Family Chiropractic
204 Pinehurst Dr. SW #103
Tumwater, WA 98501

Dr. Betsy Burgos Diaz

Newborn - Preschooler (0-6 y/o)
Chiropractic Intake form

Welcome to our office!! The following information is confidential. It will be used to complete your history and understand your condition, so please be as accurate as possible while completing this form. If you have any questions about this form, please ask at the front desk.

PATIENT INFORMATION Date ____/____/____

Patient Name _____
LAST FIRST MI

Date of birth _____/_____/_____ Age _____ Height_____ Weight_____lbs. Sex Male Female

Address _____

City _____ State _____ Zip _____

Parent/Guardian Name(s)_____

Cell Phone (_____)_____ Work Phone (_____)_____

Home Phone (_____)_____ Best time to reach you _____

Parent/Guardian email_____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Primary Phone (_____)_____ Secondary Phone (_____)_____

REFERRAL INFORMATION

How did you hear about us? Facebook Family/Friend (Whom may we thank for referring you? _____)
Internet Search Primary Physician Staff Other _____

Can we send them a thank you note for referring you to us? Yes No

AUTHORIZATION FOR CARE OF A MINOR

Parent/Guardian Name_____
I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature:_____ Date ____/____/____

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PATIENT CONDITION

What health condition(s) bring your child to be evaluated by a chiropractor:_____

_____

When did this condition begin?____/____/____ How did the problem start: Suddenly Gradually Post-Injury

How often does your child experience this condition? Constant Frequently Intermittent Occasionally

Does this condition interfere with Sleep Sitting Standing Walking Bending Lying Down

Has your child received treatment for this condition before? No Yes

If yes, please explain_____

What makes the problem better?_____ What makes the problem worse?_____

HEALTH GOALS

What are the top 3 health goals for you child?

1._____

2._____

3._____

What would you like to gain from chiropractic care?

Resolve existing condition Overall Wellness Both

PREVIOUS TREATMENT

Pediatrician_____ Date of last visit____/____/____

Previous Chiropractic Care: No Yes Name:_____ Date of last visit____/____/____

Other Health Care Professional_____

Previous Diagnosis_____

HEALTH HISTORY

Please mark any of the following conditions that your child currently experiences or has ever had

Abnormal bleeding	Discipline problems	HIV/AIDS
Allergies	Eczema/Skin Problems	Irritable/temper problems
Asthma/Wheezing	Emotional problems	Kidney/Bladder problems
Bedwetting	Ever eating dirt, paint or plaster	Mouth breather/snoring
Cancer	Eye problems	Mumps, Measles
Chicken Pox	Frequent colds or sore throats	Nightmare/sleep problems
Child doesn't get along well with other Children	Frequent ear infections	Night sweats

FAMILY HISTORY (*any parents, siblings, grandparents, aunts & uncles have the following?)*

Mark all that applies

Diabetes	Heart Disease	Hight blood pressure	Stroke
Breast Cancer	Ovarian Cancer	Colon Cancer	High Cholesterol
Blood Clots	Mental Illness	Osteoporosis	Blood disorders
Uterine cancer	Cancer (other)_____		
Other_____			

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HEALTH HISTORY (cont...)

Colic	Handicaps/Disabilities	Pneumonia
Congenital heart defect	Hearing problems	Reflux
Convulsions/Epilepsy	Heart murmur	Rheumatic Fever
Croup	Hemophilia	Speech problems
Dental problems	Hepatitis	TB/Lung Disease
Developmental problems	High Blood Pressure	Thumb sucking
Diabetes	High Cholesterol	Toilet training problems
Diarrhea or Constipation	Oral Thrush	Jaundice

Other _____

Please explain any medical issues that your child has: _____

_____

LABOR & DELIVERY HISTORY

Child's birth was? Natural Vaginal Birth Scheduled C-Section Emergency C-Section

Child's birth was. At home At a birth center At a Hospital Other_____

At how many weeks was your child's birth? _____ Birth weight_____ Birth height_____

Please check any applicable interventions or complications

Breech Induction Pain Meds Epidural Episiotomy Vacuum Extraction Forceps

Were any of the following used throughout pregnancy? Doula Midwife Chiropractor

Any evidence of birth trauma? (Bruises, odd shaped head stuck in the birth canal, fast or excessively long birth, respiratory depression, cord around the neck, other)_____

GROWTH & DEVELOPMENTAL HISTORY

Was/Is the child breastfed? No Yes If yes, how long?_____ Difficulty with breastfeeding? Yes No

Did/does your child ever use formula? No Yes If yes, at what age?_____ If yes, what type?_____

Does your child frequently arch their neck/back, feel stiff, or bang their head? No Yes

At what age did the child: Respond to sound_____ Follow an object_____ Hold their head up_____

Vocalize_____ Teethe_____ Crawl_____ Walk_____ Begin cow's milk_____ Begin solid food_____

Known food sensitivities/allergies_____

Typical diet Mostly whole, organic foods Pretty average High amount of processed foods

Number of meals each day_____ Number of snacks per day_____

Has your child been vaccinated? Yes. No If yes, which ones and list of reactions to them if any_____

_____

_____

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GROWTH & DEVELOPMENTAL HISTORY (cont…)

Has your child ever been on any antibiotics? No Yes How many courses_____

List any medication, vitamins, herbs, minerals your child is currently taking?_____

_____

Please list any major illnesses, injuries, falls, auto accidents or surgeries including dates: _____

_____

How often is your child using screen time? (Cell phone, iPad, computer/laptop, television) Hours per day_____

Office Policies

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. _____(initials)

In the event that you are not able to keep your scheduled appointment, please give 24 hours' notice prior to canceling. Canceling with less than 24 hours' notice or missing an appointment will result in. being charged the cost of the appointment_____(initials)

NOTICE OF PRIVACY PRACTICE *We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us or the law authorizes or compels us to do so. You may see your records to get information about it by contacting our office at (360) 352-8112. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information. _____(initials)*

Informed Consent

The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures. If your history and examination indicate the need, you will receive further diagnostic tests or a referral to a specialist. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. Adjustments are usually performed by hand but may also be performed by hand-guided instruments or equipment. In addition to adjustments, other treatments used by chiropractors include soft tissue manipulation, nutritional recommendations, and exercise. Please list any preferences here_____

I have read the previous information regarding the risk of chiropractic care, and my doctor has verbally explained the risks (if any) and suggested alternatives when those risks exist. I understand the purpose of care and have been explained the treatment, the frequency of care, and alternatives to this care. All my questions have been answered to my satisfaction. I agree to this care plan, understanding any perceived risk(s) and alternatives to this care for the above minor patient. By signing, I give consent for examination, tests, and procedures for the above minor patient. _____(initials)

By signing, I have read and understood the Office Policies and Informed Consent:

Print Patient Name _____

Print Parent/Guardian Name _____

Parent/Guardian Signature_____ Date _____/_____/_____

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Financial Policy

APPOINTMENTS: Your appointments are times reserved and committed exclusively to you. We realize emergencies do occur, and appointments must sometimes be changed. Charges MAY be made for missed appointments and appointments cancelled without two hours' advanced notice. (Initial)_____

INSURANCE: We must emphasize that as chiropractic and massage providers, our primary relationship is with you. As a service to our patients, we do accept assignment of insurance benefits of most policies. In addition, we are participating providers with several insurance carriers and payers. YOU are responsible for payments of your co-pay at the time of service. If your deductible has not been met, YOU are responsible for full payment until it has been met; then, only your part thereafter. Once the claim has been processed by your insurance provider, we will bill you your patient responsibility part. Payment is due within 30 days of the bill. (Initial)_____

****NOTE:** *We are happy to assist you in verifying your chiropractic and massage benefits, all insurance companies begin verification with a message which states: 'This verification of benefits is not a guarantee of payment. This is a simple overview of the policy. Only when a claim is received can it be reviewed for medical necessity and for policy provisions. Again, this is not a guarantee of payment."***

I RECEIVED A BILL EVEN THOUGH I HAVE SECONDARY INSURANCE: Having secondary insurance does not necessarily mean that your services are 100% covered. Secondary insurance policies typically pay according to a coordination of benefits with the primary insurance.

WHAT IF FAMILY CHIROPRACTIC DOES NOT CONTRACT WITH MY PLAN OR I DON'T HAVE INSURANCE: If we are not a provider under your insurance plan or you don't have insurance, you will be responsible for payment in full at the time service. You will be charged our office's time-of-service rates. At the sole discretion of the practice, extended payment agreements may be made for patients. Please speak to our office manager to discuss a mutually agreeable payment plan. It is never out intention to cause hardship to our patients, only to provide them with the best care possible and reasonable costs.

PAYMENTS: Payment is due at the time of services are rendered, unless other arrangements have been made in advance. We accept cash, check, Visa/MasterCard, Discover/American Express. Returned checks are subject to a $30.00 service charge. Any account that becomes will be subject to collections service. Should our clinic receive information that your insurance will no longer be covering services, such as in the incidence of maximum insurance payout met, you will be charged the applicable discounted to time-of-service rates and supplied receipts if needed. (Initial)_____

Credit/Debit Card Authorization

Patients are responsible for all charges and services that are not covered by their insurance provider. In accordance with our office's payment policies, we ask that you review the following terms and conditions and provide an alternative payment method.

1. I understand that the Provider will submit all billing claims to my insurance provider for reimbursement, but I am solely responsible for all charges and services I receive from this Provider, including those covered by my insurance.
2. I understand that payment may be expected at the time of service. This may include a co-pay and additional payment if this practice decides that the cost of my visit today will not be reimbursed by my insurance provider.
3. I understand that I may be charged a service fee, or service may be denied for failure to pay co-pay or any outstanding balance at the time of service.

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4. I understand that it is my responsibility to ensure that the Provider always has current information on file, including my address, contact details, insurance information and a valid credit/debit card or other payment information.
5. I understand that my signature and payment information will be held on file for future use by the Provider.
6. I understand that I may receive a monthly statement any outstanding balance that is not satisfied by a charge to payment method and that I am responsible for paying this balance by its due date.
7. I understand that unpaid balances may incur additional fees and interest charges.
8. I authorize Family Chiropractic to send electronic account statements, invoices, and receipts to the email address I have provided to the office. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.
9. I authorize Family Chiropractic to send me a text message of my current balance that is due, and I may request a statement be emailed to me at the email address I have provided to this office.
10. I understand this authorization will remain in effect until the expiration of the credit card or until I provide a 30-day written notice of cancellation to Family Chiropractic.

Acknowledgement and Authorization:

I have read all the information on this form and have completed on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify Family Chiropractic IMMEDIATELY of any changes in my health status or the above information, including changes of insurance policies.

By signing this form, I acknowledge that I have received, reviewed, and understood Family Chiropractic's payment policies. I authorize Family Chiropractic to charge my card in accordance with the payment policy. I certify that I am an authorized cardholder or user of this credit/debit card.

Name (print) _____

Signature _____

CC Type _____ CC Number _____

CC Expr date _____ CC CVC Code _____

Approval to keep CC on file in the computer system (signature)_____

Signature if patient is a minor:_____ Date_____
Relationship if patient is a minor:_____