BEDOGNE
CHIROPRACTIC CLINIC
SPORTS & FAMILY WELLNESS CARE

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CONFIDENTIAL PATIENT INFORMATION *(Pediatric 0-15)*

Personal Information

Child's Full name:			**Date:**
Address: Street	City	State	Zip
Home phone:		**Work phone:**	
Cell phone:		**Email address:**	
Mother's Name:		**Father's Name:**	
Best time/place to contact you:			
Date of birth:		**Age:**	
Height:		**Weight:**	
Pregnant? Yes □ No □			
Insurance: Yes ☐ No ☐		**Primary Subscriber:**	**DOB:**

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

*If your child has no symptoms or complaints and is here for Chiropractic Wellness Services, please skip to the **"Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate/travel anywhere? If so, where?

_____

_____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

What have you done for this condition? Was it of benefit?

_____

_____

I do (do not) have a family history of this or similar symptoms (Please explain):

_____

_____

Which activities aggravate your condition?

_____

_____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Does your child eat well? □ Yes □ No Does your child have regular bowel/bladder movements? □ Yes □ No

Health History

Child's birth was □ Athome □ At a birthing center □ At a hospital

My obstetrician/midwife/family physician was

_____

Child's birth was:

□ Scheduled □ Emergency

□ Natural vaginal (no medications/interventions) □ Vaginal with interventions

□ Induction □ C-section □Pain medication □ Epidural □ Vacuum extraction □Forceps

Please list reasons for any interventions/complications

_____

Child's birth weight _____ Child's birth height _____

Growth & Development

Was your child alert and responsive within 12 hours of delivery? □ Yes □ No

If no, please explain

_____

At what age did the child:

Respond to sound _____ Follow an object _____ Hold head up _____ Walk_____

Vocalize _____ Sit alone_____ Teethe _____ Crawl _____

Hospitalization/Surgical History (please list all including the year)

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year

_____

_____

Is/was your child breastfed? □ Yes □ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance

_____ _____

Did mother smoke during pregnancy? □ Yes □ No Did mother drink alcohol during pregnancy? □ Yes □ No

Any illness of mother during pregnancy? □ Yes □ No

If yes, please explain including treatment/medications/supplements

_____

List any drugs/medications (including over the counter) taken during pregnancy

_____

List any supplements taken during pregnancy

_____

Has the child received any vaccinations? □ Yes □ No

If yes, which ones and list any reactions _____

Has the child received any antibiotics? □ Yes □ No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? □ Yes □ No If yes, please explain

_____

Any difficulty with bonding? □ Yes □ No If yes, please

explain_____

Any behavior problems? □ Yes □ No If yes, please explain

_____

Any night terrors, sleepwalking or difficulty sleeping? □ Yes □ No If yes, please explain

_____

Age child began daycare _____ Average number of hours of TV per week _____

Does your child seem normal for their age? □ Yes □ No If no, please explain

_____

Family Health History

Check those involving immediate family and add identification: M= Mother; F= Father; S= Siblings; G= Grandparents

□ Cancer, type _____ M F S G	□ Depression M F S G	□ Diabetes M F S G	□ Back problems M F S G
□ Heart Disease M F S G	□ Liver Disease M F S G	□ High Blood Pressure M F S G	□ High Cholesterol M F S G
□ Lung Problems M F S G	□ Scoliosis M F S G	□ Neck Problems M F S G	□ Osteoporosis M F S G
□ Seizures M F S G	□ Osteoarthritis M F S G	□ Rheumatoid Arthritis M F S G	□ Osteoporosis M F S G

Is there anything else which may help to better understand your current problem, which has not been discussed, such as increased stress?

_____

_____

_____

____ I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.
I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature of Parent/Legal Guardian: _____

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Advanced Beneficiary Notice (ABN)
Wellness/Maintenance Care

Insurance companies do not pay for everything, even some care that you or your healthcare provider have good reason to think you need. Your insurance will not pay for Chiropractic Maintenance/Wellness or services deemed medically unnecessary per insurance.

Verbiage your insurance company may use to describe medically unnecessary treatment may include some of the following:

- Continued chiropractic care for the same of similar condition would not be considered medically necessary.
- Treatment will not be covered when you have recovered from the **ACUTE** stage of an illness or Injury.
- Treatment for a chronic condition if there is no **reasonable** expectation of improvement.
- Treatment to prevent a relapse or exacerbation (maintenance) of a condition.
- Treatment provided on a routine schedule, even if intended to maintain optimal function.
- Services provided after visit allotment per insurance verification/doctor's discretion.

This notice is to inform you of possible non-covered services that you may be responsible for payment.

Any services deemed not medically necessary or unpaid by your insurance, will be discounted to our cash fees.

Upon signing this notice, I am declaring that I fully understand what has been described above and agree to pay all uncovered services. I fully understand that my insurance company will no longer be billed for treatment received and I cannot appeal to see if my insurance will pay for said treatment.

Patient Signature: _____

Date: _____

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

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

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at this office will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that everybody has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that unlike many other health care professions, the risk associated in receiving chiropractic care is extremely minimal. In recent years there have been rare incidents or injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, or emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. 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. Please discuss care alternatives with the attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At Bedogne Chiropractic, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

I _____ have fully read and understand the above statement.
(PRINT PATIENT'S NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Anna and Dr. Sontino Bedogne or other attending chiropractors.

_____

(SIGNATURE) (DATE) (WITNESS)

CONSENT TO ASSESS AND ADJUST A MINOR:

I _____ , being the parent or legal guardian of _____ have
(PARENT/GUARDIAN NAME) (CHILD'S NAME)

Read and fully understand the above terms of acceptance and hereby grant permission for my child to receive a chiropractic assessment and chiropractic care.

_____

(PARENT/GUARDIAN SIGNATURE) (DATE) (WITNESS)

CONSENT TO X-RAY/VERIFICATION OF NON-PREGNANCY

I do hereby state that, to the best of my knowledge, I am not pregnant. I also state that pregnancy is neither suspected nor confirmed at this time. I do hereby release Bedogne Chiropractic from any liability and authorize them to complete any x-ray examination they deem necessary.

Patient (Parent or Guardian) Signature: _____

Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use for Health Information

Name: _____ Date: _____

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this _____ day of _____, 20_____

By: _____

Patient's Signature

If patient is a minor or under guardianship order as defined by state law:

By: _____

Signature of Parent / Guardian (circle one)

Authorization and Releases

The Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my Protected Health Information. I hereby give permission to Bedogne Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

Specific Authorizations:

- I give permission to Bedogne Chiropractic to use my address, phone number, e-mail address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If Bedogne Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine/voicemail or with the person who answers the telephone at home, work, or cell number I have provided.
- I give permission to Bedogne Chiropractic to use my name on a welcome board, referral board and birthday board.
- I give permission to Bedgne Chiropractic to use my photograph on their waiting room slideshow, patient of the month gallery and other marketing materials such as their brochure, website, social media and ads in print media.
- I give permission to Bedogne Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on social media, patient of the month gallery and ads in print media.
- I give Bedogne Chiropractic permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving Bedogne Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Bedogne Chiropractic plus 7 years or until revoke by me.

I have read and consent to the Bedogne Chiropractic's Specific Authorization policies.

Signature _____ Date _____

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Appointment Reminders

As a courtesy, an appointment reminder will be sent out via text message to the cell phone number we have on file with your records. Appointment reminders are sent out approximately 24 hours in advance of scheduled appointment.

If your phone number changes, please let our office staff know so we may update our records.

**please note: you are able to opt out of reminders and any other information coming through via text by replying "stop" to the message received.*

Phone Number: _____

☐ I do **not** wish to receive text messages of any kind from Bedogne Chiropractic

Appointment Sign In

In order to stay compliant with health care initiative laws (HIPAA), we will have you sign-in for each appointment with a self-selected pin.

Please write your 2-5 digit numeric pin. *If you forget, we can look it up.*

Already have a pin? Let us know!

_____

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Office Policies

Cancellation/No-Show Policy: We are committed to offering the best service to everyone who needs our services. Therefore, we require a minimum 24-hour cancellation notice on all appointments, unless in cases of emergency. **We will bill you $25 for your second missed appointment if not cancelled within 24 hours.**

Late & Rescheduling: Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Need Extra Time?: If you think of other problems you wish us to work on during your appointment, please let us know and we will be happy to schedule additional time for your next appointment.

Insurance: Your insurance is an agreement between you and your insurance company. We offer a complimentary benefits check to verify coverage; however, the **benefits quoted to us by your insurance company are not a guarantee of payment**. You are responsible for payment of any non-covered services, deductibles or co-pays.

Time of Service: We understand not everyone has chiropractic coverage. A discount can be applied when you pay on the same day as the treatment given, but not to supplies used. *Once the discount is given, it cannot be billed to an insurance company.*

Injury/Worker's Compensation: If your condition is due to an injury, please let us know on your first visit in the clinic and give us any billing information. If we do not receive the billing information on your first visit, the full amount will become your responsibility. We do not accept third party billing or attorney assignments.

I have read, understand and agree to Bedogne Chiropractic Clinic's Office Policies.

_____ _____

Patient Signature Date