Discover Life CHIROPRACTIC

Date: _____ Office ID# _____

NEW CLIENT INTAKE FORM – PEDIATRIC/CHILD

Child's first name: _____ Last name: _____ M.I.____

Child's birth date: _____/_____/_____ Child's sex: ¦M ¦F

Parent(s) name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #'s: _____

Email: _____

Parent(s) occupation(s):

Mother: _____ Work #: _____

Father: _____ Work #: _____

Siblings names:

_____ Age: _____ ¦M ¦F

_____ Age: _____ ¦M ¦F

_____ Age: _____ ¦M ¦F

How did you hear about us?

_____

Is there anyone specifically we can thank for referring you?

_____

REASON(S) FOR SEEKING CHIROPRACTIC CARE

What is your primary reason(s) for seeking care?

_____

When did this begin? _____Suddenly or Gradually?

Any major injuries and/or surgeries we should know about?

_____

What is this affecting that is MOST important to your child's life?

_____

Has your child seen a chiropractor before? ¦Yes ¦No

How long ago? _____ Clinic/Doctor name: _____

Names/Specialties of other providers or physicians for your child:

_____

_____

On a scale of 1-10, ten being the highest, rate your commitment to correcting your child's health issues? _____

I understand that I am directly and fully responsible to Discover Life Chiropractic for all fees associated with chiropractic care my child receives. The risks associated with spinal adjustments have been explained to me to my complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of. o Under the terms and conditions of my divorce, separation or other legal authorization, 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.

_____ _____

Parent or Legal Guardian's Signature Date

RECENT HISTORY

Medications the child is on currently:

_____

Supplements the child is on currently:

_____

Has your child received all recommended vaccinations? ¦ Yes ¦ No

If no, please explain: _____

Any allergies? ¦ Yes ¦ No If yes, please explain: _____

Suspected food allergies/sensitivities: ¦ Yes ¦ No If yes, please explain: _____

_____

Select the foods most commonly in your child's diet:

¦ dairy (milk / yogurt / cheese) ¦ carbohydrates (bread / pasta / cereal)

¦ meat (chicken / fish / red meat) ¦ vegetables (potato / greens / carrots)

¦ fruits (banana / apple / berries) ¦ snacks/sugary foods and/or drinks

Does your child exercise daily? ¦ Yes ¦ No How much: _____

Does your child have difficulty sleeping? ¦ Yes ¦ No

Does your child have positive self-esteem or self-image? ¦ Yes ¦ No

Describe your child, including his/her history. Please be as detailed as possible:

_____

_____

_____

_____

_____

Please check any other health concerns you wish to discuss:

¦ Sleep Issues ¦ Difficulty Latching ¦ Difficulty Gaining Weight ¦ Constipation/Diarrhea

¦ Autism/Asperger's ¦ Frequent Sickness ¦ Nausea/Vomiting ¦ Colic/Acid Reflux

¦ Ear Infections ¦ Anxiety/Depression ¦ Fatigue/Sleep Issues ¦ Sinus Troubles/Allergies

¦ Asthma/Bronchitis ¦ Overweight Headaches ¦ ADD/ADHD ¦ Learning Disorders

¦ Diabetes ¦ Back/Neck Pain ¦ Bed Wetting

Explain the selected health concerns: _____

_____

Select any of the following your child has experienced:

¦ Fall in baby walker ¦ Fall from bed/couch ¦ Fall from crib ¦ Fall off swing

¦ Fall off bicycle ¦ Fall from high chair ¦ Fall off slide ¦ Fall down stairs

¦ Fall off changing table ¦ Fall off monkey bars ¦ Fall off skateboard/skates

¦ Walking difficulties ¦ Broken bones ¦ Been in a car accident ¦ Plays contact sports Explain the selected instances: _____

_____

Please list any other history, pertinent thoughts, or questions that you want addressed:

_____

_____

_____

Please note any other event, action, etc. you think may have some bearing/relationship to your child's condition:

_____

_____

_____

PRENATAL/BIRTH HISTORY

Location of birth: ¦Home ¦Birthing Center ¦Hospital ¦Other

Maternal age at delivery: _____

Did any of the following happen during delivery:

¦C-section delivery ¦Doctor pulled/twisted baby ¦Anesthesia ¦Labor was induced

¦Forceps/vacuum extraction ¦Premature delivery (_____weeks)

¦Special medical procedures/tests ¦Full term delivery (_____weeks)

Any other complications during delivery:

_____

Medications during labor/delivery:

_____

Illnesses during pregnancy? ¦Yes ¦No If yes, please explain: _____

Medications during pregnancy? ¦Yes ¦No If yes, please explain: _____

Any complications during pregnancy? ¦Yes ¦No If yes, please explain: _____

Any complications after pregnancy? ¦Yes ¦No If yes, please explain: _____

Medications given to child at hospital: ¦Yes ¦No If yes, please explain: _____

Did you breastfeed the baby? ¦Yes ¦No If yes, how long: _____

Did you formula-feed the baby? ¦Yes ¦No If yes, how long: _____

Age which you introduced: Solid foods: _____ Cow's Milk: _____

Discover Life
CHIROPRACTIC

We are glad you have entrusted our office with your child's health care. To provide you with quality, timely care, we need your cooperation with certain matters to make sure every client has his/her needs met.

Insurance

We are not participating providers with any insurance companies. **At your request, we can provide you with a receipt of services that you can send to your insurance company for your reimbursement.**

Payment

Payment for services is due at the time of service. We accept cash, checks, MasterCard, Visa, Discover Card, and American Express. There is a **$25** charge for any returned checks. Balances beyond 30 days will be charged an additional 1.5%. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.

Cancellation & Missed Appointment Policy

We require a minimum of 24-hour notice when a client cancels their appointment. When a patient does not show up for any appointment or cancels with less than 24-hour notice, a **$25** fee will be charged to the patient. With three missed appointments, the patient may be asked to transfer their records to another doctor.

Personal Injury

Discover Life Chiropractic will accept assignment for Personal Injury Cases with a signed lien. Understand, ultimately it is the patient who is responsible for the accrued balance.

X-Rays

All X-rays taken in this office are the property of this office. Any copies needed are subject to a **$35** per X-ray copy fee. Copies of X-rays may take up to 10 days to complete.

Authorization

- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I authorize Dr. P. Paige Mott/Discover Life Chiropractic to release any information concerning my physical condition which may be deemed appropriate and necessary to an insurance company/adjuster, billing agent, or attorney in order to process any claims for reimbursement of charges by me as a result of professional services rendered by Dr. P. Paige Mott, DC.
- This is the entire agreement between Discover Life Chiropractic and the patient below. I have read this agreement, understand it and agree with its provisions. I received a copy of it at the time of signing it below.

_____ _____

Signature of parent or guardian Date

Dr. P. Paige Mott
2216 Hoffman Dr. Unit A
Loveland, CO 80538
(970) 622-0075

Notice of Privacy Practices
Consent Acknowledgement

My signature below confirms I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly and indirectly.
- Obtain payment for third-party carriers for my health services.
- Conduct normal health care operations such as assessment and improvement activities.

I have been informed of my health care providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to change the Notice of Privacy Practices**.** I understand that my provider has the right to change the Notice of Privacy Practices and that I may contact this office at this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions.
I have been informed of my Notice of Privacy Practices on the following date(s):

Patients name (please print): _____

Signature of parent or guardian: _____

Date: _____

Relationship to patient:

_____