Pediatric New Patient Application

Welcome to our practice! Please thoroughly complete all questions.

Child's Name: _____ Today's Date:_____
Date of Birth: ___/___/____ Age:____ Gender:____ Social Security Number:_____

Parent/Guardian's Name:_____
Address:_____City:_____State:_____Zip_____
Phone: Cell_____Work_____Email:_____
Parent/Guardian's Current Employer & Address:
Name:_____Phone Number:_____
Address:_____

How did you hear about us/who may we thank for referring you?_____

Prior Doctor of Chiropractic:_____ Office Location:_____
Last time your child was checked by your prior Doctor of Chiropractic:_____

General Practitioner:_____ Office Location:_____

Why are you seeking Chiropractic care for your child?

____Health and Wellness

____Earaches/Infections	____Headaches
____Breathing Problems	____Tubes
____Bed Wetting	____Reflux
____Problems Lactating	____Colic
____Irregular Bowel Movements	____Asthma
____Distress while eating	____Allergies
____Frequent Colds	____Other_____

Currents Medications:_____

Surgeries:_____

Hospitalizations:_____

Falls/Accidents:_____

Complications of pregnancy?_____
_____

Complications of delivery?_____
_____

Natural Childbirth? Yes/No
Forceps used? Yes/No
How many weeks of gestation was the baby at birth? _____ weeks
How was the baby presented? _____ Head _____Face _____Breech
Babies birth weight _____ pounds
Babies birth length _____ inches
Was the baby admitted to the Neonatal Intensive Care? Yes/No

Is your child meeting their major milestones? Yes/No If no, explain_____
Learned to crawl _____ months
Learned to walk_____ months
Child's hours of sleep per night?_____ hours
Are you breastfeeding? Yes/No
Does the baby prefer one breast over the other? Yes/No If yes, which side?_____
Is your child gassy/colicky Yes/No
Does your child have any known allergies? Yes/No If yes, what?_____
Is your child vaccinated? Yes, following schedule / No

Other concerns you have?_____
_____

What benefit do you hope to gain for your child from regular Chiropractic care?_____
_____

Family Medical History: Please list all known medical problems and known diagnoses in your *immediate* family. (Specify M=Mother F=Father B=Brother S=Sister GM=Grandmother GF=Grandfather)
_____
_____
_____
_____
_____
_____

The above information is true and accurate to the best of my knowledge. My reason for consultation with the doctor is for evaluation of my child's physical health and the potential for improvement.

Parent/Guardian Signature:_____ Date:_____

Informed Consent to Chiropractic Treatment

Pickaway Chiropractic Center

778 North Court Street
Circleville, OH 43113

I hereby request and consent to the performance of Chiropractic adjustments and other Chiropractic procedures, including various modes of physical therapy on myself (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named above.

I have had the opportunity to discuss with the doctor the purpose and benefits of the Chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though Chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations, and sprains.

I understand that Chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the Chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Doctors Signature:_____ Date:_____

Notice of Financial Policy

Please carefully review the following policies regarding our financial practices pertaining to the collection of payment for the services provided at our office. Although we make every attempt to provide you with accurate information regarding your insurance benefits and coverage for all our services, we CAN NOT GUARANTEE your benefits will provide coverage for all of our services. **You insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize as health care providers, our relationship is with you and not your insurance company.** We ask that you also become familiar with your insurance policy by calling the Member Services phone number located on your insurance card or by logging in to your insurance company's website.

_____**MEDICARE:** Medicare provides chiropractic coverage for SPINAL ADJUSTMENTS ONLY. X-rays are not covered and will be a separate charge. Medicare patients will be required to sign an Advanced Beneficiary Notice (ABN). This form will explain which services Medicare may not cover and that you may be responsible for those charges.
ABN (Advanced Beneficiary Notice) Signed Yes ☐ No ☐

_____**MEDICAID:** We accept CARESOURCE and Medicaid card.. ODJS allows 15 chiropractic treatments per calendar year. Payment for any additional treatment will be the patient's responsibility.

_____**WORKER'S COMPENSATION:** We are a certified Ohio Worker's Compensation provider. Only active, allowed claims are eligible for treatment authorization requests. ALL TREATMENT MUST BE PRE-APPROVED. We require a secondary insurance in the event treatment is not authorized through Worker's Compensation. If you have no other insurance we will make every effort to arrange a comfortable payment schedule.

_____**AUTO ACCIDENTS/PERSONAL INJURY:** If you have been involved in an auto accident we will bill treatment for your injuries to YOUR AUTO INSURANCE. If you have comprehensive coverage (not just liability) you have "medpay" coverage. We will need to verify how much medpay coverage is available. If you were not the at-fault party your insurance company will recover any money paid from the at-fault party's insurance company. We will honor a LETTER OF PROTECTION from you attorney until 6 MONTHS AFTER THE LAST DATE OF TREATMENT. If we have not received payment after 6 months we will bill your auto insurance medpay. If you do not have medpay benefits we will bill your private health insurance or make a comfortable payment schedule.

_____**GENERAL HEALTH INSURANCE:** We are IN networks with the following major health insurance providers: Anthem BC/BS. Medical Mutual of Ohio, Aetna, Cigna, United Health Care. Also, please be aware of any deductibles and co-insurance that you may owe. Chiropractic services are typically reimbursed as a SPECIALIST or PHYSICAL THERAPY. Therefore, your co-pay may only apply to the initial office visit. Co-insurance and deductibles are calculated by your insurance company and reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement, payable upon receipt.

_____**NO COVERAGE/SELF PAY:** We do not have alternative payment options if you do not have insurance that provides chiropractic benefits or if you have no insurance at all. We will customize a cash payment plan based on your individual treatment plans. Pre-pay, Monthly, or Pay as you Go are available based on your needs and frequency of care.

Massage Therapy Services, Spinal Supports, Pillows, Retail Goods, and all other non-physician provided services are NOT BILLED TO YOUR INSURANCE and payment is required at the time of service/purchase

Please remember your overall health needs are our NUMBER ONE priority here. We will not turn you away because you are underinsured or uninsured. We understand financial strains and will be respectful of your decisions to alter you recommended treatment plans to accommodate your payment responsibilities.

By signing below I acknowledge that I have read and understand the Financial Policies of Pickaway Chiropractic Center and that I am responsible for arranging payment of all services provided to me at this office.

Patient Signature (or Parent of Minor)_____Date _____

Text Appointment Reminder

I would like to receive text reminders for my upcoming appointments with Pickaway Chiropractic Center.

Phone Number:_____

Name:_____

Date:_____

Signature:_____