Volz Family Chiropractic

1995 N Cedar Street, Suite #3
Holt, MI 48842
(517) 699-3000

Case # _____

Date _____

Child History – 2 months to 2 years

Patient Name_____ DOB _____ Age _____ Sex _____

Parent/Guardian Name_____ Email _____

Address _____ City _____ State _____

Zip Code _____ Cell Phone _____ Home Phone _____

Current Concerns

Reason for today's visit _____

When did this first occur? _____

What makes it better or worse? _____

Has your child has this problem before? Yes No If so, when? _____

What treatments were previously done? _____

Birth History

At how many gestational weeks was your child born? _____

What he/she born vaginally or via cesarean section? _____

Where forceps or vacuum extraction used? _____

How long was labor and delivery? _____

Was epidural or any other medications given during labor? _____

Where there any complications with pregnancy or delivery? If so, what? _____

_____

Growth & Development

Yes No Can your child sit unsupported? Started at what age? _____months

Yes No Can your child crawl yet? Started at what age? _____months

Yes No Can your child walk yet? Started at what age? _____months

Yes No Does your child often trip and fall? _____

Yes No Do you have any other concerns about your child's growth and development?

_____

Nutrition

Yes No Is your child still breastfed? If no, how long was he/she breastfed?_____

Yes No Is your child formula fed? Which formula or milk source?_____

Yes No Does your child eat solid foods? What foods does his/her diet contain?_____

_____

Yes No Does your child have any feeding difficulties? _____

Yes No Have any digestive disturbances? _____

Yes No Have any known food allergies? _____

Yes No Have any persistent or intermittent skin rashes? _____

Yes No Does your child take any vitamins or supplements? If so please list, _____

_____

Trauma

Yes No Has your child had any recent falls or trauma? If, so describe trauma and date

_____

Yes No Ever fallen down stairs or from any height? _____

Yes No Ever been in a motor vehicle accident? _____

Yes No Ever had a bone fracture or dislocation? _____

Yes No Ever had any other trauma or injuries? _____

Health History

Yes No Has your child had colic? _____

Yes No Upper respiratory infections? How often? _____

Yes No Have asthma? _____

Yes No Does your child complain of neck or back pain? _____

Yes No Pain in arms or legs? _____

Yes No Had any earaches? At what age? _____

Yes No Do earaches tend to occur in both ears? If not, right or left ear? _____

Yes No Has you child had any other illnesses? List each and approximate age: _____

_____

Yes No Does your child currently take any medications? _____

Yes No Has your child been to hospital or ER? _____

Yes No Has baby had any surgeries or hospitalizations? If yes, list surgery and date performed _____

Health History Con't

Yes No Has your child been vaccinated? If yes, which schedule? Regular / Delayed

If delayed schedule, which vaccines have they received so far? _____

Yes No Do you have any other concerns about your child's health? _____

_____

Child's Primary Doctor _____ Last visit _____

Family History

Circle all that apply

Cancer Diabetes Heart Disease Stroke/TIA Arthritis Epilepsy

Alzheimer's Autoimmune Disease Multiple Sclerosis Parkinson's

Hypertension Osteoporosis Spinal Disc Disease Other _____

How did you hear about us?

Friend/Family Website Ins. Co. Drive By Phonebook Other _____

Review of Systems

Please check any symptoms or condition that you either have NOW or in the PAST

General
(Now / Past)
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain

Muscle/Bone
(Now / Past)
- ☐ ☐ Joint pain
- ☐ ☐ Stiffness
- ☐ ☐ Muscle ache
- ☐ ☐ Bone pain

Head
(Now / Past)
- ☐ ☐ Headache
- ☐ ☐ Dizziness
- ☐ ☐ Head trauma
- ☐ ☐ Fainting
- ☐ ☐ Concussion

Eyes
(Now / Past)
- ☐ ☐ Vision changes
- ☐ ☐ Light sensitive
- ☐ ☐ Spots in vision

Mouth
(Now / Past)
- ☐ ☐ Jaw pain
- ☐ ☐ Bleeding gums
- ☐ ☐ Dentures

Skin
(Now / Past)
- ☐ ☐ Rash
- ☐ ☐ Easy bruising
- ☐ ☐ Itching/peeling
- ☐ ☐ Change in moles

Nose
(Now / Past)
- ☐ ☐ Sinus problems
- ☐ ☐ Nosebleeds

Lungs
(Now / Past)
- ☐ ☐ Asthma
- ☐ ☐ Difficulty breathing
- ☐ ☐ Persistent cough
- ☐ ☐ Coughing blood

Vascular
(Now / Past)
- ☐ ☐ Chest pain
- ☐ ☐ Palpitations
- ☐ ☐ Ankle swelling
- ☐ ☐ Cold hands/feet
- ☐ ☐ Leg cramps
- ☐ ☐ Calf pain
- ☐ ☐ Varicose veins
- ☐ ☐ Low blood pressure
- ☐ ☐ High blood pressure

Neurologic
(Now / Past)
- ☐ ☐ Seizures/epilepsy
- ☐ ☐ Stroke/TIA
- ☐ ☐ Tingling
- ☐ ☐ Numbness
- ☐ ☐ Weakness
- ☐ ☐ Difficulty walking
- ☐ ☐ Poor coordination

G-U system
(Now / Past)
- ☐ ☐ Difficulty urinating
- ☐ ☐ Painful urinating
- ☐ ☐ Blood in urine
- ☐ ☐ Incontinence
- ☐ ☐ Increase urination

G-I system
(Now / Past)
- ☐ ☐ Heartburn
- ☐ ☐ Indigestion
- ☐ ☐ Ulcers
- ☐ ☐ Vomiting/nausea
- ☐ ☐ Abdominal pain
- ☐ ☐ Persistent Diarrhea
- ☐ ☐ Constipation
- ☐ ☐ Blood in stool
- ☐ ☐ Hemorrhoids

Conditions
(Now / Past)
- ☐ ☐ Anemia
- ☐ ☐ Osteopenia
- ☐ ☐ Osteoporosis
- ☐ ☐ Arthritis
- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Tuberculosis
- ☐ ☐ Gallbladder disease
- ☐ ☐ Liver disease
- ☐ ☐ Urinary infection
- ☐ ☐ Pneumonia
- ☐ ☐ Thyroid condition
- ☐ ☐ ADHD
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Parkinson's disease
- ☐ ☐ Gout
- ☐ ☐ High Cholesterol
- ☐ ☐ Cancer

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my dependent during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Volz Family Chiropractic insurance benefits that are otherwise payable to me. I understand that my Chiropractic insurance carrier may cover only a portion of or not cover all of the services rendered.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

X _____ _____

Signature of Patient or Guardian of minor Date

Volz Family CHIROPRACTIC PLLC

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OFFICE, FINANCIAL AND CANCELLATION POLICIES

Thank you for choosing our office to meet your Chiropractic healthcare needs. It is our optimal goal to provide you and your family with the highest quality of chiropractic care, while maintaining a friendly and relaxing environment. In order to keep our standard of care at a level which best serves your chiropractic needs, we ask you to please observe the following guidelines.

Office and Financial Policies

- We require you to pay any remaining deductible and the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. For your convenience, we accept cash, check, Visa, Mastercard, American Express and Discover.
- We cannot emphasize too strongly that the extent of your insurance benefits is a contract between you, your employer and your insurance company. We are not a party to that contract. We had no input into any of the decision-making. As your chiropractic health care provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that the services were rendered. Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. We will help you by processing your insurance claim form and sending it in promptly, however, we highly recommend that you know your specific chiropractic benefits before your care begins by calling your insurance company, as you are ultimately responsible for any of the monies not covered by your insurance.
- ***Your personal balance may not exceed $100 at any time or your care may be terminated.***

Cancellation Policy

- The office requires a minimum of 24 hours notice if an appointment must be rescheduled. If less than 24 hours notice has been given a $35 fee will be assessed. In the event that no notice is given and the patient does not show up for their appointment, then a $55 fee will be assessed. Special circumstances will be taken under consideration. Please note that this fee is not covered by insurance and payment is the patient's responsibility.

I accept full financial responsibility for expenses incurred at Volz Family Chiropractic PLLC.

I accept full financial responsibility for failures on my part to provide or know my insurance benefits information at the time services are rendered.

I have read and understand the above conditions.

_____ _____

Patient's Name (Please Print) Date

_____

Signature of Responsible Party

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TO OUR PATIENTS

There are over 1000 insurance plans in America. Therefore, it is IMPOSSIBLE for our office to know the covered benefits of YOUR insurance plan. As a courtesy, we try to verify what coverage you may have to inform you of your benefits before starting care. However, it is the RESPONSIBILITY of the PATIENT to know and understand the policies and benefits of their insurance plan. These include but are not limited to:

1. Required referrals obtained and presented PRIOR to services being rendered.
2. Deductibles, Co-payments, and Co-insurances as they are different.
3. Covered exams, re-exams, x-rays, spinal manipulations (aka adjustments), mechanical traction, and massage therapy
4. Necessary prior authorization for procedures (MRI, CT) or specialists
5. Current claim address and phone numbers

SHOULD YOU HAVE ANY QUESTIONS REGARDING YOUR BENEFITS YOU WILL NEED TO CONTACT YOUR INSURANCE COMPANY. THE NUMBER TO REACH CUSTOMER SERVICE IS USUALLY PRINTED ON YOUR INSURANCE CARD OR MAY BE OBTAINED FROM YOUR HUMAN RESOURCES DEPARTMENT OR A PREVIOUS EXPLANATION OF BENEFITS!

_____ _____

Patient Signature Date

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HIPAA Privacy Papers

I received a summary of the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to this office.

The full disclosure forms are available at the front desk.

_____

Print PATIENT Name

_____

Patient Signature

_____

If patient is a MINOR, Signature of Parent or Legal Guardian

_____

Date

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 care or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses 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.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your Chiropractor and members of the practice staff 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, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. 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. In addition, 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.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the remainder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us authorization. If you do not give us authorization, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

MARKETING AUTHORIZATION

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your Chiropractor and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from Volz Family Chiropractic to you. We are specifically requesting authorization to market the following products and/or services to you – from time to time we will mail you reminders about the importance of real Chiropractic care, we may take pictures of our patients which we use on our website, in newspaper articles or newsletters, and with individual permission, we send birthday cards which may offer complementary services to our patients.

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time, however, your revocation must be in writing and mailed to us at our office address. 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 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 and of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

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PATIENT CONSENT

CONSENT FOR CARE:

I voluntarily consent to the rendering of care, including care and performance of procedures. I understand that I am under the care and supervision of the attending Chiropractor and it is the responsibility of the staff to carry out the instructions of the Doctor of Chiropractic

RELEASE OF INFORMATION:

By signing this form, you are granting consent to **Volz Family Chiropractic** to use and disclose protected health information for the purposes of care, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (517) 699-3000. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of care, payment or health care operations. We are not required by laws to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

RELEASE OF X-RAYS FOR RADIOLOGIST

By signing this form, I authorize the release of x-rays and medical information necessary to SAFEGAURD Radiology for interpretation of my diagnostic imaging studies. I request payment of benefits for this service to the party who accepts assignment, Volz Family Chiropractic.

VERIFICATION OF PREGNANCY / NON-PREGNANCY (Female Patients Only):

I do hereby state to the best of my knowledge, I am pregnant, or pregnancy is suspected. Due Date _____.

OR

I do hereby state to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature or Signature of Parent or Legal Guardian Witness

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION OF A MINOR

I, _____, authorize *Volz Family Chiropractic*
Name of Patient or Guardian

to disclose to _____ the following information:
_____
_____

_____ Appointment Scheduling
_____ Account Financial Reports
_____ All Information
_____ Progress Notes
_____ Education Information
_____ Other:_____

Exchange of information by: ___ Telephone ___ Correspondence ___ Email ___Text
Information is to be two-way: _____Y _____N

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose, confidentially may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as other wise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. For patient records applicable under federal law 42 CFR Part 2.

Volz Family Chiropractic has my consent to care for my child that is under 18 years of age in the event that I am unable to accompany them to their appointment.

Date:_____ _____
Patient's Signature

Witness:_____ _____
Signature of Parent, Guardian or Authorized Representative