SIGNATURE CHIROPRACTIC

## *Patient Information*

**Child's First Name**: _____ **Last Name**: _____ **DOB**: _____

**Preferred Name**: _____ ☐ Male ☐ Female **Social Security #**: _____

**Parents' Names**: _____

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

**Best Contact Phone**:_____ **Email**: _____

**Emergency Contact**: _____ **Relation**: _____ **Phone**: _____

Health Insurance Co.: _____ Member ID # _____ Group: _____

Who can we thank for referring you or how did you hear about us? _____

**Please mark if your child condition is the result of:* ☐ Auto ☐ Slip/Fall ☐ Other _____

## *Patient Condition*

Describe reason for today's visit? _____

What caused this condition? _____ Date condition began? _____

What is this affecting that is MOST important in your child's life? (List all that apply) _____

_____

Has your child had this condition in the past? ☐ Yes ☐ No If **yes**, when was the last time he/she had it? _____

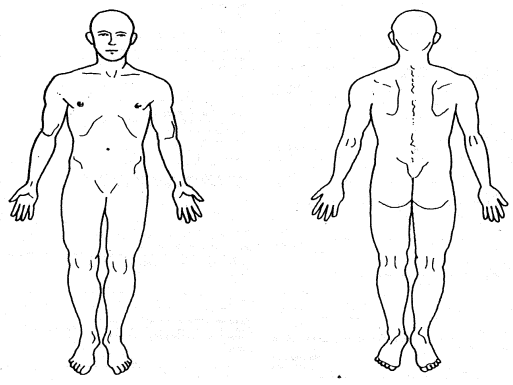
How is this condition changing? ☐ Getting Better ☐ Getting Worse ☐ Not Changing/Same

How often does your child feel the condition? ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

What is the intensity of your child symptoms? ☐ Slight ☐ Mild ☐ Moderate ☐ Severe

What activities aggravate your child symptoms? _____

What relieves your child symptoms? _____



Mark the areas and describe the pain:

☐ Ache/Dull ☐ Sharp/Stabbing ☐ Burning ☐ Throbbing

☐ Radiating ☐ Numbness/Tingling ☐ Pins/Needles

Rate your pain **RIGHT NOW** on a scale of 0 to 10
(0 = no pain and 10 = worst possible pain)

0 1 2 3 4 5 6 7 8 9 10

Has your child seen any other providers for this condition? (List all that apply) _____

_____

Has your child seen a chiropractor before? ☐ Yes ☐ No Name of Chiropractor: _____

Reason for care: _____ When? _____

## *Health Concerns* (Check all that apply)

☐ Anxiety/Depression
☐ Fatigue/Sleep Issues
☐ Constipation/Diarrhea
☐ Asthma/Chronic Bronchitis
☐ Nausea/Vomiting
☐ Colic/Acid Reflux
☐ Diabetes
☐ Back Pain /Neck Pain/Stiffness
☐ Bed Wetting
☐ Difficulty Gaining Weight
☐ Overweight
☐ Ear or Other Infections
☐ Frequent Sickness
☐ Headaches
☐ ADD/ADHD
☐ Learning Disorders
☐ Eating Disorder
☐ Detachment/Distant
☐ Sinus Troubles/Allergies
☐ Irritability/Nervous
☐ Autism/Asperger's
☐ Other _____

## *Medications* (Check all that apply)

☐ Anxiety/Depression
☐ Migraine/Headache
☐ Asthma
☐ Acid Reflux
☐ ADD/ADHD
☐ Antibiotics
☐ Digestive
☐ Pain Narcotics
☐ Other _____
☐ Other _____

## *Vitamins/Supplements* (Check all that apply)

☐ Multi-Vitamin
☐ Vitamin Bs
☐ Calcium
☐ Potassium
☐ Fish Oil/Omega-3
☐ Probiotics
☐ Iron
☐ Other _____

## *Social History*

1. Diet: How many meals per day? _____ How many snacks per day? _____ How many soda per day/week? _____
2. Sleeps: _____ hours Quality: ☐ Good ☐ Fair ☐ Poor Position: _____
3. Stress: ☐ None ☐ Low ☐ Moderate ☐ Severe What causes stress? _____
4. Exercise: ☐ None ☐ 3-5x/week ☐ Daily List your exercise activities: _____

## *Personal Health History*

Has your child had any injuries and/or surgeries in the past?

1. _____ When: _____ Care Received: _____
2. _____ When: _____ Care Received: _____
3. _____ When: _____ Care Received: _____

List ANY allergies your child may have: _____

*Female*: Are you currently pregnant or nursing? ☐ Yes ☐ No If **yes**, when is your due date? _____

## *Family History*

Family Members – Past and Present Health conditions (arthritis, cancer, diabetes, heart disease, scoliosis, etc.)

_____
_____

# CONSENT FORM

**Child's Full Name:** _____

## PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, gives Dr. Tiffany Le at Signature Chiropractic permission to examine, diagnose, x-ray (if necessary), and treat _____.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

## HIPAA

I acknowledge that I have received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I hereby consent to the use of my health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal law. I understand that this form will be placed in my patient chart and maintained for six (6) years. A full copy is available upon request.

## INFORMED CONSENT

I hereby request and consent to the performance of chiropractic examinations, adjustments and any other associated chiropractic procedures on me, including various modes of therapy modalities and diagnostic x-rays on myself (or on the individual named above, for whom I am legally responsible) by Dr. Tiffany Le at Signature Chiropractic. I understand and am informed that, as in the practice of chiropractic there are some risks and certain complications, which may arise during chiropractic treatment. Those risks and complications include but not limited to: physical burns, fractures, disc injuries, strokes, dislocations, muscle strain, cervical myelopathy, and costovertebral strains and separations. 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 of exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose, and risks of chiropractic care and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines. I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

## X-RAY CONSENT

X-rays are utilized in the office to help locate and analyze vertebral subluxations. These x-rays are not to be used to investigate for medical pathology. Dr. Tiffany Le does not diagnose or treat medical conditions; however, if any abnormalities are found, Dr. Le will bring it to your attention so that you can seek proper medical advice.

By my signature below I am acknowledging that the doctor has discussed with me the hazardous effects of ionization and I have conveyed my understanding of the risks associated with exposure to x-rays.

_____ _____

**Parent/Guardian Name** **Date**

_____

**Parent/Guardian Signature**

# OFFICE POLICIES

We want to thank you for choosing Dr. Tiffany Le as your chiropractic health provider. Our goal is to serve you with exceptionally friendly and prompt service, and provide the best family health care available. In return, you will receive restored health. It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

**Late, Cancelation & No Show Policy**
When you schedule an appointment, it is your responsibility to keep it. We will make every attempt to remind you via phone, text or email, but we cannot guarantee that you will receive a reminder.

For chiropractic appointments, if you miss or cancel with less than 24-hours notice, you have 24-hours from the time of the missed visit to schedule another visit within 2 business days to make up that appointment, or you will be charged a $35 late fee.

At times, there may be a need for Dr. Tiffany Le to cancel or reschedule an appointment. We will make every effort to notify you promptly and offer alternative appointment times as soon as possible. Please be sure you have updated your contact information so that we may reach you if necessary.

**Payment Policy**
All payments and cost of treatments are due at the time of your visit. There is a $30 fee for returned checks. Payments can be made by cash, check, or credit card.

**Personal Responsibility Policy**
Signature Chiropractic is in no way responsible for the safekeeping of your personal belongings while you are in an appointment or session.

**Returns Policy**
We cannot accept returns on purchased items, unless an item is defective. In this case please contact us to let us know, bring in the item, and we will exchange it for the same or similar item.

**Photo Policy**
We are PROUD of our patients and the progress they make while under our care! We love to celebrate our patients' successes along with them. And when something good is happening in our lives, we feel inclined to share it with others, right? If the moment arises, we would love to share your photo, story, or progress on our Social Media (i.e. Facebook, Instagram, etc.) pages or website in the interest of showing others that "real people" visit our office and are smiling while they're here – and most importantly, getting results!

Please check the box that applies to you:

☐ Sure! You can use my picture on the Signature Chiropractic's Website and Social Media pages.

☐ No thanks! I'll pass for now.

Thank you for understanding our Office Policies. Please let us know if you have questions or concerns.

I have read the Policy. I understand and agree to this Policy.

**Signature _____**

# FINANCIAL POLICY

**We ask that you read and understand our policy as it applies to your particular situation.**

**SELF-PAY:** We request that you pay in full of your visit at the time the services rendered. Care plan may paid in full at time of service (TOS) discounted rate. You may choose to make weekly payment when you agree to keep a debit/credit on file and authorize to process your payment. We are happy to accept cash, check, Master, Visa, Discover or AMEX.

**PATIENT WITH INSURANCE**: Your insurance is an agreement between you and your insurance company, not between your insurance company and Signature Chiropractic. It is important that you take responsibility for understanding your benefits. Most of the common services in the office are covered by your insurance plan, depending on your policy. We will verify benefits with your insurance carrier prior to receiving care; however, the benefits quoted to us by your insurance carrier are not a guarantee of payment. As a courtesy to you, the office will complete any necessary insurance forms at no additional charge, and file them with your insurance carrier. **It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of deductibles, co-pays or any non-covered services at time of service**. If your policy prohibits collection of co-pay, deductible and/or co-insurance prior to claim processing, we will require a credit/debit card to be kept on file. Payment for services not covered due to unmet deductible, co-insurance amount or policy exclusions will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier.

**MEDICARE/MEDICARE ADVANTAGE**: We do accept assignment from Medicare. **Medicare Part B** only covers manipulation of the spine. All other services are not covered and will be your responsibility. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. You will be required to meet your annual Part B deductible and pay 20% of the Medicare allowed fee on the spinal manipulation, in additional to 100% of all non-covered services.

Medicare Part B patients with a Supplemental/Secondary policy will generally have their Part B deductible and the 20% covered by the supplement/secondary. However supplemental/secondary policies generally do not pay for services that Medicare does not allow. Medicare patients will be required to sign an Advance Beneficiary Notice (ABN) prior to starting care, any time there is a significant change in diagnosis, and/or at the beginning of each year. **Medicare Advantage** plans generally follow the same guidelines as Medicare Part B, except you may have a copay instead of a deductible/20% plan. We file and submit Medicare claims at no charge.

**FLEX PLANS/MEDICAL SAVINGS ACCOUNTS:** Please inform us if you have a medical savings account, sometimes known as a 'flex plan' or “health saving plan”. We provide you with a statement of your charges for reimbursement upon request.

**ACCOUNT BALANCES**: Any charges you incur after your insurance has been billed, including co-insurance, deductibles, and any unauthorized or out of network services are your responsibility. Payment for these balances is expected within 60 days. If you are unable to pay within this timeframe, please contact the office. We are willing to negotiate payment arrangements to enable you to avoid additional action. Additional fees for payment letters will be added to the account balance. Account balances that older than 60 days will be charged 10% interest. Balances that reach 90 days will be charged to the debit/credit card on file. Remaining balances will be sent to collections.

*By my signature below, I hereby authorize and direct my insurance company to issue payment directly to Signature Chiropractic for medical services rendered on my behalf. If I receive payment for these services from my insurance company in error, I understand I am obligated to forward the money immediately to Signature Chiropractic. I understand that services rendered by Signature Chiropractic and Dr. Tiffany Le are a necessary part of the medical care for which I have been referred to this office to receive. I hereby consent to and authorize the administration of the recommended services. I authorize Signature Chiropractic to obtain or secure any medical records as may be required for continuity of care on my behalf.*

*By my signature below I confirm I have read and fully understand financial policy of Signature Chiropractic. I have been given an opportunity to ask questions and receive a copy of this document. I also understand that if my insurance does not respond within 60 days, or if my attorney no longer represent my lawsuit, or if I suspend or terminate my schedule of care as prescribed by Dr. Tiffany Le at Signature Chiropractic that fees will be due and payable immediately. My account balance will be charged to the debit/credit card on file.*

**Patient or Responsible Party Name: _____ Patient DOB: _____**

**Patient or Responsible Signature: _____ Date: _____**