PEDIATRIC CARE APPLICATION AT CROSSROADS CHIROPRACTIC

PATIENT DEMOGRAPHICS

Child's Name: _____ ☐ Male ☐ Female Birth Date: _____

Birth Weight: _____ Birth Height: _____ Current Weight: _____ Current Height: _____

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

Mother's Name: _____ Phone: _____ DOB: _____

Father's Name: _____ Phone: _____ DOB: _____

Mother's Social Security #: _____-_____-_____ Father's Social Security #: _____-_____-_____

Which Parent is Responsible for payment for care? _____

Pediatrician/Family MD: _____ City & State: _____

Last Visit: ____/____/____ Reason for Visit: _____

HISTORY OF COMPLAINT

Please identify the condition(s) from which your child is suffering: **Primary**: _____

Secondary: _____ **Third**: _____ **Fourth**: _____

When did the problem(s) begin? _____ Was its onset ☐ Sudden ☐ Gradual

Is this the result of an accident or injury? ☐ Yes ☐ No

If yes, how did this injury happen? _____

Has this condition been treated by anyone in the past? ☐ Yes ☐ No If yes, when? _____

By whom? _____ How long under care? _____ Outcome? _____

How is the complaint progressing? ☐ Rapidly Improving ☐ Slowly Improving ☐ Staying Same

☐ Rapidly Worsening ☐ Slowly Worsening ☐ Off and On

Please list all medications taken by your child: _____

_____

Has your child ever sustained a sports injury? ☐ Yes ☐ No If yes, explain: _____

_____

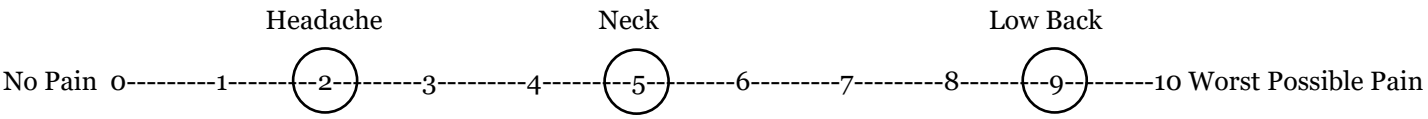
Has your child ever sustained an injury in an auto accident? ☐ Yes ☐ No If yes, explain: _____

_____

Please Read and Follow Instructions Carefully:

Instructions: Please circle the number that best describes the question being asked. If your child has more than one complaint, please answer each question for each complaint, indicating the score for all complaints.

Example:



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1. **What is your pain RIGHT NOW?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

2. **What's your TYPICAL or AVERAGE pain?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

3. **What is your pain level at its BEST (How close to "0" does it get at its best)?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

4. **What is your pain level at its WORST (How close to "10" does it get at its worst)?**

No Pain 0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10 Worst Possible Pain

PEDIATRIC HISTORY

Please mark all things your child has experienced:

☐	Headaches	☐	Arm Problems	☐	Digestive Disorders	☐	Fall from Changing Table
☐	Dizziness	☐	Joint Problems	☐	Stomach Aches	☐	Fall from Bicycle
☐	Fainting	☐	Orthopedic Problems	☐	Acid Reflux	☐	Fall from Monkey Bars
☐	Seizures	☐	Colic	☐	Constipation	☐	Fall from Bed or Couch
☐	Heart Trouble	☐	Asthma	☐	Diarrhea	☐	Fall from High Chair
☐	Chronic Earaches	☐	Autism	☐	Hypertension	☐	Fall from Skate Board
☐	Sinus Trouble	☐	Convulsions	☐	Sleeping Trouble	☐	Fall Down Stairs
☐	Scoliosis	☐	Growing Pains	☐	Broken Bones	☐	Fall from Slide
☐	Bed Wetting	☐	Colds/Flu	☐	Walking Trouble	☐	Allergies to:
☐	Poor Appetite	☐	Muscle Pain	☐	Behavior Problems		
☐	Neck Problems	☐	ADD/ADHD	☐	Poor Posture	☐	Other:
☐	Leg Problems	☐	Anemia	☐	Ruptures/Hernia		

FAMILY HISTORY

Does anyone in your family suffer from the same condition(s) you are currently experiencing? ☐ Yes ☐ No

If yes, who? ☐ Grandfather ☐ Grandmother ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter

Any other hereditary conditions the doctor should be aware of? _____

I, the undersigned, attest that the answers given are true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Crossroads Chiropractic and Wellness Center for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize use of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Crossroads Chiropractic and Wellness Center for any and all services my child receives at this office.

Patient Name (Please Print): _____

Parent/Legal Guardian Name (Please Print): _____

Parent/Legal Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date Forms Reviewed: _____

Crossroads Chiropractic and Wellness Center

Informed Consent

Pediatric Patient Name (Please Print): _____

Regarding: Chiropractic Adjustments, Modalities, and Therapeutic Procedures

Chiropractic care, like all forms of healthcare, holds certain risks. While the risks are most often very minimal, in rare cases complications such as sprain/strain injuries, irritation of disc condition and, although exceedingly rare, minor fractures and risk of stroke, which occurs at a rate of between 1 in 1 million to 1 in 2 million, have been associated with chiropractic adjustments.

I understand that the above list of items is not inclusive of all possible risks associated with chiropractic care and, after careful consideration, I do hereby consent to treatments by any means, method, and/or techniques the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of my child's care, and I voluntarily assume all risks. I acknowledge that, like in all forms of healthcare, results are not guaranteed.

_____ _____

Parent/Legal Guardian Signature Today's Date

Regarding: X-Rays/Imaging Studies

During your child's examination, the doctor may feel that x-rays will be needed in order to provide your child treatment. Diagnostic x-rays provide the doctor with valuable information that cannot be evaluated otherwise.

I understand that modern digital x-ray equipment exposes patients to a very low dose of radiation. After careful consideration, I hereby consent to have the x-ray examination the doctor has deemed necessary for my child's case.

_____ _____

Parent/Legal Guardian Signature Today's Date

FEMALE PATIENTS OF CHILD-BEARING AGE ONLY regarding the possibility of pregnancy

The first day of my child's last menstrual cycle was _____ (Date)

This is to certify that, to the best of my knowledge, my child is **NOT** pregnant. The doctor and staff of Crossroads Chiropractic and Wellness Center have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child.

_____ _____

Parent/Legal Guardian Signature Today's Date

Crossroads Chiropractic and Wellness Center

NOTICE OF PRIVACY PRACTICE AND POLICIES

This office is required to notify you in writing that, by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition, we must provide you with written notice concerning your rights to gain access to your child's health information and the potential circumstances under which, by law or as dictated by our office policy, we are permitted to disclose information about you or your child to a third party without your authorization. Once you have read this notice and signed the following page, you are welcome to tear out this page and keep it for your records. Should you choose not to take this page, please review it thoroughly before leaving the office. The signature page following must be turned into the reception desk along with the rest of your paperwork

Permitted Disclosures:

1. Treatment purposed – discussion with other healthcare providers involved in your child's care
2. Inadvertent Disclosures – open treating areas mean open discussion. If you need to speak privately to the doctor, please let our staff know so that we can place you in a private consultation room.
3. For payment purposes – to obtain payment from your insurance company or any other collateral source
4. For workers compensation purposes – to process a claim or aid in investigation
5. Emergency – in the event of a medical emergency, we may notify a family member
6. For public health and safety – in order to prevent or lessen a serious or imminent threat to the health or safety of a person or persons or the general public.
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness, or missing person.
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons – discussions with coroners and medical examiners in the event of a patient's death
10. Telephone calls or emails and appointment reminders – we may call your home and leave messages regarding missed appointments or apprise you of changes in practice hours or upcoming events.
11. Change of ownership – in the event this practice is sold, the new owners would have access to your PHI

Your rights:

1. To receive an accounting of disclosures
2. To request mailings to an address different than residence
3. To request restrictions on certain uses and disclosures and to whom we release information, although we are not required to comply. If we agree, the restriction will be in place until we receive written notice of your intent to remove the restriction.
4. To request amendments to information. However, like restrictions, we are not required to agree to them.
5. To obtain one (1) copy of your child's records. Timely notice (72 hours) is required. Copying and postage fees may apply.

Refunds and Cancellation Policy:

Requests for refunds must be submitted in writing and will be reviewed upon receipt. If a refund is payable, it will be processed and a credit will be applied to your credit card or paid by check within 30 days of request.

In situations where insurance has been applied: A quote of benefits is not a guarantee of payment. Your child's claim will process according to your child's plan. If your child's claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. Once processed and applied, any refund will be issued in accordance with our refund policy.

Cancellation of a care plan negates extended discounts, and our standard office fee schedule will be applied to all services rendered. Your child is expected to do therapies (traction, rehab, wobble chair, vibration plate, etc.) when and as instructed. Should your child choose to skip any or all therapies during a visit to the office, you must inform the front desk receptionist before leaving the office.

Returns and Exchanges:

Home Care Kits will not be eligible for refund, exchange, or credit.

Complaints:

If you wish to make a formal complaint about how we handle your child's health information, please call the office at 912-353-7611 to make an appointment to speak to the appropriate person.

Crossroads Chiropractic and Wellness Center

NOTICE OF PRIVACY PRACTICE AND POLICIES continued

I have received a copy of Crossroads Chiropractic and Wellness Center's NOTICE OF PRIVACY PRACTICE AND POLICIES. I understand my child's rights as well as the practice's duty to protect my child's health information and have conveyed my understanding of these rights to the doctor. I further understand that this office reserves the right to amend this NOTICE OF PRIVACY PRACTICE AND POLICIES at any time in the future and will make the provisions effective for all information that it maintains, past and present.

I understand that I have been given the opportunity to discuss any of my concerns and questions about this notice and the privacy of my child's healthcare information.

Patient Name (Please Print Clearly): _____

Patient Date of Birth: _____

Parent/Legal Guardian Name (Please Print Clearly): _____

_____ _____

Parent/Legal Guardian Signature Today's Date

_____ _____

Witness Signature Today's Date