Patient Introduction

Child's Name: ______________________Parent/Guardian Name:______________________
Address: ____
City: ___________________________________ State: ________ Zipcode: ______________
Home Phone: _________________ Cell Phone: ______________ Work Phone: _____________
Email Address: ____
How did you hear about us? ____

Sex (circle one): Male Female
Date of Birth: _____/_____/_____ Age: ____
Social Security # (used for insurance billing only): _______- _______ - _______

Insured Information (the person that carries the insurance):
Name of Insured: ____
Address of Insured: ____
Phone number of Insured: ____
Insured's Date of Birth: _____/_____/_____ Sex: Male Female

Reference: Nearest relative NOT living with you:
Name: ______________________________________ Phone #:_________________________
Address: ____
Relationship: _________________________________

Authorization to Treat a Minor
I, ____________________ the undersigning parent/guardian having legal custody/guardianship of _____________________, a minor, do hereby authorize, request and direct Dr. Jessica Serwe to perform in judgment any chiropractic examination, adjustment, diagnosis or treatment deemed necessary.

Print Parent/Guardian Name:_______________________________________
Parent/Guardian Signature:____
Date:__________________

Prenatal History

Was your child adopted? ☐ Yes ☐ No
Was your child ☐ Premature ☐ Full-term ☐ Over due
A Difficult Pregnancy? ☐ Yes ☐ No
Any Labor Complications? ☐ Yes ☐ No

____

____

Symptom Description

What is the reason you are seeking chiropractic care for your child?

____

____

Are you concerned with your child having pain? ☐ Yes ☐ No

____

Are you concerned with any signs/symptoms your child is having? ☐ Yes ☐ No

____

Do you notice your child has any irregular body positions/postures? ☐ Yes ☐ No

____

Please mark any of the following body signals that your child has or had previously.

☐ Asthma
☐ Allergies
☐ Autism/PDD
☐ Colic
☐ Colds (frequent)
☐ Sustained Head Tilt
☐ Constipation
☐ Crying Spells (frequent)
☐ Diarrhea (frequent)
☐ Ear Infections (frequent)
☐ Fevers (frequent)
☐ Irregular Body Position
☐ Headaches
☐ Seizures
☐ Sleeping issues
☐ Bed Wetting
☐ Frequent thirst/urination
☐ Signs of Discomfort
☐ Other____

Any falls down the stairs, off furniture or bed etc.? ☐ Yes ☐ No

____

____

Does your child take any Medications? Yes No

If Yes, please list below:

Medication:______________________________ Medication:______________________________
Condition treated:________________________ Condition treated:________________________

Medication:______________________________ Medication:______________________________
Condition treated:________________________ Condition treated:________________________

Medication:______________________________ Medication:______________________________
Condition treated:________________________ Condition treated:________________________

Any hospitalizations/surgeries/illnesses? Yes No

If Yes, please list what it was and year it occurred

____
____
____

<u>Family History</u>

Please describe any family history of illnesses (cancer, diabetes, high blood pressure etc.) and who in your family has them. Please list blood relatives only.

Condition:	Relative:
_______________________________	_________________________________
_______________________________	_________________________________
_______________________________	_________________________________

Ideal Chiropractic Policies

Late-Cancellations and No-Shows

We kindly ask that you give us 24 hour notice if you need to cancel an appointment. Late-Cancellations and No-Shows leave gaps in our schedules that cannot be filled without timely notice. This notification courtesy enables us to schedule another patient and, in turn, maintains a higher availability of services for you, as well as others**. Late-cancellations and No-shows will be charged $30.00.** After-hour messages regarding cancellations may be left at (920) 907-1700. Insurance will not cover charges for no-show/late-cancellation or eligibility fees.

Late Arrivals

In consideration of our scheduling commitments to other clients, we may need to reschedule any appointment for which you are more than 8 minutes late. You will be considered a no-show and charged accordingly.

Collection Agency Fee

Please be aware that any accounts sent to a collection agency are subject to an additional 35% charge added to the account balance.

By signing below, you acknowledge that you read and understand the policies stated above.

Parent/Guardian Signature:___________________________

Date:_______________

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any standard forms to assist me in asking collection from the insurance company. Any payments received by the Doctor's office from my insurance company will be credited to my account upon receipt. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable and any legal fees necessary to collect outstanding balances. I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of chiropractic care of my spine and joints. It is understood and agreed that all records, including x-rays, are property of this office. I am entitled to request copies of any or all of my records and am aware that there are fees associated with obtaining any copies. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand that if my insurance is an HMO plan, I will be switched to a cash patient upon reaching maximum coverage with the HMO. I understand that appropriate credit reports may be obtained, when credit is extended.

Parent/Guardian Signature ________________________________ Date______________________

TERMS OF ACCEPTANCE INFORMED CONSENT FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment.

Care: Care may consist of Exercise, Adjustment, and/or Traction. These are specific applications of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by exercise, adjustment and traction of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or symptom.

Vertebral Subluxation: A misalignment of one or more of vertebra in the spinal column which causes alteration of nerve function and interferes in the transmitting of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

Results: The purpose of chiropractic services is to promote health through the release of maximum nervous energy. Since there are so many variables, it is sometimes difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes results are phenomenal. In some cases, there is a more gradual response; occasionally the results are mediocre or dismal. Many people find results with chiropractic care, in turn we must admit that conditions which do not respond chiropractically, may come under the control of medical science. We will do our best in determining if you need chiropractic care, however we cannot be held responsible for a medical diagnosis, or under Wisconsin trial law be responsible for a medical referral.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, however, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. In remote instances, chiropractic manipulative treatment has aggravated disc conditions, and cardiovascular conditions. Literature shows this to be very infrequent, but can happen.

Regardless of what the disease is called, we do not treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our method is specific exercises, adjustments and or tractions to correct vertebral subluxation.

I, ______________________________ have read and fully understand the above statements.

All questions regarding the Doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I agree with the above statements.

I therefore accept chiropractic care on this basis.

(Parent/Guardian Signature)____ (Date) ________________________________

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Please check one option below to either CONSENT or DECLINE CONSENT

☐ I **CONSENT** to my personal health information being used in the manner described above**.**

☐ I **DECLINE** to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

I ACKNOWLEDGE receipt of the PRIVACY POLICY. I am also acknowledging that I may receive a copy of this consent upon request.

______________________________	______________________________
Patient Name	Date
______________________________	______________________________
Parent/Guardian Signature	Authorized Provider Representative
______________________________	______________________________
Parent/Guardian's Name Printed	Personal Representative's Authority