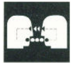
Welcome to our Office!

To ensure your **first visit** is a pleasant one, here are the Procedures you can expect during the next 30 minutes with us:

Paperwork Complete this brief questionnaire to help us get to know you. The doctor will use this information to help formulate the recommendations for your care



Consultation You'll meet the doctor who will review your health history and determine if yours is a chiropractic case.

Examination Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause(s) of your condition.

X-Ray Exam Necessary views may be taken to visualize the location of any spinal problems, reveal any pathology, and make your chiropractic care more precise.

Correlation Before proper care can be rendered the doctor will study your all of your examination findings.

Adjunctive Procedures The doctor may suggest the application of ice, heat, or the use of other modalities to help reduce pain and inflammation and make you more comfortable.

Next Visit Your first visit is complete. Plan to spend about 30 minutes on your next visit. The Doctor will give you an in-depth report of findings for your particular condition.

At your **second visit** the doctor will explain the result of your examinations and offer choices for appropriate chiropractic care. Here's what to expect:

Patient Education The doctor will help you understand your x-rays, the doctor's report of findings, and recommendations for chiropractic care.

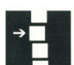
Report of Findings You'll see your x-rays and receive a complete report of the examination findings from the doctor.

Treatment Plan The doctor will outline a treatment plan designed for your unique spinal problem and health complaint.

Questions Ask questions at anytime. Make sure you fully understand the nature and severity of your condition and what we are doing to help you.

Expectations Based on clinical experience, the doctor will explain to you prospects for recovery and what you can do to help speed the healing process.

Financial Issues So we can direct all of our attention to your recovery, the financial responsibility for your case will be discussed.



Adjustments The doctor will use carefully directed and controlled pressure to restore the movable bones of your spine to a more normal motion and position. Our patients enjoy their "adjustments" and often report the beginning feelings of relief and well-being.

The Future Your second visit is complete. Future visits will be of a more typical length, usually about 15 to 20 minutes.

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Pediatric History Form

1

PATIENT INFORMATION

Today's Date ____/_____/_____

Name ________________________________ ______ Date of Birth ____/____/____

Address____ City _________________ State _____ Zip _________

Phone (home) ____________________Mother's mobile __________________ Father's mobile _________________

Mother________________________ DOB____/____/____ Father _______________________ DOB ____/____/____

Pediatrician/Family MD_______________________ City & State____________________ Last Visit ____/____/____

Purpose of last visit ____

Birth Height: ______ Birth Weight: ______ Current Height: ______ Current Weight: ______ Age: ___________

Ever been under chiropractic care? ☐ No ☐ Yes: Who/When? ____

Who is responsible for this bill? ☐ Mother ☐ Father ☐ Other (*please explain*) ________________________________

Insurance Company ____

2

PREGNANCY HISTORY

PREGNANCY HISTORY:

Third Trimester Presentation: ______ Vertex ______ Breech ______Transverse ______ Face/Brow

Type of Birth: ______Normal vaginal ______ Forceps ______ Cesarean ______ Suction Cap/Vacuum

Location: ______ Home ______ Hospital ______ Birthing Center _______ Other:____________________

Problems during Pregnancy: ____

Problems during Labor/Delivery: ____

Was there presence of: ______ Jaundice? (Yellow) ______ Cyanosis? (Blue) ______ Congenital Anomalies/Defects?

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INFANT HISTORY

INFANT HISTORY:

Infant feeding: ______ Breast ______ Bottle If Bottle; which Formula? ---

Number of Hours sleep per night ______ Quality of Sleep: ______ Good ______ Fair ______ Poor

List all **IMMUNIZATIONS** your child has had: ______________________________

Has your child ever been treated at the emergency room? ______ If yes; please explain ______________________

Has your child ever been hospitalized? ____ If yes; please explain ______________________

Has your child ever had and Surgeries? ______ If yes; please explain ______________________

Is your child currently on any medication? ______ If yes; please list: ______________________

AT WHAT AGE DID THE CHILD:

Respond to sound ______ Follow an object with his/her eyes ______ Hold heel up ______

Sit Alone ______ Crawl ______ Stand ______ Walk alone ______

AT WHAT AGE, IF EVER, DID CHILD SUFFER FROM THE FOLLOWING:

Chicken pox ______ Mumps ______ Measles ______ Rubella ______

Whooping Cough ______ Other: ______________________

HAS YOU CHILD EVER SUFFERED FROM:

☐ Headaches	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsion	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to__________
☐ Sinus Trouble	☐ Poor Posture	☐ Hypertension	☐ Allergies to__________
☐ Asthma	☐ Scoliosis	☐ Anemia	☐ Allergies to__________
☐ Colds/Flu	☐ Walking Trouble	☐ Bed Wetting	☐ Other: __________
☐ Colic	☐ Broken Bones	☐ Sleeping Problems	☐ Other: __________

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

☐ Fall in baby walker	☐ Fall from bed or couch	☐ Fall off skateboard or skates
☐ Fall from crib	☐ Fall off swing	☐ Fall off bicycle
☐ Fall from high chair	☐ Fall off slide	☐ Fall down stairs
☐ Fall from changing table	☐ Fall off monkey bars	☐ Other: __________

Has your child ever sustained an injury playing organized sports? ______ If yes; please explain______________________

____

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FAMILY HISTORY

FAMILY HISTORY:

Please indicate if your child or a family member has had any of the following: *Write "C" for child, "F" for family member:*

______ Heart Disease ______ Diabetes ______ Stroke
______ Cancer ______ High / Low blood pressure ______Asthma
______ Gastrointestinal disease ______ Memory/mood disorder ______ Thyroid problem

CHILD'S CURRENT PROBLEM:

Purpose of this visit: ______ Wellness ______ Check-up ______ Other: ____

______ Pain/Discomfort; explain____

______ Injury; explain____

If due to ***Pain/Discomfort/Injury,*** ***please fill out:***

1. **Onset** of Problem: Date______/______/______ ______ Unknown ______ Gradual ______ Sudden
2. **Ever had** this problem **before?** ▯ No ▯ Yes If yes When?____
3. Any **bowel or bladder** problems since this problem began? ▯ No ▯ Yes *(Describe)* ____
4. Any **medication taken** for this problem? ▯ No ▯ Yes ____
5. Have you seen any **other doctors** for this problem? ▯ No ▯ Yes ____
6. How is this problem **NOW:** ▯Rapidly Improving ▯ Improving Slowly ▯ About the Same ▯ Gradually Worsening ▯ On & Off

I understand that I am directly and fully responsible to Faulkner Chiropractic & Orthotics for all chiropractic care my child receives. It has been explained to me that all fees paid for x-rays taken at this office are for the examination, and that I am only entitled to a copy of the written imaging report, which explains the results of my child's examination. The actual films themselves are considered part of my child's original health record and as such will not be released to anyone, under any circumstances, including me. I further understand and agree that they are **the sole legal property** of this practice and that by law the doctor must retain these films for a period of no less than 5 years.

I hereby authorize this office and its Doctor(s) to administer care, as they so deem necessary to my son/daughter

____ _____________________________________

Parent or Legal Guardian Signature Date

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DOCTOR'S NOTES

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Informed Consent

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or Surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. IT is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found chiropractic adjustments and ancillary procedures may e given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal Medicine specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure the other opinions if he/she has many concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as tot whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care of the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment of other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course will not give a chiropractic adjustment, or health care, if he/she is aware that such may contraindicated. Again, it is the responsibility of the patient to make it known or to learn though health care procedures whatever he/she is suffering from. Patient pathological defects, illnesses, or deformities; that would otherwise not come to the attention of the doctor of chiropractic provides a specialized, non-duplicating health services. The doctor of chiropractic is licenses in special practice and is available to work with other types of providers in your health regime.

RESULTS
The purpose of chiropractic services is to promote natural health though the reduction of the VSS or VSC. Since there are o many variables; it is so difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. in most cases there is a more gradual, but quiet satisfactory response. Occasional, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to al problems. Both have made great strides in alleviating pain and controlling disease.

I hereby certify, by my signature below, that the following statements are true
1) The injuries presented are real
2) Any statements, written, or oral, concerning any accident as a cause of my current condition is true.
3) I am in no way attempting to file, or have the doctor file, a false claim against my insurance carrier.
4) The driver's license and/or SS card presented are actual and are not forged or falsified.
5) I am not an agent representing other interests and am only interested in relieving treatment for legitimate health reasons.
6) The identity and the nature below are my legal identity and legal name.
7) I am personally responsible and legally liable for any suits, judgments, or legal proceedings including legal fees which are brought against this office or any of its employees as a result of false statements given.

_______________________________________ ____________

SIGNATURE OF PATIENT OR GUARDIAN (IF A MINOR) DATE

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FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. If you have insurance we are willing to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

We accept assignment on your insurance benefits. With your signature bellow we are able to send information to the insurance company and receive direct payment for your care. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We will accept cash, check, MasterCard, or Visa, Discover for your deductible and co-payment. Payment will be expected at the time of treatment unless other arrangements have been agreed to in writing. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of “U.C.R.” (usual, customary, and reasonable fees for this region.)
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, please contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I understand and agree that regardless of my insurance coverage, I am responsible for the balance on my account for any services rendered. Patient is responsible for late fees, attorney fees or any type of collection fees needed to collect on unpaid balances.

____ __________

Signature of Patient or Parent/Guardian Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDI AL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INOFMRATION. PLEASE REVIEW CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS A PRIORITY OF Timothy Faulkner Chiropractic.

HOW YOUR HEALTH INFORMATION MAY BE USED:

To Provide Treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office [procedures designed to optimize scheduling and coordination of care between all staff members. In addition we may share your health information with referring physicians, clinical laboratories or other health care personnel providing you treatment.

To Obtain Payment: We may include your health care information with an invoice or billing summary to collect payment for treatment you receive in our office. We may do this with insurance forms filed to you in the mail or sent electronically. We may also use this information for the purpose of gaining insurance benefit information and an estimate of covered expenses. We will be sure to work only with companies with a similar commitment to the security of your heal information.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to court of administrative orders, subpoena, discover request, or other lawful process, under certain circumstances.

To Conduct Health Care Operations: Your health care information may be used during staff training and/or evaluation to provide the best possible care to our patients. It is also possible that health information may be disclosed during audits by insurance companies or government appointed agencies as a part of their quality assurance and compliance reviews. Your health information may be reviewed during routine processes of certification, licensing or credentialing activities.

In Patient Reminders: Because we believe regular care is very important to your general health, we will use your health information to contact you to remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and progress and inform you of treatment options and services that may be beneficial to you. Theses communications are an important part of our mission of partnering with our patients to provide the best benefits of chiropractic care. They may include letters, telephone reminders or electronic reminders such as email (unless you direct us that you do not want to receive these reminders as directed by your individual patient authorization.)

Abuse or Neglect: We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading s disease 0r condition.

Family, Friends, and Caregivers: We may share your health information with those you tell us will be helping you with your hone care or financial responsibility for payment of your care.

Workers Compensation: WE may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

YOUR RIGHTS

To restrict use of your information within reason in writing.
To request communication preferences in writing.
To inspect your health information.
To express questions or complaints to us or to the Secretary of Health and Human Services.

PRIVACY PRACTICES ACKNOWLEDGEMENT

Thank you very much for taking your time to review how carefully we are using your health information. If you have any questions we want to hear from you. If you do not have any questions or concerns, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form in the enclosed stamped self addressed envelope we have provided for your convenience.

We will request at the time of your next visit for you to complete and sign an individual patient authorization for your permanent file. This form will allow you to exercise your right to express any limitations or concerns regarding the use and disclosure of your health information.

____ ________________________

SIGNATURE OF PATIENT OR GUARDIAN (IF A MINOR) **DATE**

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