APPLICATION FOR CARE AT Ace Family Chiropractic

Pediatric History Form

PATIENT DEMOGRAPHICS

Child's Name: _____ **Birth Date**: ____-____-_____ Age: _____

□ **Male** □ **Female** **Height**: _____ft _____in. **Weight**:_____ lbs

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

Parent or Guardian Name: _____ Phone Number: _____

Pediatrician/Family MD: _____ City/State: _____

CHILD'S CURRENT COMPLAINT

Please explain the health concerns and/or symptoms that prompted you to seek care today:

_____

_____

When did this concern first begin? Date: _____-_____-_____ □ Unknown □ Gradual □ Sudden

Has this problem occurred before? □ No □ Yes If yes, please describe: _____

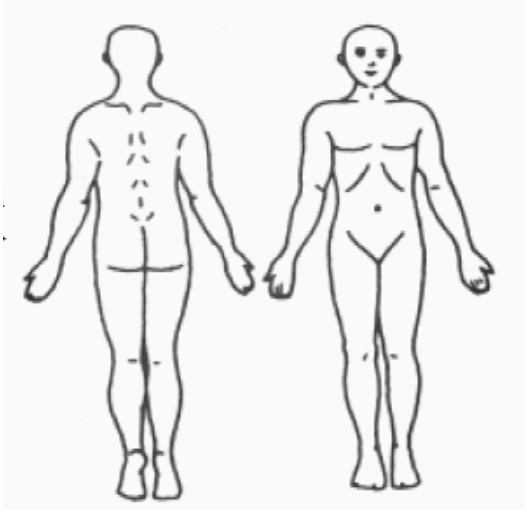
Is this the result of: □ Fall □ Auto Accident □ Birth/Delivery □ Sports/Activity □ Other: _____

Previous Chiropractic Care? □ Yes □ No

Level of discomfort: (*No pain)* 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 *Worst Pain Ever*

If applicable, PLEASE MARK the areas on the Diagram with the following **letters** to describe your symptoms:

R = **R**adiating **B** = **B**urning
D = **D**ull **A**= **A**ching
N = **N**umbness **S** = **S**harp/**S**tabbing
T = **T**ingling



Have you seen any other doctors for this problem? □ No □ Yes If yes, whom? _____

What were the results of past treatment?

_____

Please list any medications:

_____

HAS YOUR CHILD EVER SUFFERED FROM - Check all that apply

○ **Headaches**	○ **Digestive Issues**	○ **Behavioral Problems**
○ **Dizziness**	○ **Constipation**	○ **ADD/ADHD**
○ **Fainting**	○ **Diarrhea**	○ **Hernia/Ruptures**
○ **Seizures**	○ **Broken Bones**	○ **Asthma**
○ **Chronic Earaches or Infections**	○ **Frequent Colds/Flu**	○ **Sleeping Problems**
○ **Sinus Issues**	○ **Neck Aches**	○ **Poor Appetite**
○ **Scoliosis**	○ **Back Aches**	○ **Sports Injury**
○ **Bed Wetting**	○ **Significant Fall as a Child**	○ **Growing Pains**
○ **Colic**	○ **Significant Fall as an Infant**	○ **Cancer**

○ **Allergies to : _____**

○ **Surgeries or Hospitalizations: _____**

○ **Other: _____**

INFORMED CONSENT REGARDING: Chiropractic Adjustments and Modalities

I understand that I am directly and fully responsible to Ace Family Chiropractic for all fees associated with chiropractic care my child receives. If applicable, the consent of a spouse/former spouse or other guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and all other procedures provided at Ace Family Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____

Parent or Legal Guardian's Signature ***Date***

FINANCIAL POLICY: Insurance Billing, Patient Responsibility and Payment Options

Insurance Billing:

We do our best to contact your insurance company and verify your insurance coverage prior to your visit, when possible. Please note, verification of benefits is NOT a guarantee of payment. You are responsible for any copays, deductibles, coinsurances or services not covered by your insurance plan.

We cannot promise that an insurance company will reimburse our office or you for the services rendered. In the event that an insurance company denies payment, it is your responsibility to pay these charges and seek reimbursement from your insurance company. It is your responsibility to let Ace Family Chiropractic know if your insurance policy has changed.

Patient Responsibility:

Payment for copays, deductibles and all other services are due **at the time of service.** If the insurance company does not pay within 45 days, the remaining balance may become your responsibility. You will receive a statement for any unpaid balances.

Payment for unpaid balances are due within 30 days of the statement date. Accounts remaining unpaid after 30 days will accrue a monthly late fee until the balance is paid in full. Accounts remaining unpaid after 90 days will be referred to a collections agency. If your account is sent to collections, you will be responsible for any additional fees.

We accept cash, debit/credit cards, checks, HSA/FSA cards and Care Credit. There is a $25 fee for returned checks.

Payment plans are available upon request and require a card on file. You may conveniently store a card on file with our office. This can be used for payment for services and outstanding balances. You will receive notice of any charges made to your card. Your information is stored securely and protected in compliance with HIPAA and PCI standards.

I have read and understand Ace Family Chiropractic's Financial Policy and agree to the terms above. If applicable, I authorize Ace Family Chiropractic to store and charge my card for any patient balances as described in this policy.

_____ _____

Parent or Legal Guardian's Signature ***Date***

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Chiropractic