Pediatric Patient Information

Child's Name: ____ Date of Birth: __________________________
Age: _______________ Sex: _______________ Pediatrician and Phone Number: ________________________________

Parent/Guardian: ____
Parent's Email (required): ____
Home/Cell Phone (required): ____
Address: ____City: _____________________ State/Zip: _____________
Previous Chiropractic Care: ____

Primary Insurance Carrier and State:____________________
Subscriber Name: ___________________________________
Subscriber DOB: ____________________
ID#: ____
Group #:____

Secondary Insurance Carrier and State:_________________
Subscriber Name: ___________________________________
Subscriber DOB: ____________________
ID#: ____
Group #:____

Reasons for Seeking Chiropractic Care

Please check reasons for pursuing chiropractic care for your child:

________ He /She is continuing ongoing care from another chiropractor.

________ I recently had my spine checked and see the value in getting my child checked.

________ I am concerned about his/her health.

________ I want to improve my child's immune function.

________ He/ She has a specific condition that concerns me.

Explain:______________________________

Child's Current Body Signals

Please check any of the following body signals he/she has or has previously had:

_______Torticollis
_______Car Accident
_______Tongue/Lip Tie
_______Frequent Colds
_______Sleep Problems
_______Sinus Problems
_______Allergies
_______Other: ________________
_______Ear Infection
_______Back issues
_______Constipation
_______Headaches
_______ADD/ADHD
_______Scoliosis
_______Bed Wetting

Which of the problems that you have checked off are the **worst?**______________________________

Has your child been involved in any high-impact or contact type sports? If yes, please explain:

____

Has your child suffered from an injury/accident that caused the current condition?

____

Has your child been seen in an emergency room/Pediatrician for this condition?

____

Has your child had any surgeries?

____

Prescription medications/Vitamins/OTC Meds:

____
____

Consent to Treat a Minor Child

I, ____________________________________ being the parent or legal guardian of (PATIENT)______________________, hereby grant permission for my child to receive chiropractic care from the practitioner(s) at this establishment.

Patient Name: ____Date: ______________________________

PARENT Name: ___________________________________ **PARENT** Signature: ______________________________

INFORMED CONSENT TO CHIROPRACTIC CARE

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions prior to signing if anything is unclear.

The Chiropractic Adjustment:

The primary treatment that Dr. Sedgwick uses is spinal manipulative therapy. The doctor will use that procedure to treat you, the patient. The doctor may use her hands or an instrument upon your body as a way to correct the alignment of your joints. This may cause an audible "click" or "pop". You may feel a sense of movement. The goal of this treatment is to restore mobility to the area and relieve associated nerve pressure.

Risks:

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to fractures, dislocations, stroke, muscle strain, cervical myelopathy, costovertebral strains, and disc injuries. Some patients feel soreness and stiffness following the first few days of treatment. The doctor will make every effort to minimalize any risks.

Fractures are rare and usually result from underlying weakness of the bone, which the doctor will check for during the history and examination. Stroke has been the subject of tremendous disagreement. The incidence of stroke is estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Alternative Options:

Other treatment options available to you include: no treatment, self-administered over the counter analgesics and rest, and medical intervention such as prescription medications, hospitalizations, and surgery.

I have read and understand the above, and I have discussed my concerns with the doctor. Having been informed of the risks, I hereby give my consent to treatment.

Name (Printed): ____ Date: _______________________

Patient Name (if different from above): ____

Signature: ____

Patient Health Information Consent Form

We want you to know how your **Patient Health Information (PHI)** is going to be used by **Shaker Women's Wellness** and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you with Dr. Sedgwick before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Dr. Sedgwick to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Dr. Sedgwick is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient at their home/office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. We have taken all precautions that are known to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Dr. Sedgwick has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: ____ Date: _________________________

Signature: ____

SHAKER WOMEN'S WELLNESS
Premier Chiropractic Care

FINANCIAL POLICY

The following is an explanation of the policy implemented by Shaker Women's Wellness. We believe that a clear definition of our financial policy will allow both the doctor and you to concentrate on re-establishing, retaining and maintaining your health.

Payments

- We will be happy to verify your benefits and health coverage with your insurance company; however, that is not a guarantee of payment. It is your responsibility to understand your health insurance policies. We are not responsible for knowing when you meet your deductible or out of pocket.
- ALL CO-PAYS and CO-INSURANCE are due at the time of service.
- If you do not have insurance or choose not to file with your insurance company, all payments are expected at the time of service.
- There will be a $10 charge added to all balances every 30 days overdue. In addition, there will be a 1.5% finance charge added to all balances after 60 days.
- There will be a $25.00 charge on all returned checks.

Insurance Coverage

- Our fees are considered usual, customary and reasonable by most companies, and therefore covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing not relationship to the standard of care in this area.
- If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

Assignment and Release

I, ___________________________________, agree to assign Dr. Angela Sedgwick of Shaker Women's Wellness, all insurance benefits, if any, otherwise payable to me for services rendered. I also authorize the use of my signature on all insurance submissions.

____ I agree to pay my deductible/copay/co-insurance at the time of service

____ Please place a credit card in my file for this and future payments. (Credit card charge will occur day of visit)

Credit Card No: _________________________________ Exp:____/_____

CVV: _____________________ Zip Code for Card: ________________

I have read and understand the financial policies of Shaker Women's Wellness, and I will honor them. If a credit card is placed on file, it will be secured through Square Payment Processing.

Patient Signature: ____ Date: ____________________