PEDIATRIC

chiropractic profile & release form

Please complete in black ink.

village health
wellness spa

Patient Information

Name _____
First M.I. Last

Address _____

City _____ **State** _____ **Zip** _____

Sex ☐ M ☐ F **Age** _____ **Birthdate** _____ /_____ /_____
Month Day Year

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Patient SS# _____

Home Phone _____

Cellular Phone _____

Work Phone _____ Ext. _____

Email _____

Occupation _____

Employer _____

Spouse's Name _____

Emergency Contact _____

Relationship _____ **Tel** _____

How did you hear about us? _____

Email me monthly exclusive spa specials ☐ Yes ☐ No

Insurance Information

Insurance Co. _____

Policyholder's Name _____

Relationship to Patient _____

Policyholder's Birthdate Month _____ / Day _____ / Year _____

Policyholder's SS# _____

ID # _____

Group # _____

Do you have Medicare? ☐ Yes ☐ No

Authorization, Assignment & Release

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company(ies) and assign directly to Village Health Georgia, P.C. 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 authorize the use of my signature on all insurance submissions.

Village Health Georgia, P.C. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____
Signature of Parent or Legal Guardian

_____ _____
Relationship to Patient Date

Height ____ Ft. ____ In. **Weight** _____ Lbs.

Dominant Hand (Check all that apply)
☐ Right ☐ Left ☐ Ambidextrous

Sleeping Position
(Check all that apply)
☐ Back ☐ Stomach ☐ Right Side ☐ Left Side

Exercise
(Check all that apply)
☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity
(Check all that apply)
☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Patient Condition

Reason for Visit _____

When did your symptoms appear? _____

Is the condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain (0=no pain to 10=severe pain) _____

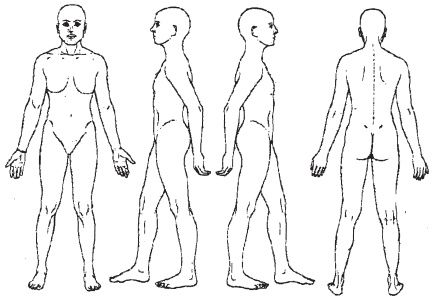
Type of pain: ☐ Sharp ☐ Burning ☐ Throbbing ☐ Numbness ☐ Aching ☐ Swelling ☐ Dull ☐ Tingling ☐ Stabbing ☐ Shooting ☐ Stiffness ☐ Other_____

How often do you have this pain? _____

Describe your pain: ☐ Constant ☐ Comes and Goes ☐ Other _____

Activities/Movements painful to perform: ☐ Sitting ☐ Standing ☐ Lying Down ☐ Walking ☐ Bending ☐ Other _____

Mark an X on any area(s) where you have pain, numbness and/or tingling.



front left side right side back

Previous treatment for this condition: ☐ None ☐ Chiropractic ☐ Physical Therapy ☐ Medication ☐ Surgery ☐ Other _____

Is your condition due to an accident? ☐ Yes ☐ No If Yes, type: ☐ Auto ☐ Work ☐ Other _____ Date: _____

Health History

Indicate if you *currently have* or *have ever had* any of the following:

ADD/ADHD	☐ Yes ☐ No	Ear Infections	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No
Allergies/Sinus	☐ Yes ☐ No	Fracture	☐ Yes ☐ No	Recurring Fevers	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Growing/Back Pains	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rubella	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Head/Neck Injury	☐ Yes ☐ No	Rubeola	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Autoimmune Disorder	☐ Yes ☐ No	Herniated/Bulging Disc	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Bed Wetting	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Spinal Fracture	☐ Yes ☐ No
Bleeding Disorder	☐ Yes ☐ No	Joint Dislocation	☐ Yes ☐ No	Spinal Surgery	☐ Yes ☐ No
Bone Disease	☐ Yes ☐ No	Joint Surgery	☐ Yes ☐ No	Sprain/Strain	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Temper Tantrums	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Meningitis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Colic	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Torticollis	☐ Yes ☐ No
Chronic Colds	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Tumor/Growth	☐ Yes ☐ No
Digestive Problems	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Uneven Leg Length	☐ Yes ☐ No
Dyslexia	☐ Yes ☐ No	Neck Pain/Stiffness	☐ Yes ☐ No	Weight Loss/Gain	☐ Yes ☐ No

☐ Other _____

Describe/explain any treatment(s) you have had or are currently receiving for any of the conditions checked 'Yes' above. _____

_____

List all past/present injuries, dislocations, broken bones and/or surgeries with date.

_____ Date _____

_____ Date _____

_____ Date _____

Medications & Vitamins/Herbs List all medications, vitamins and/or herbs you are currently taking & reason.

_____

_____

Pediatric Consent

I, being the parent or legal guardian of _____ **(patient name)**, hereby consent to the treatment of my child by Village Health Georgia, PC. I understand that the nature of the treatment may include diagnostic examination, chiropractic manipulation, x-ray and/or various ancillary procedures such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, traction and stretches.

_____ _____ _____

Signature of Parent or Legal Guardian | Relationship to Patient | Date

Acknowledgement of Privacy Practices

I acknowledge that I have been presented with a copy of the Village Health Georgia, PC 'Notice of Privacy Practices'. This notice describes how Village Health Georgia, PC may use and disclose by protected health information, certain restrictions on the use and disclosure of my healthcare information, and the rights that I have regarding my protected health information.

_____ _____ _____

Signature of Parent or Legal Guardian | Relationship to Patient | Date

Informed Consent & Release

The nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a click or a pop such as the noise when a knuckle is cracked and you may feel movement of the joint(s). Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, traction and stretches may be utilized.

Possible Risks: As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints or injury to the intervertebral disks, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries in the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. The risks of complications due to chiropractic treatment have been described as rare, about as often as complications from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in ten million and can be further reduces by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

I have read the above information, have fully evaluated the risks and benefits of being treated and hereby give my full consent for examination and chiropractic treatment(s) to be performed on me by Village Health Georgia, PC (dba Village Health Wellness Spa). I further acknowledge and state that each and every visit or appointment I have with Village Health Georgia, PC, at any location, subsequent to this date, shall constitute a continuation, revival, and renewal of this release.

_____ _____ _____

Signature of Parent or Legal Guardian | Relationship to Patient | Date

Patient Financial Agreement

Village Health Wellness Spa is dedicated to providing the best possible service in a cost effective manner. In order to accomplish this, we depend upon prompt payment for the services we provide and have adopted the following policies:

Payment Due at Time of Service
I acknowledge that payment is due at the time of service. I agree that in return for the services provided to the patient by Village Health Wellness Spa, I will pay my account at the time service is rendered. I consent that I am responsible for any and all charges assigned to me by my insurance plan including, but not limited to, yearly deductibles, co-insurances, co-pays, non-plan coverage, etc. All past due balances are due and payable at the time of service.

Patient Responsibility
I understand that filing a claim with my insurance plan does not relieve me from my responsibility for the payment of all charges. If no payment is received from my insurance plan, the full balance of my account will be my responsibility. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I accept financial responsibility for any services which are determined by my insurance plan not to be covered and/or denied. I understand and agree that if my account is delinquent, I may be turned over to a collection agency and responsible for collection expenses.

Insurance Assignment & Release of Information
I hereby authorize Village Health Wellness Spa to release all information necessary for claim reimbursement from insurance companies to who claims may be submitted and/or to secure the payment of benefits. I assign payment of insurance benefits to Village Health Wellness Spa for services rendered.

Blue Cross Blue Shield Payment Acknowledgement
In some cases, Blue Cross Blue Shield remits payment checks directly to the patient rather than the chiropractic office at which services were rendered. If this occurs, I understand that I am responsible for forwarding these payments to Village Health. I understand and agree that if my account is delinquent for these payments, I may be turned over to a collection agency and responsible for collection expenses.

Self-Pay Accounts
Self-pay accounts are patients who are covered by insurance plans that the practice does not participate in, or patients without an insurance card on file or at the time of service. I agree that I am individually obligated to pay the full charges at the time of service. If a group or organization discount is received for service(s) and I am not enrolled or a member of that organization at the time of service, I will be responsible for the difference between the discounted charge and the full charge.

Minors
Minors (patients under the age of 18) must have a signed consent for treatment by a parent or legal guardian on file. Minors must be accompanied by a parent or legal guardian in order to be treated. The parent(s) or guardian(s) accompanying a minor are responsible for payment.

Late Fee
Past due accounts and balances not paid by the due date on the statement are subject to a late fee of $25.00.

Returned Check Fee
Any payment by check returned by the bank will be subject to a returned check fee of $35.00.

By signing below, I acknowledge that I have read, understand and agree to the above Financial Agreement.

_____ _____ _____

Signature of Parent or Legal Guardian | Relationship to Patient | Date