

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.

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?

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 YOUR CHILD EVER SUFFERED FROM:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Ruptures/Hernia |
| <input type="checkbox"/> Seizures/Convulsion | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Reflux | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Allergies to _____ |
| <input type="checkbox"/> Colds/Flu | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Other: _____ |

HAS YOUR CHILD EVER SUFFERED THE FOLLOWING SPINAL TRAUMAS:

- | | | |
|---|---|--|
| <input type="checkbox"/> Fall in baby walker | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall off skateboard or skates |
| <input type="checkbox"/> Fall from crib | <input type="checkbox"/> Fall off swing | <input type="checkbox"/> Fall off bicycle |
| <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall down stairs |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> Other: _____ |

Has your child ever sustained an injury playing organized sports? _____ If yes; please explain _____

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:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> High / Low blood pressure	<input type="checkbox"/> Asthma
<input type="checkbox"/> Gastrointestinal disease	<input type="checkbox"/> Memory/mood disorder	<input type="checkbox"/> 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

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 be 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 to 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 be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through 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 licensed 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 through the reduction of the VSS or VSC. Since there are so 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. Occasionally, 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 all 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



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



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. 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 health information.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to court or 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. These 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 disease or condition.

Family, Friends, and Caregivers: We may share your health information with those you tell us will be helping you with your home 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