Steele Chiropractic Pediatric Intake Form

1218 Ellis St Kewaunee, WI 54216

(920) 388-3440

About the Child

Name_____ Age_____ Today's Date_____

Gender □ Male □ Female Height_____ Weight_____ Date of Birth_____

Address:_____

City/State/Zip:_____

Mother's name and phone #_____

Father's name and phone #_____

How did you hear about us_____

Preferred language_____ Race_____ Ethnicity_____ Smoking status_____

Reason for Visit

Describe in detail reason for today's visit_____

_____

□ Sports □ Auto □ Fall □ Wellness Care □ Other (please specify)_____

When did this begin?_____ Experienced before □ Yes □ No

□ Getting better □ Worse □ Staying the same

Pain Level 1-10 _____ Type of pain: □ Tight □ Ache □ Sharp □ Tingling □ Numb

Does the problem/pain interfere with: □ School □ Playing □ Exercise/sports

□ Sleep □ Daily routine

Anything make it better? (ice, heat, pain meds…)_____

Anything make it worse?_____

Health Concerns

□ Anxiety □ Depression
□ ADD □ ADHD
□ Allergies □ Sinus problems
□ Asthma
□ Back pain □ Neck pain □ Joint pain
□ Bed wetting
□ Colic □ Acid Reflux
□ Concussion □ Torticollis
□ Constipation □ Diarrhea
□ Dizziness
□ Ear infections
□ Fatigue □ Sleep issues
□ Headaches □ Migraines
□ Nausea □ Vomiting
□ Overweight □ Underweight
□ Scoliosis
□ Seizures
□ Torticollis □ Head tilt
□ Other_____

Has your child seen a chiropractor before? □ Yes □ No

Previous surgeries_____

Previous broken bones_____

Allergies_____

Medications (Name and what they are used for):

1._____ 2._____

3._____ 4._____

5. _____ 6._____

Vitamins/Supplements:

□ Multivitamin □ Fish Oil/Omega 3 □ Vitamin D □ Probiotics

□ Other_____

_____

Lifestyle Habits

Does your child exercise daily? □ Yes □ No

Does your child have difficulty sleeping? □ Yes □ No

Does your child eat balanced meals? □ Yes □ No

Prenatal History (fill out if child is 3 years old or younger)

During pregnancy, did the mother: □ Experience significant illness, difficulties, or trauma?_____

_____

□ Take any drugs/medications?_____

_____

Did any of the following happen during delivery?

□ Labor was induced □ Premature Delivery □ Forceps/vacuum extraction

□ C-section □ Additional complications

Explain_____

_____

□ Formula-fed □ Breast fed □ Food Allergies/Intolerances List: _____

Parent/Guardian's signature_____ Date_____

INFORMED PATIENT CONSENT

Patient Name: **Account #:**

- My signature below indicates that I understand that if I am accepted as a patient of STEELE CHIROPRACTIC, I am authorizing them to proceed with any further treatment that may be necessary. I understand that there are risks that can be associated with care including stroke, increased nerve sensitivity/numbness, and increased muscle and joint pain. I also understand that any risks involving chiropractic treatment will be explained to me in depth upon request.
  _____ staff initials

_____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

_____

Printed Name and Relationship to Patient

- My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for Steele Chiropractic and have read and understood its content.

_____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

_____

Printed Name and Relationship to Patient

BUSINESS/FINANCIAL BILLING ARRANGEMENTS

_____ **NO INSURANCE/PRIVATE PAY:** Payment in full is expected at the time of service.

_____ **COMMERCIAL INSURANCE:** As a service to our patients, Steele Chiropractic accepts assignment of insurance benefits and bills the insurance company for services provided at our office. Insurance is a contract between you and your insurance company. You will be responsible for any deductible, coinsurance and copays. Copays are expected to be paid at the time of service. Failure to present the correct insurance information at the time of your appointment may result in the entire balance becoming your responsibility. This also includes returning requests of information to your insurance company in a timely manner. While we do our best to estimate your insurance benefits, the insurance company makes the final determination on your benefits and coverage. If we are out of network with your insurance company, you are responsible for any portion of the charges not covered by them.

_____**MEDICARE:** We are a participating provider with Medicare and therefore agree to bill and accept assignment from Medicare. Chiropractic manipulations to the spine to improve an injury or health condition are considered medically necessary and are the only service that is covered by Medicare. Medicare does not cover maintenance manipulations, manipulations to an extremity, exams, therapies or supplements and supplies at this office. I understand that if I do not have a supplemental insurance, I will be responsible for all deductible, coinsurance, and non-covered services at this office. If you do have a Medicare supplemental policy, most will cover the Medicare coinsurance. If you have chosen additional Riders on your policy, it may cover deductible services as well. Any supplemental plans written in the state of Wisconsin also follow the Wisconsin State Mandate, meaning many of them will cover maintenance manipulations, manipulations to an extremity, exams, and therapies.

_____**MEDICARE ADVANTAGE PLAN:** We are a participating provider with many Medicare advantage plans, and we accept assignment of benefits for services provided at our office. Most of these plans follow Medicare guidelines, and therefore only cover chiropractic manipulations to the spine to improve an injury or health condition. They normally do not cover maintenance manipulations to the spine, manipulations to an extremity, exams, or therapies. I understand that I will be responsible for all deductible, coinsurance, copays, and non-covered services at this office.

_____**STATE MEDICAL ASSISTANCE/FORWARDHEALTH:** We are a participating provider with Wisconsin State Medical Assistance and agree to bill and accept assignment of benefits for the services provided at our office. Chiropractic manipulations to the spine and exams are the only services covered by Medicaid, and they are limited to 20 visits per condition. Medicaid does not cover maintenance manipulations to the spine, manipulations to an extremity, therapies, or supplements and supplies at this office. I understand that I am responsible for all copays and non-covered services at this office.

_____**WORKERS COMPENSATION/AUTO ACCIDENT:** We agree to bill and accept assignment of benefits from your workers compensation or auto carrier. I understand that opening a claim does not guarantee acceptance of fault nor

does it guarantee payment. It can also take a long time for settlement to be reached in these cases, and some companies will not pay until settlement has been reached. In these circumstances, I understand I may be asked to begin making payments on my account. I also understand that I am responsible for all charges that are denied or non-covered by my insurance carrier.

- PAYMENT is expected at the time of service, unless other arrangements have been made.
- INSURANCE is a contract between the patient and the insurance company and therefore, it is the responsibility of the patient to make sure the account remains current. This includes presenting correct insurance information at the time of service and returning any and all information necessary to the insurance company to get their claims processed. While we will do everything, we can to assist in getting your claims paid and processed, you are ultimately responsible for the services received at this office.
- Patients involved in LITIGATION, WORKERS COMPENSATION, OR AUTO ACCIDENT cases are ultimately responsible for the services received at this office.
- When asking us to bill any insurance, you are acknowledging that the insurance company will pay this office directly for any covered services provided by this office.
- If there is a patient balance, we will send you a monthly statement. Patients are responsible for all charges for services rendered and supplies provided by this office. Payment in full is due within 30 days of receipt of this statement, unless other financial arrangements have been made.

By signing this agreement, I acknowledge that I understand and agree to the policies and terms contained herein.

_____

Patient Signature OR Parent/Guardian/Personal Representative Signature Date

_____

Printed Name/Relationship to Patient

_____

Printed Patient Name and Chart #

Patient Consent for Electronic Reminders

Patients at Steele Chiropractic may be contacted via text messaging to be reminded of an appointment. If at any time I provide a phone number at which I may be contacted, I consent to receive appointment reminders via text from Steele Chiropractic.

_____ (Patient initials) I consent to receive text messages from Steele Chiropractic on my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders is_____.

Steele Chiropractic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Printed Name and Chart #: _____

Parent/Representative Signature: _____Date_____

Patient Signature _____ Date _____

Revocation:

__I hereby revoke my request to receive any future appointment reminders via text messages.
NOTE: This revocation only applies to communications from this Practice.