Harbor Front Family Chiropractors, LLC

Pediatric History Form

Child's Name Last_____ First_____ MI_____

Sex: Male / Female Birth Date _____ Previous Chiropractic Care? Yes / No

Address _____ City_____ State_____ Zip_____

Parent/Guardian's Name(s) _____

Mom: Home # _____Work # _____Cell # _____ Preferred? H / W / C

Address _____ City_____ State_____ Zip_____

Email_____

Dad: Home # _____ Work # _____ Cell # _____ Preferred? H / W / C

Address _____ City_____ State_____ Zip_____

Email_____

Responsible for Account/Insurance: Mom____ Dad____

Occupation_____ Employer_____

Address_____ City_____ State_____ Zip_____

Whom may we thank for referring you to our office? _____

Your Child's Health Profile

List your child's specific complaints / the reason you consulted our office in order of severity:

1) _____ For how long?_____

2) _____ For how long? _____

List other doctors (medical, chiropractic, etc.) that you have consulted for these conditions:

1 _____ Clinic/Address _____

2 _____ Clinic/Address _____

List any over the counter and prescription medications or vitamins your child is taking:

Medication _____ Reason_____

Medication _____ Reason_____

Your Child's Health History

Let's Begin At Birth: *A German Medical researcher discovered the over 80% of the infants that he examined shortly after birth were suffering from injuries to the cervical spine, the neck, causing all types of health issues.*

Were you born: ___ in a hospital? ___ at home? Were you premature? Yes / No # of weeks? ____

Who was present at your birth: ___ Obstetrician ___ Midwife ___Dad ___Other Family

Were any instruments used for your delivery? Yes / No If Yes: ___ Forceps ___ Vacuum Extractor

Was your mother given any drugs during delivery? Yes / No If Yes: ___To numb from waist down ___ to sedate

Was your mother induced? Yes / No If yes: Were you past your due date? Yes / No # of weeks_____

Were you born Cesarean Section? Yes / No If Yes: ___ planned ___emergency

Was your presentation on delivery: ___ Head first ___Feet first ___ Breech ___ Buttocks first

How many hours from beginning to end was your labor? _____

How does your mother describe your delivery? _____

Following your delivery, was there: ___ bruising on the head ___ Neck/face ___Malformation of skull

Broken bones or other injury from delivery _____

Were you breast fed? Yes / No If yes, for how long? _____

Were you considered a sickly child? Yes / No

What was your early history of sickness? Y=Yes A=Always F=Frequent S=Seldom N=Never

___ Colic ___ Pneumonia ___Ear Infections ___Tubes ___ Tonsillitis

___ Tonsillectomy ___ Upper Respiratory Infection/ Bronchitis ___ Allergies- at what age?____

___ Prone to colds ___ Prone to flu ___ given allergy shots ___vaccinated

Were you on antibiotics? ___Never ___Seldom ___Frequently ___Almost all the time

Expectations

I would like to have the following benefits from Chiropractic Care: (Check all that apply)

____ Relief of a symptom or problem

____ Relief and prevention of a symptom or problem

____ Healthier spine and nerve system

____ Optimal health on all levels

Dr. Merisa Stokely-Toellner, Dr. Christopher R. Toellner

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HARBOR FRONT FAMILY CHIROPRACTORS, LLC

TERMS OF ACCEPTANCE

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 method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: *An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.*

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

Vertebral Subluxation*: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

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 evaluation, 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.

Regardless of what the disease is called, we do not offer to 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 only method is specific adjusting to correct vertebral subluxations.

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

(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

(signature) (date)

Consent to evaluate and adjust a minor child

I**, _____** being the parent or legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

HARBOR FRONT FAMILY CHIROPRACTORS, LLC

INSURANCE ASSIGNMENT AGREEMENT

This office is pleased to accept your case on an insurance assignment basis as soon as your insurance company or responsible party verifies your coverage. We will file your claim forms to assist you in every way we can for reimbursement.

However, it must be understood that insurance contracts are between you, the patient, and your insurance company; you are responsible for any amount not paid by your insurance company.

In accepting your insurance on assignment we are extending you credit. We will extend a credit limit of $50.00. This courtesy may be withdrawn if circumstances below warrant it.

1. Our office does **not** guarantee that your insurance will pay. You will need to make every attempt to obtain verification of your policy coverage. However, if for any reason, your insurance claim is denied, you are responsible for the full amount of your bill.

2. Deductibles must be confirmed and satisfied prior to assignment being enacted.

3. Your insurance contract may state that you have a maximum monetary yearly benefit or visit benefit. Once you have reached your limit, we have cash plans that we can transfer you to.

4. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, then you are required to pay the balance due. You will be reimbursed by your insurance company if and when it pays.

5. We will continue to bill your insurance on 30 day cycles as long as you are receiving active chiropractic care in this office.

6. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

7. If you choose to cease or dismiss yourself from care without the doctor's authorization, the balance of your account is due and payable in full at time of your discontinuance even if your insurance has been filed. If and when your insurance pays, the remainder will be credited/refunded once you have a zero balance.

8. Any special arrangement regarding finances must be signed by the doctor and patient and/or their representatives.

9. Any balances beyond 30 days will be assessed a $10 late fee. Any balances beyond 90 days will be assessed to collections which could potentially double your balance for any legal or collections fees incurred.

If you understand and agree with all the above policies, sign your name below and we will accept your insurance assignment as stated above.

_____ _____ _____

Patient Signature Date Staff Signature

HARBOR FRONT FAMILY CHIROPRACTORS, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice is effective as of November 28, 2005. By signing and dating below, I acknowledge that I was given the opportunity to read Harbor Front Family Chiropractors' Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Consent for Care:

By signing below, I voluntarily consent to chiropractic care. I understand that I am under the care and supervision of Merisa Stokely-Toellner and Christopher Toellner, D.C. and it is the responsibility of the staff to carry out the instruction of the said chiropractors.

Consent for Release of Information:

By signing below, I authorize Harbor Front Family Chiropractors to release any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Assignment of Benefits:

By signing below, I hereby authorize payment of medical benefits to Harbor Front Family Chiropractors.

Signature: _____ Date: _____

_____ _____

Personal Representative Printed Personal Representative Signature

_____ _____

Description of personal representative's authority to act for the patient Date

If acknowledgement could not be obtained from the patient, the reasons must be documented below.

_____

_____

_____

_____

_____

_____

_____

(Authorized Staff Signature and Date)

Harbor Front Family Chiropractors, LLC

Photo Consent Form

I, _____ (print patient name) on this date_____ do hereby give my authorization and consent to **Harbor Front Family Chiropractors, LLC** to use the photograph(s) taken within the office. By signing this consent, I irrevocably release all rights of this image(s) to **Harbor Front Family Chiropractors, LLC** and/or any of its representatives, without further compensation to me for use and publication in any social media including, but not limited to, print, Facecbook, the official office website, and the newspaper. All negatives and positives of this photograph(s), together with the print shall be the property of **Harbor Front Family Chiropractors, LLC** solely and completely.

Subject/Patient's Full Name

(Print):_____

Signature: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Date:** _____

Witness (Print Name): _____

Signature: _____ **Date:** _____