y , How Long: _____

Formula Fed: _____ N _____ Y , How Long: _____ Type: _____

Introduced to Solids at: _____ Months , Cows' Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y , List: _____

_____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Saftey Council, approximately 50% of children fall head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child ? _____ N _____ Y

Is / has your child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.) ? _____ N _____ Y , List: _____

_____

Has Your Child Ever Been Involved in a Car Accident ? _____ N _____ Y , List: _____

Has Your Child Been Seen on an Emergency Basis ? _____ N _____ Y , List: _____

Other Traumas Not Described Above ? _____ N _____ Y , List: _____

Prior Surgery: _____ N _____ Y . List: _____

Menarche: _____ N _____ Y , Age: _____

Childhood Diseases:

Chicken Pox	N / Y, Age _____	Mumps	N / Y, Age _____
Rubella	N / Y, Age _____	Whooping Cough	N / Y, Age _____
Rubeola	N / Y, Age _____	Other	N / Y, Age _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son / Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ Policy #: _____

Signed: _____ Witnessed: _____ Date: ____ / ____ / ____

ARNDT FAMILY CHIROPRACTIC

NON – COVERED CHIROPRACTIC SERVICES

CONSENT FORM

This Consent is to clarify our policy regarding non-covered services. Non covered services are those procedures and services deemed not medically necessary by the insurer or their administrator. In this Office, our major concern is to assist you in maintaining overall good health. The health plan's chiropractic and therapy benefit are for acute, active therapeutic care. Once your symptoms have been reduced to a level of supportive or maintenance care, the responsibility for payment of services is that of the patient.

We believe it is beneficial for the patient to continue supportive or maintenance care on a regular basis in order to maintain correction. If you elect to continue care, please be aware that you are responsible for payment of our services.

If you have any questions regarding your insurance benefits, you may contact your health plan through your customer service representative. As always, we strive to render the highest quality of care. Thank you for choosing our office. We pledge to continue to earn your trust and confidence.

It is very important that you understand your choices so there is misunderstanding or confusion. The costs should be explained to you prior to procedures and / or treatment. You will be asked to sign this Consent to verify your understanding of your financial obligation. A copy of this signed Consent will remain in your chart as proof of understanding.

Disclosure Statement

I have read and understand the above information. I am in acceptance that will be responsible to pay full charges for all non-covered services.

_____ _____

Patient Name (please print) Date

_____

Patient Signature

ARNDT FAMILY CHIROPRACTIC

FINANCIAL AGREEMENT

The purpose of this Agreement is to clarify the financial aspects of your chiropractic care at Arndt Family Chiropractic. By your reviewing this information and signing below, we can devote our efforts to effectively helping you to achieve the best results – in the shortest amount of time.

Services:
Our fees vary based upon the severity of your condition(s) and the amount of time required to achieve the best result. Below are the most common services that we provide.

Procedure	Purpose	When Performed	Fee
Consultation	Tour the office, meet the doctor & staff. Discuss your issue(s) and health history.	Initial Visit	N/C
Examination(s)	Accurately determine the nature of your issue(s) and determine best course of action.	Initial Visit – Repeat every 10th to 15 visit	$50 - $95
X-Ray(s)	Visualize the location of spinal pathologies and confirm other examination findings	If necessary – 1st Visit, Re-injuries. As needed for progress exams.	$25 - $75 Per Region
Evaluation/ Management/ Adjustment(s)	Assess and evaluate Patient's health, determine appropriate course of care and reduce the Vertebral Subluxation Complex, Stabilize spine or joint problems.	Every Visit	$30 - $60
Therapy	Reduce inflammation and swelling, enhance the healing process and help to provide relief	As indicated by exam or office visit	$16 – $28
Laser Therapy	Reduces short term inflammation. Lowers risk of arthritis. Provides deep tissue therapy.	As indicated by exam	$20 - $90

Forms of Payment:
If you have health insurance, managed care, Medicare, Medicaid or personal injury coverage, we will submit the necessary paperwork and billing. Some exceptions may apply. You are responsible for any deductibles, co-pays or charges not covered by your insurance company.

You may also choose the option of paying on the day of service and receiving a day of service discount. We accept cash, personal checks, Visa, Master Card, Discover and AMEX.

Questions:
Please do not hesitate to ask should you have any questions about this Agreement. If your ability to comply with the provisions of this Agreement changes, please let us know. We are here to help.

Patient Agreement:
I have read, understand, agree to and have received a copy/declined a copy *(please indicate)* of this Agreement.

X_____ _____ _____

Patient/Responsible Party Signature Date Office Representative

ARNDT FAMILY CHIROPRACTIC

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP HEALTH INSURANCE

RE: _____

Patient: _____

Employer: _____

Claim/Group # _____ SSN _____

I hereby instruct and direct _____ (insurance company) to pay by check made out and mailed directly to:

Tricia L. Arndt, D.C.
7130 Muirfield Drive
Dublin, OH 43017

OR

If my current policy prohibits direct payment to said Doctor, then I hereby also instruct and direct _____ (insurance company) to make the check to me and mail it as follows:

Tricia L. Arndt, D.C.
7130 Muirfield Drive
Dublin, OH 43017

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for professional services rendered. *THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.* This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charge over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at Arndt Family Chiropractic, this _____ day of _____, _____

_____ _____

Signature of Policyholder Witness

_____

Signature of Claimant, of other than Policyholder

ARNDT FAMILY CHIROPRACTIC

OFFICE POLICY DEFINITIONS

Please initial all that apply:

____ **Payment of Your Bill**
It is the ultimate responsibility of the Patient/Guarantor to pay or provide third-party coverage for payment of all services received at Arndt Family Chiropractic.

____ **Medicare Patient**
We are on assignment with Medicare, therefore, payment will be directly reimbursed to our office based upon Medicare Chiropractic coverage. According to Medicare policy, Chiropractic coverage varies upon each additional patient's condition/diagnosis, therefore, upon termination of Medicare Chiropractic coverage, the Patient is responsible for the deductible, co-pay and office visits at that time.

____ **Medicaid Patient**
If you are a Medicaid patient, and you have provided our office with a valid Medicaid card, we will bill Medicaid for you. If you don't have a valid Medicaid card, your account will be treated as a self-pay account and payment will be expected from you.

____ **Commercial Insurance**
If you have supplied this office with complete insurance information at the time of registration, our office will submit your bill directly to your insurance company. Payment will be expected with 60 days of billing. If payment is not received 60 days, or your insurance company(ies) denies your claim, or the balance due is owing after your insurance company(ies) have paid, your account will be re-classified as a self-pay account, and we will bill you directly.

____ **Worker's Compensation**
If this is a Worker's Compensation claim, and you have a valid claim number, this office will bill the account for you. If you don't have a claim number, it will be your responsibility to complete the necessary forms to obtain a claim number. We will assist you with the necessary forms.

____ **Self-Pay**
If you have no insurance coverage, and you are ineligible for any government programs such Medicare, Medicare, Medicaid, etc., you will be responsible for payment of services provided at Arndt Family Chiropractic. Payment is due at the time of services.

ARNDT FAMILY CHIROPRACTIC

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT AND HEALTCARE OPERATIONS

I, _____, hereby give consent to Arndt Family Chiropractic (the "Practice") to use and disclose my Protected Health Information for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purpose. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conducted upon my consent as evidence my signature on this document. For purposes of this Consent, "Protected Healthcare Information" means any information, including my demographic information, created or received by the Practice that relates to my past, present or future physical or mental health condition; the provision of health care to me; or the past, present or future payment for the provision of health care services to me, and that either identifies me or from which this is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purpose of treatment, payment or healthcare operation of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

Release of Information

- I hereby authorize Arndt Family Chiropractic to release any formation needed for completion of their claims for payment, for continuity of care of for Worker's Compensation claims. This includes, but is not limited to, my insurance company, my employer, any physician, hospital, social agency, welfare agency or governmental agency. I permit release of information concerning dates of chiropractic care, condition, diagnosis, procedures or treatments.
- Arndt Family chiropractic is authorized to release my medical records and/medical information to other physicians who will assist and/or will provide medical care to me, but who are not my primary treating physicians.
- I authorize Arndt Family Chiropractic to utilize my social security number when required for purpose of releasing information.
- I understand that if the authorized recipient is not a provider, health plan or clearing house required to comply with the federal standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standard and my health information may be re-disclosed by the recipient without obtaining any further authorization.

Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Arndt Family Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Witness