Binder Family Chiropractic LLC Child Registration & History Form

Patient Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____
DOB: ____ / ____ / ____ Sex: _____ Weight: _____ Height: _____
Names of Parents / Guardians:
_____
Home Phone #: (_____)_____ Cell Phone #: _____
Email: _____
In Case of Emergency Contact: _____ Phone #: (_____)_____
Who should we thank for referring you?
_____

Has your child ever received Chiropractic care? ____**YES** ____**NO**

If yes, previous Chiropractor's name and date of last visit:
_____

Present Health Complains/Concerns

Major: _____

_____

Minor: _____

_____

Please check any of the current or past problems your child has had on the list below:

__Dizziness	__Asthma	__Bed wetting	__Headaches
__ADHA	__Runny Nose	__Behavioral	__Frequent Colds
__Autism	__Itchy Eyes	__Allergies	__Neck Pain
__Backaches	__Fever/Chills	__Chronic Ear Infections	

When did this problem begin:
_____
_____

Is this problem (circle) **occasional** **frequent** **constant** **intermittent**

Does this problem radiate? ____**YES** ____**NO** If yes, where? _____

What makes this worse: _____

What makes this better: _____

Is the problem worse during a certain time of the day? ____**YES** ____**NO**

If yes, when: _____

Does this interfere with the child's (circle) **sleep** **eating** **daily routine**

Is this becoming worse: _____

Other professionals seen for this condition: _____

Medications prescribed for this condition:

_____

_____

Results with that treatment:

_____

_____

Has your child been injured in any type of accident (ie. Sports, car accident, major fall, etc)? __**YES** __**NO**
If yes, please describe with dates:

_____

_____

Prior surgeries? ____**YES** ____**NO** If yes, type and date:

_____

_____

I, the undersigned, give authorization for care of the above named minor child. Additionally, I certify that I (or my dependent) have insurance coverage and assign directly to Binder Family Chiropractic LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use if this signature on all insurance submissions.

Parent Signature: _____ Date: _____

X-ray release: I certify **(*if applicable and age appropriate – menstrual cycle*)** that my child is not pregnant.

Parent Signature: _____ Date: _____

***If this does not apply, check here: _____**

Binder
FAMILY CHIROPRACTIC LLC

Binder
FAMILY CHIROPRACTIC LLC

Patient Name: _____

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to Binder Family Chiropractic, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Binder Family Chiropractic.

Authorization to Release Medical Record Information

Binder Family Chiropractic is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Binder Family Chiropractic. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Chiropractor.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient responsible party with the power to execute this document and accept these terms.

Signature of Patient or Responsible Party: _____

Binder Family Chiropractic LLC, Financial Policy

Thank you for choosing Binder Family Chiropractic LLC. It is our policy to provide quality chiropractic services with minimal financial stresses. We are members of the most preferred provider networks to keep your costs low. We will file all insurance claims for your convenience. We also provide affordable cash plans for those without insurance or those who choose not to use their insurance.

Pre-Pays: All accounts are audited upon the cessation of care or end of care plan. Any pre-payment for services not rendered will be refunded or applied to future care as directed by patient. Payments are applied to services not rendered, not based on time. Any pre-payment savings given at the beginning of care for decreased bookkeeping costs are therefore not given if audit before the end of care plan is needed and bookkeeping costs arise because of this. This previous credit will be deducted from any refund amount.

As with all medical procedures, payment of service does not guarantee or imply cure. Individual results are reliant on a multitude of internal and external factors which in no way can be guaranteed. Payment is expected irrespective of outcomes. Healing takes both time and repetition.

*All payments are due upon receipt

If an account balance becomes greater than 90 days past due and if no other prior payment arrangements have been made, the account will be turned over to our collections department. You will be responsible for all collection agency fees above and beyond your past due balance.

I have read and understand the financial policy:

Signature_____ **Date**_____

TERMS OF ACCEPTANCE

CHIROPRACTIC INFORMED CONSENT

Patient Name: _____

When a patient seeks chiropractic health care and we agree to provide this care, it is essential for the patient and Binder Family Chiropractic to be working toward the same objective. It is important that each patient understand both the objective and the method with which it will be obtained. This prevents any confusion or disappointment.

Adults: Chiropractic care can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system. Healing takes both time and repetition.

Kids: Children's spines are very sensitive, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxations and begin any necessary treatment as young as possible.

Duration of care: While pain relief may only take a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from six months to two years. Following correction, the doctor will make a recommendation for wellness care.

As a rule, informed and cooperative patients can achieve positive chiropractic results. Thus, the following information is routinely supplied to all who consider Chiropractic care. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Binder Family Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Binder Family Chiropractic and will be credited to my account upon receipt. However, I clearly understand and agree that all my services rendered are charged directly to me and that I am personally responsible for payment.

I, _____, have read and fully understand the above statements.
(Print Name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Consent to evaluate and adjust a minor/child: I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature of parent/legal guardian:_____ Date:_____

Pregnancy Release: This is to certify that to the best of my knowledge, I am not pregnant. The above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature: _____ Date:_____

NOTICE OF PRIVACY PRACTICE (NPP):

- **To Family and Close Friends Involved in Your Care:** Our office has an open, family centered approach to wellness and we believe it is in all our patients best interests to have the support and cooperation of their families. Therefore, our office strongly encourages that the spouse or significant other be present when the doctor goes over the patients report and recommendations for care.

  In addition, we may disclose your PHI (Personal Health Information) to a family member or a close friend if those persons accompany you while you are receiving health care services; or if we determine that it is in your best interest so we can provide you with the best health care possible. We may also disclose your PHI to a family member or someone else who helps pay for your chiropractic care.

- **Right to Inspect and Copy:** You have the right to inspect and copy PHI that may be used to make decisions about your care. Usually, PHI includes medical and billing records. To inspect and copy PHI, you must submit your request in writing on the form provided by our practice.

Signature:_____ Date: _____

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Binder Family Chiropractic, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your medical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be an interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide us with this authorization; it will not affect the care provided to you, or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency

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Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible, following the changes. Any change in our privacy notice will apply for all of your health information in our files.

_____ _____ ___/___/_____

Name (Printed) *Signature* *Date*

**If you are a minor, or if you are being represented by another party:*

_____ _____ ___/___/_____

Representative (printed name) *Signature* *Date*