New Chiropractic Patient Intake Form - Infant- 2yrs

Date ____________

PATIENT INFORMATION

Name:___________________________________ ___________________

(First) (Last) (MI) (Name called by)

Name of Legal Guardian (if under 18 years old):____________________________

Date of Birth ___/____/____ Age ____ ❒ Male ❒ Female

Address ___________________________________

____

How did you hear about us? ______________________________

GUARDIAN INFORMATION

Father/Legal Guardian:

Home phone ___________ Cell phone _____________ Work phone ____________

Email _____________________________________

Best way to reach you: ❒ Home phone ❒ Cell phone ❒ Work phone ❒ Email

Mother/Legal Guardian:

Home phone ___________ Cell phone _____________ Work phone ____________

Email _____________________________________

Best way to reach you: ❒ Home phone ❒ Cell phone ❒ Work phone ❒ Email

Primary contact _________________________________

INSURANCE

❒ I will be taking advantage of the pay at time of service discount and not using insurance

❒ I will be using my health insurance towards my child's care (please complete section below)

Who is responsible for this account? ___________________________

Relationship to patient ______________________

Insurance Company ________________________________

ID # __________________________ Group/claim # ______________________

Policy Holder ____

Please present insurance card(s) so we may put a copy in your file

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FINANCIAL POLICY

Our goal is to make your visits with us as smooth and efficient as possible. Juli, our office manager, will assist you with any questions you may have regarding your insurance billing or payment requirements.

Participating Insurances

Our doctors participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. As a courtesy to you, our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance cover chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance, however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or copays.

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INFANT HISTORY - 2 MONTHS TO 2 YEARS

Yes No

❒ ❒ Is your child still being breast fed?
How long were they breast fed? ______________________________
How much cows milk does the mother consume each day? ______________________
❒ ❒ Is your child formula fed? Which formula or other milk source? ____________________
❒ ❒ Is your child eating solid food?
Which foods? ______________________________
What is your child's favorite food? ______________________________
❒ ❒ Does you child have any feeding difficulties?
If yes, please explain ______________________________
❒ ❒ Does your child have any digestive disturbances?
If yes, please explain ______________________________
❒ ❒ Does your child have any food allergies?
If yes, please explain ______________________________
❒ ❒ Does your child have any persistent or intermittent skin rashes?
If yes, please explain ______________________________
❒ ❒ Is your child receiving any vitamin supplements?
If yes, please explain ______________________________
❒ ❒ Has your child had any recent falls or trauma?
Describe the trauma ______________________________
Date of occurrence ____________________
❒ ❒ Has your child ever fallen down stairs or fallen from any height?
If yes, please explain ______________________________
❒ ❒ Has your child ever been in a motor vehicle collision or near-miss?
If yes, please explain ______________________________
❒ ❒ Has your child ever had a bone fracture or joint dislocation
If yes, please explain ______________________________
❒ ❒ Has your child had any other trauma or injuries?
If yes, please explain ______________________________
❒ ❒ Does your child ever bang his/her head repeatedly against a wall, bed or other object?
If yes, please explain ______________________________

BIRTH HISTORY

How long was the labor from the first regular contractions to birth? ____________________
How long was the 2nd stage (the pushing phase) of the labor? ______________________

Yes No

❒ ❒ Hospital birth
If no, please explain ______________________________
❒ ❒ Home birth
❒ ❒ Midwife assisted
❒ ❒ Vaginal Delivery

Non Participating Insurances

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❒ ❒ Planned C-Section
❒ ❒ Emergency C-Section
❒ ❒ Was birth induced (Pitocin)
❒ ❒ Forceps delivery
❒ ❒ Vacuum Extraction
❒ ❒ Anesthesia administered
❒ ❒ Fetal distress
If yes, please explain ____
❒ ❒ Meconium staining
❒ ❒ Head presentation
❒ ❒ Face presentation
❒ ❒ Breech presentation

Apgar Scores: At 1 minute ____ /10 At 5 minutes ____/10

Baby's Crying: Baby cried immediately after birth ___
Cried strongly __ Weak cry __ Did not cry for ____ minutes

Baby's Color: Pink all over ___ Blue face ___ Blue hands/feet ___

Baby's activity: Arms and legs actively moving __ Floppy baby__

Intensive Care: Was required __ Days in NICU ____

Medication given at birth ____

Vaccines administered ____

Birth Weight _____ lbs/kgs Birth length ______ ins/cms Baby home on day ______

AUTHORIZATIONS AND CONSENT

Initial each of the following:

____ I understand an accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary and to the chiropractic care including spinal adjustments and Graston Therapy, if needed, as reported following my assessment.

____ I authorize LeftHand Back and Body or Dr. Illman to release or obtain my medical information to any insurance company, attorney, insurance adjuster, employer or their representative as may be necessary in the treatment and payment of my care.

____ I have been offered a copy of LeftHand Back and Body's HIPAA privacy act, and I may obtain one for my personal use at any time.

We will gladly call to determine your chiropractic benefits and bill your insurance

___________________________________ ____________
Patient (or Guardian) Signature Date

company for you. Payment is due at the time of services for all deductibles, copays and non-covered therapies unless arrangements have been made with the office staff. Please note that it may be beneficial to you to take advantage of our Time of Service discount and submit the claim to your insurance directly. In this case we will gladly provide a statement of services rendered for you to provide your insurance company.

Secondary Insurance

Please inform us of any secondary insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer.

Self-Pay Patients

We require 100% of the examination fee be paid at the time of the visit. To qualify for our Time of Service discount, you must pay on the day the service was performed. We prefer payment of either cash or check, though we will accept major credit cards. We offer treatment packages which expire one year from the date of purchase. If you choose to terminate treatment, the cost of any unused visits will not be refunded.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account or a “flex spending plan”. We will be happy to provide you with a statement of your charges for reimbursement.

Personal Injury or Automobile Accidents

We require verification of all auto insurance and billing information (i.e. claim number, policy number, billing address, etc) before your first appointment.

There are four payment options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill and accept assignment from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor’s Lien from an attorney. Account balances of 90 days past the release date of treatment will incur a 1.5% monthly charge.
4. We will bill your standard health insurance plan and you will be responsible for all copays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6 (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Cancelation Policy

We require **24 hours notice** for all cancelations. If you call with less than 24 hours notice, or don’t call at all, you will be billed a **$25 fee** for your missed appointment. This fee will be billed directly to you and will not be billed through any insurance. If you have purchased a treatment package and miss a scheduled appointment, one office visit will be deducted from your package.

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at LeftHand Back and Body. I agree to the above terms and authorize LeftHand Back and Body to collect from me payment if it is not received within 90 (ninety) days after my time of service.

Patient or Guardian's Signature ________________________________