MILTON
CHIROPRACTIC & MASSAGE

Pediatric New Patient

Today's Date: _____

Patient Name: _____Date of Birth: _____ Age: _____

Parent/Guardian Name: _____Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Email: _____ Consent to email/text appointment reminders & office updates: ☐Yes ☐No

Home Phone: _____ How did you hear about us?

Cell Phone: _____ ☐ Friend who is a patient _____

☐ Internet Search ☐ Event ☐ Social Media ☐ Drive by ☐ Other

1. Reason for Chiropractic Care: _____

Other Doctors seen for this condition: ☐ No ☐ Yes Name of Doctor: _____

Check any of the following conditions your child has suffered from during the past six months:

☐ Ear Infections	☐ Reflux/Excessive Spit Up	☐ Chronic Colds	☐ Constipation
☐ Scoliosis	☐ Asthma/Allergies	☐ Stomach Pain/Gassy	☐ Headaches
☐ Seizures	☐ Food Sensitivities	☐ Hyperactivity	☐ Growing/Back Pains
☐ Temper Tantrums	☐ Colic	☐ Sensory Processing Issues	☐ Bed Wetting

☐ Other: _____

Has child been evaluated for tongue and lip tie? Yes No If yes, has it been revised? Yes No

2. Birth History

Birth Weight _____ Birth Length _____ Apgar scores (if known) _____

Infant's gestational age: ☐Full Term ☐Preterm If so, # of weeks _____ ☐Post-term

Type of Delivery: ☐Vaginal ☐C-Section ☐VBAC

Any use of instrument assisted tools during delivery? ☐Yes ☐No If yes, ☐Forceps ☐Vacuum

Initial feeding of baby: ☐Breast ☐ Bottle If bottle, was breast feeding attempted ☐Yes ☐No
If breast, any pain with latching or difficulty feeding on one side? ☐Yes ☐No

Were there any problems/complications during labor? ☐Yes ☐No If yes, explain _____

Name of Midwife or Obstetrician _____

Did you deliver in a hospital? ☐Yes ☐No If yes, name of hospital _____

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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, to detect and correct/reduce the vertebral subluxation complex. It is important to each patient to understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method 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 maximum health potential.

Patient Inform Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modalities of physical therapies and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, included but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known to him/her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend to this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Healthcare Authorization and Privacy Policy

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes they types of uses and disclosures of the chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This 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 Milton Chiropractic and Massage to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Milton Chiropractic and Massage to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, newsletters, information about treatment alternatives, or other health related information.
- If Milton Chiropractic and Massage contacts me by phone, I give them permission to leave a phone message on my answering or voicemail.
- I give permission to Milton Chiropractic and Massage to use my testimonial written by me for marketing purposes, such as sharing with other patients or potential patients, in their brochures, on their website, or in ads in print media.
- I give Milton Chiropractic and Massage 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 on my protected health information during the course of care. Should I need to speak with my doctor at any time in private the doctor will provide a room for these conversations.
- By signing this form, I am giving Milton Chiropractic and Massage permission to use and disclose my protected health information in accordance with the directives listed above.

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

Initial _____

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AUTHORIZATION AND ASSIGNMENT
AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photo static copy of this agreement shall serve as the original.

I authorize the following health care professional, medical facility, medical records service, employer, family member, etc. to receive information regarding my entire medical record, treatment records, and diagnostic records.

Person/Organization to Release Information: _____ Relationship: _____

Person/Organization to Release Information: _____ Relationship: _____

Right to Revoke Authorization

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official at Milton Chiropractic and Massage. The written notice must contain the following information: Your name, Social Security Number, a date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature. The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Milton Chiropractic and Massage for its own use/disclosure of PHI. (*Minimum necessary standards apply)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, it will not be possible for Milton Chiropractic and Massage to file third party billing on my behalf, and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Milton Chiropractic and Massage will be unable to contact me 3) all contact with Milton Chiropractic and Massage regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

I have read and understand this Healthcare Authorization Form, the Right to Revoke Authorization Form, and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

No Show Policy

I understand that I will be charged a $35 “no show fee” for not notifying the staff that I would be unable to make my scheduled appointment.

Insurance Disclaimer

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at the time of service.

Beneficiary Agreement

I understand that my health insurance company may deny or revoke payment for the services received. If my health insurance company denies or revokes payment, I agree to be personally and fully responsible for payment. I also understand if my health insurance company does not make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.

Milton Chiropractic & Massage, PC

Authorization

Patient Name (please print): _____ Date of Birth: _____ Social Security # XXX-XX-_____

Patient Signature: _____ Date: _____

If Patient is Under 18 Years of Age

Parent or Legal Guardian Name (please print): _____ Signature: _____

Description of Authority to act on patient behalf: _____ Date: _____