

CHILD WELLNESS INFORMATION

ABOUT THE CHILD

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____

Birth date: _____ Age: _____

ABOUT THE PARENT

Name: _____

Employer: _____

Work address: _____

Work phone: _____ Cell: _____

Type of work: _____

E-mail address: _____

Social Security #: _____

REASON FOR THIS VISIT

Describe the purpose of this visit: _____

Is the purpose of this appointment related to:

Sports Auto Fall Home Injury Other

Please explain: _____

When did this condition begin? _____

Has this condition:

Gotten worse Stayed constant Comes and goes

Does this condition interfere with:

Sleep Daily routine Other activities

Please explain: _____

Has this condition occurred before? **Yes No**

Please explain: _____

Have you seen other doctors for this condition? **Yes No**

Doctor's Name(s): _____

Type of treatment: _____

Results: _____

AWARENESS OF CHIROPRACTIC PRINCIPLES

Were you aware that:

Yes No

- * Doctors of Chiropractic work with the Brain STEM?
- * The Brain STEM controls ALL parts and functions of your brain and body?
- * Chiropractic is the largest natural healing profession in the world?
- * If Chiropractic care starts at birth, you can achieve a higher level of success throughout life?

VACCINATIONS

Have you chosen to vaccinate your child? **Yes No**

If yes, circle all that your child has received.

DPT MMR Chicken Pox Hepatitis Other

Describe any and all reactions to vaccine(s).

EXPERIENCE WITH CHIROPRACTIC

Who referred you to this office? _____

Have you been adjusted by a Chiropractor before? **Yes No** Reason for those visits? _____

Doctor's name: _____ Approximate date of last visit: _____

Has any adult in your family seen a Chiropractor? **Yes No**

Has any child in your family seen a Chiropractor? **Yes No**

MOTHER'S PREGNANCY & LABOR

During Pregnancy:

Drugs / Medicine Tobacco / Alcohol

Please explain _____

Any illness during your pregnancy? _____

How was your delivery? _____

Labor chemically induced Labor was Dr. assisted
 C-section delivery Forceps/Vacuum extraction?
 Did Dr. pull or twist baby? Premature delivery

Please explain _____

Did you nurse the baby? **Yes No**

Did your baby have colic? **Yes No**

Feeding problems? **Yes No**

Vaccinations? **Yes No**

CHILD'S HEALTH HISTORY

Please check each of the diseases or conditions that the child has now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Tubes in the ears |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Ear problems | |

CHILD'S CURRENT HEALTH STATUS

	No	Yes	If Yes, please explain
Has your child ever:	<input type="checkbox"/>	<input type="checkbox"/>	
...taken antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...had a severe fall?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...been in a car accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is your child			
...accident prone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Surgery? Please Explain...			
...currently taking any medication (s)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
...having difficulty interacting with others?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior?			_____
What changes (if any) in your child's health or behavior would you like accomplished?	_____		

AUTHORIZATIONS

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed in writing.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I clearly understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered to me will be immediately due and payable.

I authorize the use of this signature to allow the insurance companies to pay Maximum Performance Chiropractic directly any amounts payable as my assignment of benefits. I authorize the use of this signature on any insurance submissions.

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctor in this chiropractic office to work with my condition through the use of adjustments and procedures the doctor deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Dr. will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand if I suspend or terminate my care for any reason, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (If applicable) directly to the provider for services rendered.

Name of parent or guardian: _____ Date: _____

PAYMENT INFORMATION

Who will be responsible for payment:

- Self Spouse Parent
- Insurance (please provide a copy of your insurance card to the front desk)

How did you find out about our office?

Please circle all that apply:

Friend _____ (Friend's name)

Business Card

Flyer

Other _____

Phone Book - Yellow Book or Verizon (circle one)

* Which "heading" did you find us under? _____

Radio: _____

(which station)

Alpena News Ad - "Regular Edition"

Alpena News Press Release - "Regular Edition"

"Shoppers' Express" (Free) Ad

Direct Mail

Internet Search - which Search Engine (Google, MSN, Yahoo): _____

TV: _____

(Which Station?)

(Approximate time of day)

Client Name: _____ Date: _____

TERMS OF ACCEPTANCE

Please Read AND Initial EACH Item

- #1. I understand that **NONE** of the **Natural Wellness SERVICES** (Chiropractic Consultations; Chiropractic Spinal Adjustments; Nutritional Consulting, Nutritional Evaluations; Nutritional Testing; Inter-Segmental Traction (IST) tables; Dry Hydrotherapy (DHT) tables; Spa Capsule Massage or Manual Massage) that are offered at or through Maximum Performance Family Wellness Center are designed or intended to cure, treat or prevent pain, symptoms or disease of any kind. _____
- #2. I understand that **NONE** of the **Natural Wellness PRODUCTS** (Whole Food Vitamins, Minerals, Herbs, Hormones, Skin Care, Body Care, etc.) that are offered through Maximum Performance Family Wellness Center are designed or intended to cure, treat or prevent pain, symptoms or disease of any kind. _____
- #3. I understand that it is my choice to see any other health care professional at any time (including a different type of chiropractor) – especially **IN ADDITION TO** continuing to utilize your services and products. _____
- #4. I understand that **NONE** of the doctors or therapists working here heals, nor do any of the services or products offered by them heal. The **ONLY** thing that heals is the life force that animates my body. _____
- #5. I understand that Kirk C. McAnsh, D.C., P.C. dba Maximum Performance Family Wellness Center disclaims any liability for consequential, incidental and punitive damages; express and implied warranties including but not limited to merchantability and fitness for a specific purpose; and any liability whatsoever in an amount greater than the amount paid by me or my insurance company or \$100, whichever is greater. _____
- #6. I understand that it usually takes 5 (five) adjustments over a 2 (two) week period in order for me to notice that my potential for enjoying life more has **STARTED** to improve. _____
- #7. I understand that it **USUALLY** take 12 (twelve) adjustments during my 4 (four) weeks of care in order for me to be well on my way to enjoying all areas of my life more. _____
- #8. I understand that I **MAY** “feel” worse (temporarily) as my potential for enjoying all areas of my life more starts to improve as a result of availing myself to the services and products offered by Maximum Performance Family Wellness Center. _____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of care, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and it's staff.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my care and follow up with multiple healthcare providers who may be involved in that care directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and/or disclosed.

FINANCIAL POLICY

I understand that MPFWC rates are as follows; New Client History & Consult - between \$50 & \$90; Spinal Adjustments - between \$20 & \$55 (depending on the number of areas adjusted, whether or not I have Medicare, or if I sign up for a discount pre-pay plan); IST (Roller Table) session is \$16.00 (\$10 if paid at time of service); DHT (Water Massage table) session is \$10 and that nutritional consulting, testing varies between \$30 and \$90 and Whole Food Vitamins vary between \$10 & \$127 - depending on my needs. I also understand that my insurance **will not** pay for the DHT, nutritional services or products and I will need to pay for those on my own.

I agree to pay in full at the time of each service unless I have insurance that will help support my care. My insurance policy may require me to pay a deductible each year and/or a co-pay for each service which I agree to pay for at the time of each service.

If I have an insurance policy that pays me directly, I agree to sign the back of each check and bring it (or mail it) to MPFWC **along with all of the paperwork that came with it**, within 7 days! Failure to do so will require me to pay for all services at the time of service from that point forward.

MPFWC does not accept payment or process claims from Auto Insurance, Personal Injury Worker's Compensation. We do not bill for these claims. I agree that the reason for my visit to this office is not a result of these type of claims.

I agree to pay MPFWC a \$5.00 Re-bill fee PER MONTH as well as a Service Charge of 7.0% A.P.R. on ALL balances 60 days and longer past due.

MPFWC agrees to bill my insurance company for me as a courtesy. However, if my insurance company has not paid within 90 days, the total amount due will be my responsibility, regardless of when I receive my statement from MPFWC or what my insurance company initially may have told MPFWC they would cover. **I understand that MPFWC can only estimate what my insurance will cover until an Explanation of Benefits or payment is received from my insurance company.**

I authorize Kirk C. McAnsh, D.C., P.C. to release any information to any insurance company, adjustor, agent or attorney that will assist in payment of a claim.

I agree to pay MPFWC \$22.50 "Return Check Fee" for any and all checks that do not clear the bank.

A photocopy of this form shall be valid as original.

Printed Name

Date

Signature

POLICIES & INFORMATION

I have received and read a copy of the following forms.

- * Terms of Acceptance
- * Notice of Privacy Policy
- * Financial Policy

I have received a copy of these policy's. I agree with them and will keep a copy for my records.

Signed

Date

Witness

Date