



Child Information and Release

PATIENT INFORMATION

Thank you for choosing our office for your chiropractic needs. Please complete this form in it's entirety. If you have any questions or concerns please don't hesitate to ask for assistance, we will be happy to help you

(Please print)

Name: _____ Date: _____

(first) (middle) (last)

Address: _____ City _____ Zip _____

Phone _____ Age: _____ Date of Birth _____ Male _____ Female _____

SYMPTOMS

Please circle or write the symptoms your child is currently experiencing or that they have experienced in the past.

Asthma Headache Ear infection Colic Allergies Bed wetting Neck Pain Back pain

Other _____

HISTORY

Please check any child disease your child has had:

Chicken pox Measles Mumps Colic Allergies Ear infections

Please comment on how often any of the above diseases have occurred and when they occurred:

Pregnancy normal? Yes No Explain: _____

Complications? _____

Delivery? Home Hospital Complications: _____

Medications during delivery: _____

Immunizations (list received and age): _____

List any surgeries or congenital conditions: _____

INSURANCE INFORMATION

Insurance Company _____ Name of Subscriber _____

Subscribers Birthday ____/____/____ Subscribers telephone # _____ SSN _____

Relationship of subscriber to Insured _____ Insurance Company _____ Policy # _____

Group # _____ Effective date _____ Termination date _____

Secondary insurance _____

Please turn to next page to finish.

FORMS OF PAYMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered after my insurance's contracted annual agreement, are charged directly to me and that I am personally responsible for payments.

I understand that I am responsible for my contracted payment at the time of service. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fee or court costs required to collect my bill.

We accept cash, personal checks, VISA, MasterCard, and DISCOVER. Any bounced checks and fee's will be my responsibility and will be paid in full. Any credit arrangements must be authorized in advance.

Other options are available if your care is covered by Workers Compensation, Medicare, Personal Injury, or the result of an automobile accident. We will not become involved in disputes with your insurance company or attorney regarding deductible, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc. other than to supply factual information.

_____Initial

HIPAA GUIDELINES

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. We may have to disclose your PHI to another healthcare provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment. We may have to disclose you health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our own practice for quality control or other operational purposes. We may need to use your PHI to remind you of appointments, send you a birthday card, send you a thank you, acknowledge your referral, send you a welcome to the office letter, invite you to participate in office workshops, or send promotional information. We have a more complete notice that provides a detailed description of how your PHI may be used or disclosed. You have the right to revise that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice.

_____Initial

YOUR RIGHTS

You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing. We are not required to agree with your restrictions. However, if we agree with your restrictions, the restriction is binding upon us. You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor you revocation request if we have already released your PHI before we receive your request. If you were required to give your authorization as a condition of obtaining insurance, they may have the right to your PHI if they decide to contest any of your claims.

I have read your consent policy and agree to it's terms. I am also acknowledging that I have received a copy this notice if requested.

Sign Name

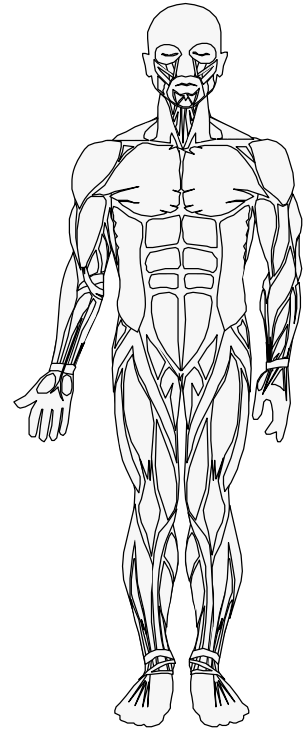
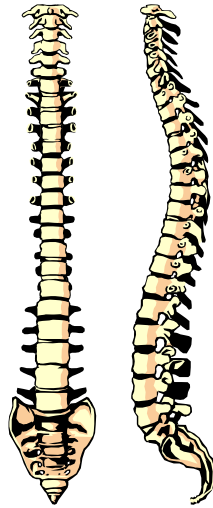
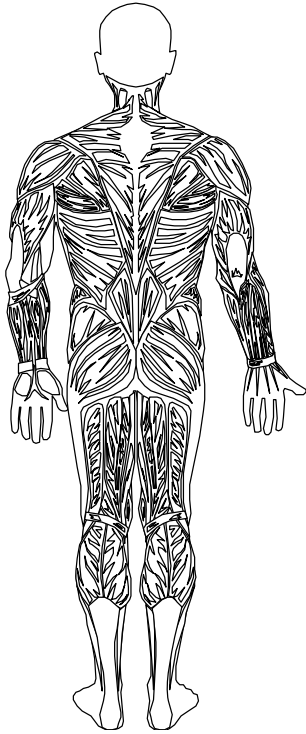
Date

Provider representative

For Doctors Use Only

Patient's Name: _____

Date: _____



Left _____ Right

BF% _____ RHR _____

Reflexes

	<u>Left</u>	<u>Right</u>
C5	_____	_____
C6	_____	_____
L4	_____	_____
L5	_____	_____
S1	_____	_____

Orthopedic Tests

	WEBBERS TEST	RINNES TEST
Pos	Neg	Pos
		Neg

Orthopedic Tests

	Pos	Neg
Georges Test		
SLR		
Kemps		
Valsalvas		
Lasauages		
Heel walk		
Toe Walk		

Range of Motion

	L	R		L	R
Cervical			Lumbar		
Flx (65)			Flx (95)		
Ext (50)			Ext (35)		
L.F.(40)			L.F.(40)		
Rot(55)			Rot(35)		

X-RAY VIEWS TAKEN

- | | | |
|--|--|--|
| <input type="checkbox"/> 2 View Cervical | <input type="checkbox"/> 4 View Cervical | <input type="checkbox"/> Davis Series |
| <input type="checkbox"/> 2 View Thoracic | <input type="checkbox"/> Full Spine | <input type="checkbox"/> 2 View Lumbar |
| <input type="checkbox"/> Spot Shot LB | <input type="checkbox"/> 2 View Pelvis | <input type="checkbox"/> Extremity |
| <input type="checkbox"/> Other: _____ | | |

DC Virginia Encounter Form

Patient's Name: _____ Date of service _____

X-RAYS

- _____ 72010 Full Spine AP/LAT
- _____ 72020 Single View
- _____ 72040 Cervical AP/LAT
- _____ 72050 Cervical 4 Views
- _____ 72052 Cervical Davis Ser
- _____ 72070 Thoracic AP/LAT
- _____ 72100 Lumbar AP/LAT
- _____ 72110 Lumbar 4 Views
- _____ 72114 Lumbar Comp w/ Bending
- _____ 72120 Lumbar Bending
- _____ 73020 Shoulder 1 View
- _____ 73030 Shoulder 2 Views
- _____ 73060 Humerous 2 View
- _____ 73070 Elbow AP/LAT
- _____ 73090 Forearm AP/LAT
- _____ 73100 Wrist AP/LAT
- _____ 73500 Hip Unilateral
- _____ 73510 Hip Complete
- _____ 73550 Femur AP/LAT
- _____ 73560 Knee AP/LAT

E/M NEW PATIENT

- _____ 99201 New Patient Problem Focused
- _____ 99202 New Patient Expanded Problem Foc
- _____ 99203 New Patient Detailed
- _____ 99204 New Patient Comprehensive

DX

1. _____ 2. _____ 3. _____ 4. _____ *Notes* _____

