

PATIENT HEALTH RECORD CHILD

ABOUT THE CHILD

Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____

Birth date _____

SS# _____

Age _____ Gender _____ Weight _____

REASON FOR THIS VISIT

Describe the purpose of this visit _____

Is the purpose of this appointment related to

Sports Auto Fall Home Injury Other

Please explain _____

When did this condition begin? _____

Has this condition:

Gotten worse Stayed constant Comes and goes

Does this condition interfere with:

Sleep Daily routine Other activities

Please explain _____

Has this condition occurred before? **Yes No**

Please explain _____

Have you seen other doctors for this condition? **Yes No**

Doctor's Name(s) _____

Type of treatment _____

Results _____

ABOUT THE PARENT

Name _____

Employer _____

Work address _____

Work phone _____ Cell _____

Type of work _____

E-mail address _____

Social Security # _____

Insurance Co: _____

Insured's Name: _____

Insured's SS#: _____ DOB: _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that

* Doctors of Chiropractic work with the nervous system? Yes No

* The nervous system controls all bodily functions and systems? Yes No

* Chiropractic is the largest natural healing profession in the world? Yes No

* If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Yes No

VACCINATIONS

Have you chosen to vaccinate your child? **Yes No**

If yes, circle all that your child has received.

DPT MMR Chicken Pox Hepatitis Other

Describe any and all reactions to vaccine(s). _____

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? **Yes No** Reason for those visits? _____

Doctor's name _____ Approximate date of last visit _____

Has any adult in your family seen a Chiropractor? **Yes No**

Has any child in your family seen a Chiropractor? **Yes No**

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

Drugs / Medicine Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy? _____

How was your delivery? _____

Labor chemically induced Labor was Dr. assisted
 C-section delivery Forceps/Vacuum extraction?
 Did Dr. pull or twist baby? Premature delivery

Please explain _____

Did you nurse the baby? **Yes No**

Did your baby have colic? **Yes No**

Feeding problems? **Yes No**

Vaccinations? **Yes No**

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Asthma	<input type="checkbox"/> Headaches
<input type="checkbox"/> Attention problems	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Irritability
<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Colic	<input type="checkbox"/> Sleeping disorders
<input type="checkbox"/> Constipation	<input type="checkbox"/> Tubes in the ears
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Vision problems
<input type="checkbox"/> Ear problems	<input type="checkbox"/>
Other _____	

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:	<input type="checkbox"/>	<input type="checkbox"/>	_____
...taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child	<input type="checkbox"/>	<input type="checkbox"/>	_____
...accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Surgery? Please Explain...	<input type="checkbox"/>	<input type="checkbox"/>	_____
...currently taking any medication (s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...having difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?			_____
What changes (if any) in your child's health or behavior would you like accomplished?			_____

AUTHORIZATIONS

It is understood and agreed that the payments to the doctor for x-rays is for examination of x-rays only. The x-ray films will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient in this office.

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Lund Family Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors in this chiropractic office and whomever they may designate as their assistant to administer chiropractic care, to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian: _____ Date: _____

HISTORY AND EVALUATION

Chief Concerns: _____

History of Condition: _____

Birth and Delivery: _____

Childhood Injuries / Falls / Accidents: _____

Temperament / Attitude: _____

Sleep: _____ Nutrition: _____

Medications: _____

What has been done to help this condition (s): _____

Family Health History: _____

Other: _____

EXAM

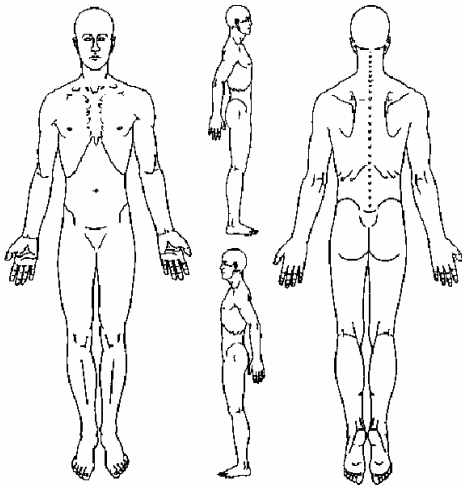
Name: _____

Date: _____

Height _____ Weight: _____

Bilateral Weights L__ R__

Short Leg L__ R__



Other Testing:

Posture Analysis

Head Tilt	Rt. Lt.
Ear High	Rt. Lt.
Apparent Cervical Curve	Rt. Lt.
Cerv. Muscle Tension	Rt. Lt.
Shoulder High on	Rt. Lt.
Apparent Thoracic Curve	Rt. Lt.
Thoracic Musc. Tension	Rt. Lt.
Apparent Lumbar Curve	Rt. Lt.
Lumbar Musc. Tension	Rt. Lt.
Ilium High On	Rt. Lt.

Subluxation Palpation

OC		T1		L1	
C1		T2		L2	
C2		T3		L3	
C3		T4		L4	
C4		T5		L5	
C5		T6		S	
C6		T7		SI	
C7		T8			
		T9			
		T10			
		T11			
		T12			

Comments:

River Falls Chiropractic

Todd Frisch, D.C. and Melissa Kolb, D.C.

215 North 2nd Street, Ste 201, River Falls, WI 54022 * Phone: 715-425-6665 Fax: 715-425-6677

Financial Disclaimer

Dear Patient,

Welcome to **River Falls Chiropractic**! We are pleased that you have chosen our clinic to address your healthcare needs. We would like to take a few minutes to explain what you can expect from your insurance company as well as what we in turn expect from you.

Your benefit under your insurance plan for chiropractic care may not cover all of your visits to our office. You are financially responsible for co-payments, co-insurance and deductibles for covered services. Services exceeding benefit limits or considered maintenance or preventative are not reimbursable by your plan. You are also financially responsible for all non-covered services. Please feel free to discuss any questions with our accounts department.

If your doctor feels that care will not be a covered expense based on the type of care you are receiving, it may be in your best interest to discuss one of the several financial plans we have available.

- If at anytime there is a change in your insurance benefits it is **YOUR RESPONSIBILITY TO NOTIFY THE FRONT DESK. WE CAN NOT BE RESPONSIBLE FOR BACK BILLING IN THESE SITUATIONS.**

- Please understand that any benefit quoted to you by this office is **NOT A GUARANTEE** that your insurance co. will make payment on your claims.

YOUR CO-PAY, CO-INSURANCE, AND OR DEDUCTIBLE IS DUE AT THE TIME OF YOUR VISIT. We welcome payments in advance by cash, check, Visa, MasterCard, and debit cards.

Also note: If you are filing your claims through AUTO INSURANCE or WORKMAN'S COMPENSATION, the insurance may not settle in your favor or your case may be denied, at which point you will be responsible to pay your balance.

By signing this statement, you acknowledge you understand the services you are receiving may not be covered by your health plan, and in that situation you would be 100% responsible for all charges incurred.

Signature

Date

River Falls Chiropractic

Todd Frisch, D.C. and Melissa Kolb, D.C.

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Non-Covered Services: Financial Disclosure Form

Chiropractic services typically covered by health insurance policies include:

Chiropractic adjustment for acute clinical conditions

Limited treatment of symptom flare-ups or exacerbations.

Services that we expect to **NOT** be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility are outlined below. Your financial responsibility is limited to services received during the treatment dates below.

Treatment plan start date: ___ / ___ / ___ Treatment plan end date: ___ / ___ / ___

Non-covered Services and Cost Per Visit*

Exam(s) (MEDICARE/MEDICARE Replacement)	\$50-75
Maintenance Care Spinal Adjustments	\$50
X-Ray(s) to detect subluxation	\$95
Durable Medical Equipment (Braces, Orthotics, Ice Pack)	Depends on Product
Decompression Therapy	\$75-150
Nerve Scan	\$35

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Name: _____

Patient's Signature: _____

Date: _____

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily and both of our doctors have waiting lists.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you to give a minimum 24 hour advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space.

We are happy to excuse one missed chiropractic appointment without charge. If there is a second missed appointment, you will be charged a \$40 cancellation fee which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

Missed Clinical Nutrition appointments will be billed at \$45 for every 15 minutes scheduled. For missed massage appointments, patients will be billed at \$70 for an hour.

I have read and understand the River Falls Chiropractic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.

I, _____, have received a copy of The Cancellation Policy.

Signature of Patient

Date