ChiroHealth

6769 Courtland Drive, Ste. 100
Rockford, MI 49341
616-863-9482

Confidential Patient Health Record

Date:_____I.D.#_____

PERSONAL HISTORY.

Name_____ City: _____

Address: _____ State:_____ Zip: _____

BirthDate:_____Age:_____Sex: ☐ M ☐ F Social Security Number:._____

Parent/Guardian Name: _____

Parent/Guardian Home Phone:_____Cell Phone:_____

Parent/Guardian Email: _____ Whom may we thank for referring you to us?: _____

Name OfEmergency Contact:_____Relationship:_____Phone Number:_____

CURRENT HEALTH CONDITION

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain

What health challenge(s) is your child here for?_____

What do you feel is the cause of your child's problem?_____

When did you first notice this sign of body dysfunction? _ /__/ ___ Please Explain:_____

Are they in pain? ☐ Yes ☐ No Rate his/her pain with the following scale: Discomfort 1 2 3 4 5 6 7 8 9 10 Intense

Did his/her pain/injury occur during: ☐Routine Activities ☐Sports/Play ☐Auto Accident ☐Other_____

Has he/she seen anyone else for this condition? ☐Yes ☐No Who?_____

Type of Treatment:_____ Results:_____

Is their condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is their condition interfering with: ☐School ☐Sleep ☐Daily routine? If so,how?_____

HEALTH HISTORY

Is your child a: ☐ Birthchild ☐ Adopted child**If your child was adopted please answer all information to the best of your ability*

Was this delivery: ☐ Vaginal Delivery ☐ C-Section

How long was labor and delivery?_____

Were forceps or vacuum extraction used?_____

Was/is your child breastfed? ☐Yes ☐No If so for how long?_____

At what age did your child crawl? _____ How long did they crawl for? _____

Did/does your child like "tummy time?" ☐ Yes ☐ No

Did/do you choose to vaccinate your kids? ☐ Yes ☐ No

HEALTH HISTORY CONT'D

Please Check and Describe:

MajorSurgery/Operations/Hospitalizations: □Tubes in Ears □Broken Bones □BoneFusions □Back surgery

Describe:

Previous Chiropractic Care: □None □ Doctor's Name & Approximate Date of Last Visit:_____

Please CIRCLE any & all of the following health challenges your child has suffered and/or continues to suffer from:

Allergies	Irregular Sleep Patterns	Mood Swings	Congenital Heart Defect
Ear Infections	Anxiety	Infected/Sore throat	Laryngitis
Tonsillitis	Asthma	Reflux/Spittingup	PoorAppetite
Neck Pain	UpperRespiratory Infections	FrequentCold/Congestion	ADD/ADHD
Psychiatric Problems	Night Terrors	Bed Wetting	Headaches
Ulcers/Colitis	Fainting/Seizures/Epilepsy	SinusProblems	Chronic Diaper Rash
Colic	Difficulty Breathing	Diabetes	Bruising
PoorDigestion(constipation/diarrhea)		Eczema/psoriasis/Other skin rashes	

Is your child *currently* taking any prescription medication(s)? □ Yes □ No

If so,please list those medication(s) here:_____

Has your child taken any prescription medication(s) in the *past*?□ Yes □No

If so, please list those medication(s) here:_____

Does your child take any supplements? □ Yes □ No

If so, please list those supplements here:_____

Does your child exercise regularly? □ Yes □ No

Please list anything that your child may be allergic to:_____

Authorization/Consent to Treat

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

***____I agree with this Statement of Authorization**

Name of the Patient: _____**(please print)**

Signature of Patient, Parent or Legal Guardian (if a minor): _____ **Date:** _____

ChiroHealth HIPAA Form

Patient's Name: _____

Patient's SSN: _____ Date of Birth: _____

SPECIFIC AUTHORIZATIONS-CHECK ALL THAT APPLY

( ) I give permission to **ChiroHealth Rockford** to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, and any information about treatment(s). If **ChiroHealth Rockford** contacts me by phone; I give them permission to leave a phone message on my answering machine or voicemail.

( ) I give **ChiroHealth Rockford** permission to use and disclose my protected health information to the entities of my choosing, some of which may or may not be listed below.

APPROVED ENTITIES FOR PERSONAL HEALTH INFORMATION

Name: _____ Relationship: _____

Approved type(s) of information: ( ) Diagnosis ( ) Treatments ( ) Appointments ( ) Financial Records

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_____

Signature of Patient or Personal Representative

( ) I understand that if applicable your substance use disorder (SUD) records, or testimony relaying the content of those records, may not be used or disclosed in any civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order that meets specific legal requirements. Any such court order must be accompanied by a subpoena or other legal mandate before we are required to disclose the record.

( ) I am aware that once we share your information with an authorized recipient (such as your insurance company or another doctor), that recipient may further share that information as permitted by law. Once redisclosed, the information may no longer be protected by the same federal privacy rules (42 CFR Part 2) that apply to our program.

Date: _____

RIGHT TO REVOKE HIPAA AUTHORIZATION

- You have the right to revoke this authorization, in writing, at any time. Please send such requests to:
  ChiroHealth Rockford
  Attn: Office Manager
  6769 Courtland Dr. Ste. 100
  Rockford, MI 49341
  Phone: 616-863-9482
  Fax: 616-863-9486

  Initials: _____

- You may refuse to sign this HIPAA authorization. If you refuse to sign this authorization it will not affect your ability to obtain treatments.
- Upon request, a copy of this authorization will be provided to you.
- Upon request, a copy of the Health Insurance Portability and Accountability Act will be provided to you.
- If you believe your privacy rights regarding substance use disorder records have been violated, you may file a complaint with us or with the Secretary of Health and Human Services through the Office for Civil Rights (OCR). You will not be retaliated against for filing a complaint.

ChiroHealth

ChiroHealth of Rockford
6769 Courtland Drive
Suite 100
Rockford, Michigan 49341
(616) 863-9482 Office
(616) 863-9486 Facsimile

OFFICE POLICIES

We understand that life and emergencies happen, but we do ask that if you cannot keep your appointment, [redacted] and reschedule your appointment. You can leave a message on our answering machine and one of our team members will gladly reschedule your appointment for you. If you do not show up for your appointment, and did not call ahead to Cancel (NO-CALL/NO-SHOW), you will be charged a $25 NO-CALL/NO-SHOW Missed appointment fee for chiropractic.

PLEASE READ BELOW FOR ALL CHARGES.....

No-Show Policy-Chiropractic Adjustment Appointments $25

A No-Show appointment fee of $25 will be charged to you for any missed Chiropractic appointments.

24 Hr cancellation & No-Show Policy-Scheduled Massage Therapy Appointments $50

A No-Show appointment fee of $50 will be charged to you for any missed Massage appointments.

Less than 24hr notice a late cancellation fee of $50 will be charged to you for any missed Massage appointments.

***Our office allows you 5 minutes before and after your massage to talk to your therapist, undress/redress, and get yourself on/off the table. This means a 30 minute massage is 20 minute hands on therapy. A 60 minute massage is a 50 minute hands on therapy. A 90 minute massage is an 80 minute hands on therapy. A 120 minute massage is a 110 minute hands on therapy. This allows your therapist to customize your session as they deem appropriate. Please note it also helps keep our scheduled appointments to run on time.*

FINANCIAL POLICY

Payment is due at the time of service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, self-pay and Third Party Administrator. The accompanying adult to a minor patient is responsible for payment. For your convenience, we accept credit card, cash, and checks.

***Insurance:** Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and collect any copy, co- insurance, or deductible due by you at the time of service. Any non-covered service fees will also be collected at the time of service. If your health plan determines a service to be **"not covered"** or is **not an eligible expense under your plan**, you will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of the explanation of benefits from your insurance company. It is uncommon, but pre-authorization from your insurance company or PCP may be required for your plan. Please contact our office or your insurance company to verify your plan benefits. If required, an authorization may be able to be processed by our office or you may need the authorization from your PCP.

***Self Pay (No Insurance):** Full payment is due at the time of service.

Personal injury/Auto Injury/Worker's Comp (Third Party Administrators): Please advise our office on your first visit whenever you have one of these listed claims. We will work with any insurance company(s)/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party within a reasonable time. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.

Special Arrangement: We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship exists, it requires an Individual Consideration Contract. Please speak with the front desk staff.

Balance: Failure to pay any balance due may result in your account being turned over to an outside collection agency. Any balance that is 60 days passed the processed insurance date will be charged an additional $5.00 late fee. For any additional 30 days after that date another $5.00 late fee will be added.

* ChiroHealth offers a time of service discount of 10% for Self Pay patients as well as for services that are a non-covered benefit when we bill Insurance. This discount does not apply to nutritional supplements, customized orthotics or supplies. For additional discounts, please ask one of our team members about CHIROHEALTH USA, which can help you save even more for Self Pay patients and non-covered services for Insurance patients.

I have read and understand the financial policy set forth by ChiroHealth, and I agree to be bound by its terms. I understand that my insurance is an arrangement between myself and my insurance company. I request ChiroHealth prepare customary forms at no charge so
I may obtain insurance benefits. I understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care prescribed to me by the doctors of ChiroHealth, fees will be due and payable immediately. I understand and agree that such terms may be amended periodically by the practice.

Patient Name: _____
Please Print

Financially Responsible Party: _____
Please Print

Patient/Financially Responsible Party Signature: _____

Date: _____