PEDIATRIC

Case #: _____

Bailey Family Chiropractic LLC

127 S. Lane St. Blissfield, MI 49228 Phone: (517) 486-1232 Fax: (517) 486-4645

Child/Patient's Name: _____ Date: _____

[redacted] _____ Date of Birth: _____ Age: _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

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

Phone (Home): _____ Cell: _____ Work: _____

E-mail: _____

Insured's Name: _____ Insured's D.O.B.: _____

Referred by: _____ How did you hear about us? _____

Present complaint: _____

Pain/problem started on: _____ Have they experienced this before? **Y** **N** When? _____

How did the symptoms begin? (i.e. gradually, suddenly, etc.) _____

Is this due to an injury or accident? **Y** **N** Describe _____

Frequency of symptoms: ____ Daily ____ 2-3 times weekly ____ Sporadic Describe _____

Pains are: ____ Sharp ____ Dull/Ache ____ Numbness ____ Shooting ____ Burning ____ Tingling

Symptoms are better with: _____ Symptoms are worse with: _____

How are the symptoms changing? ____ Getting better ____ Not changing ____ Getting worse

Is this condition worse at certain parts of the day? ____ Morning ____ Afternoon ____ Evening ____ During sleep

Are you currently or have you seen a doctor or chiropractor for this condition? **Y** **N**

Dr./Office name: _____ When? _____ What were the results? _____

Birth Weight: _____ Birth Length: _____ Current Weight: _____ Current Height: _____

Type of birth: ____ Vaginal ____ Forceps ____ Breech ____ Cesarean ____ Home ____ Birthing Center ____ Hospital

Problems during pregnancy: _____

Problems during labor/delivery: _____

Infant feeding: _____ Breast _____ Bottle _____ Formula

Immunization history: _____ Up-to-date _____ Reduced schedule _____ None

Current hours of sleep per night: _____ Quality of sleep: _____ Good _____ Fair _____ Poor

Obstetrician / Midwife: Name: _____ Location: _____

Pediatrician / Family MD: Name: _____ Location: _____

Date of last visit to MD: _____ Purpose: _____

Has your child ever been treated on an emergency basis? **Y** **N** Describe: _____

_____

Over ⟶

Please list any past and present health conditions: _____

_____

Please list any family health conditions: _____

_____

Please list and describe any operations and/or procedures: _____

_____

Please list any over-the-counter and prescription medications currently taking: _____

_____

PLEASE MARK AN (X) IF YOU HAVE EXPERIENCED ANY OF TYHE FOLLOWING IN THE PAST YEAR:

General
- _____ Fatigue
- _____ Fever
- _____ Weight gain
- _____ Weight loss

HEENT
- _____ Runny nose
- _____ Stuffy nose
- _____ Sneezing
- _____ Ear pulling
- _____ Itchy / red eyes
- _____ Drooling
- _____ Sore throat
- _____ Hearing loss
- _____ Allergies

Musculoskeletal
- _____ Decreased range of motion
- _____ Joint pain
- _____ Joint redness
- _____ Joint swelling
- _____ Joint stiffness
- _____ Muscle weakness
- _____ Muscle aches / pains

Neurological
- _____ Loss of bowel / bladder control
- _____ Dizziness / vertigo
- _____ Headaches
- _____ Numbness / tingling
- _____ Passing out
- _____ Seizures
- _____ Tremor

Psychiatric
- _____ Anxiety
- _____ Change in sleep pattern
- _____ Depression
- _____ Hallucinations
- _____ Suicidal thoughts
- _____ ADD / ADHD
- _____ Autism

Cardiovascular
- _____ Chest pain
- _____ Leg swelling
- _____ Palpitations
- _____ Irregular beat

Respiratory
- _____ Chronic cough
- _____ Difficulty breathing
- _____ Coughing up blood
- _____ Sputum production
- _____ Wheezing
- _____ Asthma

Other
- _____ Constipation
- _____ Diarrhea
- _____ Nausea
- _____ Urinary problems / bedwetting
- _____ Skin problems
- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____
- _____ _____

Patient's/Guardian's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

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Informed Consent to Care

You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic care involves what is known as a chiropractic adjustment. In some cases, there may be additional supportive procedures or recommendations. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken bones), sprains, strains, dislocations, disc injuries, and strokes. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke, and on rare occasion can result in paralysis or death. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

It is also important that you understand there are treatment options available for your condition other than chiropractic care. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

X_____

Patient or Guardian's **Signature** Printed Name Date

For MINOR children only:

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

I, _____, being the parent or legal guardian of _____ agree to allow him/her to be treated at Bailey Family Chiropractic without my direct supervision.

_____

Signature of Witness Printed Name Date

_____

Chiropractor Signature Date

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PAYMENT POLICY AND FEE SCHEDULE

We are currently accepting the following forms of payment:

1- **Self-pay.** We accept cash, check, and credit card. For patients who pay for their services on the same day as rendered, a time-of-service discount will be given.

2- **Insurance.** We accept assignment for most insurances and will be happy to pre-verify your insurance coverage. You will need to provide your insurance card for this process.

Medicare/Medicaid. We will accept assignment for Medicare/Medicaid. Patients are responsible for their co-payment and payment for any services not covered by Medicare/Medicaid.

Payment (including co-payment) is expected when service is rendered, unless other arrangements have previously been made.

If you discontinue care for any reason other than discharged by the doctor, you will be responsible for any unpaid balance regardless of any claim submitted to your insurance company, at the time you discontinue care.

This office does not guarantee that an insurance company will pay for chiropractic services. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own.

I have read and hereby agree to the above provisions.

Name (print) Signature Date

* If you would like to see a copy of the fee schedule please ask the front desk.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how chiropractic and medical information about you may be used and disclosed and how you obtain access to this information. Please review it carefully.

In the course of your care as a patient at Bailey Family Chiropractic, we may use or disclose personal and health information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if necessary to refer you for further diagnosis or care.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or employer if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to request restrictions in your use of protected health information for care, payment, or operations purposes. Such requests are not automatic and request the agreement of this office.

If you are not home to receive an appointment reminder or other information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or alternative agreement of this office.

We are permitted and may be required to use or disclose information without your authorization in these following circumstances:

- If we provide healthcare services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide you care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by persons to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also inform you regarding your health care or about the state of your account. If you receive this information at an address other than your home, or if you would like the information in a specific form, please advise us in writing as to your preference.

We are required by state and federal law to maintain the privacy of your patient file and the health information herein. We are also required to provide you with this notice of our privacy practices with the respect to your health information. We are also required to follow the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will not be a disadvantage to you.

If you have a complaint regarding our privacy practices or any aspect of our privacy activities, you should direct you complaint to our front desk staff. We will do our best to resolve the privacy issue in the office as soon as possible. If your issue does not get resolved, please contact the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with our office or with the Secretary, your care will continue and this office or our staff will not disadvantage you.

This notice is effective as of January 4, 2010 and any alterations or amendments made here will expire seven years after the date upon which the record was created. Your signature acknowledges that you have read and understand this notice and may be given a copy if so requested.

Name (print)	Signature	Date
Representative of Minor (print)	Signature	Date