

GENERAL HEALTH HISTORY (CHILD)

Patient Name _____ Mark the conditions that apply to you.

Past	Present		Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches		<input type="checkbox"/>	<input type="checkbox"/> Vision Problems
<input type="checkbox"/>	<input type="checkbox"/> Ear Infections		<input type="checkbox"/>	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/>	<input type="checkbox"/> Colic		<input type="checkbox"/>	<input type="checkbox"/> Growing Pains
<input type="checkbox"/>	<input type="checkbox"/> Allergies / Asthma		<input type="checkbox"/>	<input type="checkbox"/> Dental Problems
<input type="checkbox"/>	<input type="checkbox"/> Medication Side Effects		<input type="checkbox"/>	<input type="checkbox"/> Temper Tantrums
<input type="checkbox"/>	<input type="checkbox"/> Recurring Fevers		<input type="checkbox"/>	<input type="checkbox"/> ADHD
<input type="checkbox"/>	<input type="checkbox"/> Digestive Problems		<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Bed Wetting		<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Chronic Colds/Sinus		<input type="checkbox"/>	<input type="checkbox"/> Ever Needed Stitches
<input type="checkbox"/>	<input type="checkbox"/> Other _____			

1. List any medications being taken: _____

2. Number of courses of Antibiotics child has taken in the last 6 months: _____ Total during lifetime: _____

3. Name of Pediatrician and Other Doctors: : _____

4. Date of Last Visit ____/____/____ Reason: _____

5. Name of Obstetrician/Midwife: _____

6. Location of Birth: Hospital Birthing Center Home

7. Complications During Pregnancy: No Yes - Explain: _____

8. Ultrasounds During Pregnancy: No Yes - How Many? _____

9. Medication During Pregnancy / Delivery: No Yes - List? _____

10. Cigarette / Alcohol Use during Pregnancy: No Yes

11. Has any Doctor / Professional advised you to "Take the child to a Chiropractor": No Yes - Name _____

PAST HISTORY

12. List any past auto collisions: _____ Was any care received? _____

13. List any past falls bumps bruises: _____ Was any care received? _____

14. List any past sport, recreational, or home injuries _____

15. Please describe any past conditions and treatment received: _____

16. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Is there any other family history you want us to know? _____

OFFICE FINANCIAL POLICY

GENERAL

1. A 24 hour advanced notice is required if you are not able to be present for a scheduled appointment. If a 24 hour advanced notice is not given when you miss, cancel or reschedule an appointment, a missed appointment fee of \$50.00 will automatically be charged to your account.
2. It is important to be punctual for your appointments. If you are late for an appointment and there is not sufficient time, you will not receive treatment and a missed appointment fee of \$50.00 will automatically be charged to your account.
3. An additional fee of \$50.00 will automatically be charged to your account for emergency treatments provided to you outside of office hours.

CASH PATIENTS

1. All patients are on a cash basis until their respective insurance coverage and deductible may be verified by our staff. Payment for all services provided will be required at the time services are rendered for cash patients, or until your insurance coverage can be verified.
2. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings.

INSURANCE PATIENTS

1. If you have insurance we gladly accept assignment, provided we have prior certification from your insurance company. Some exceptions apply and you will be notified if any exceptions apply to you.
2. Once your insurance coverage has been verified, payment for all services rendered to you within a week time will be required on your last visit each week.
3. We accept assignment of your insurance coverage as a courtesy to you. You are responsible for your entire bill should your insurance not make payment for any charges on your account or for any service provided you for any reason. We are not a mediator between you and your insurance company and we will not enter into any dispute with same, as your contract is between you and your insurance company.
4. If Heartland Clinic of Chiropractic accepts assignment of benefits, we require that payment be sent directly to our clinic. By signing this Office Financial Policy you are authorizing payment to be sent directly to Heartland Clinic of Chiropractic and agreeing that if you should receive a check from your insurance by mistake for services provided here, you are required to bring it into the office upon receipt. All insurance payments, regardless of which company issues a check first, are applied to your account as long as a balance is due. If an overpayment exists on your account after all insurance billings have been processed, an overpayment check will be issued from us, not your insurance company.
5. We may request that you bring to our office any worksheet or explanation of payments that your insurance company provides you so that we may determine if proper payment has been made.
6. We accept assignment for the initial care plan only. Any follow-up visits are payable when services are rendered. Once you have been discharged from active care and placed on maintenance care, we require full payment per visit.
7. Any services not covered or coverage reductions by your insurance are your responsibility.
8. This office will resubmit a claim **ONE TIME**. We will not enter into any dispute with your insurance company. If coverage problems arise, you are expected to assist directly in dealing with your insurance company, adjustor, or agent. Any denied services will be treated as uncovered services and you responsible to pay such charges on a timely basis.
9. If you are referred to another specialist or discontinue care for any reason other than discharge by the doctor, your bill is due in full immediately; regardless of any pending claims submitted to your insurance company. If any overpayment exists after all insurance bills have been processed, we will issue you an overpayment check.
10. If you have any questions concerning this or any other matter, please speak with the receptionist prior to seeing the Doctor.

It is understood this care is highly specialized, unique, and an effective method of care. (Knowing that 70% of the Doctor's knowledge, expertise, time, and technical equipment will be utilized in the first three weeks of patients care, 20% in the second phase, and 10% in the final phases of care.)

I have read and understand the Office Financial Policy and agree to abide by these terms.

Printed Name of Patient

Printed Name of Parent/Guardian & Relation

Patient/Parent/Guardian Signature

Date

Witness Signature

Date

HIPAA - CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USE OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

Printed Name of Patient

Printed Name of Parent/Guardian & Relation

Patient/Parent/Guardian Signature

Date

Witness Signature

Date

CONSENT FORM

Please initial each of the following statement and sign and date where indicated below.

Appointment Reminders and Health Care Information Authorization

_____ Dr. Kiefat and members of the staff at Heartland Clinic of Chiropractic may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or do not answer, a message may be left on your answering machine or voicemail. By signing this form, you are giving us authorization to contact you with these reminders and information.

Authorization to Release Information

_____ I authorize Heartland Clinic of Chiropractic to release all information related to the care I receive, to my HMO, insurance company, third party payer or their designee, as may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Consent for Treatment

_____ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Assignment of Benefits

_____ I assign Heartland Clinic of Chiropractic all benefits payable to me for my care. I understand that this health care facility will be paid directly by the insurance company or other payer. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Printed Name of Patient

Printed Name of Parent/Guardian & Relation

Patient/Parent/Guardian Signature

Date

Witness Signature

Date