



TODAY'S DATE PATIENT'S FULL NAME AGE DATE OF BIRTH

STREET ADDRESS CITY STATE ZIP CODE

GRADE SEX SOCIAL SECURITY NUMBER OF GUARDIAN MOTHER FATHER

SEND TEXT REMINDERS TO THIS PHONE #: _____ No appt. reminders

Parent/Guardian 1

NAME EMAIL

ADDRESS, IF DIFFERENT THAN ABOVE

PHONE

OCCUPATION EMPLOYER / CITY

Parent/Guardian 2

NAME EMAIL

ADDRESS, IF DIFFERENT THAN ABOVE

PHONE

OCCUPATION EMPLOYER / CITY

NAMES AND AGES OF SIBLINGS

FAMILY MEDICAL DOCTOR / CLINIC

HOW DID YOU LEARN ABOUT OUR OFFICE NAME OF PERSON WHO REFERRED YOU

HAS CHILD RECEIVED PREVIOUS CHIROPRACTIC CARE? YES NO

IF YES, WHEN WAS THE LAST ADJUSTMENT

CLINIC NAME / DOCTOR



HISTORY OF PRESENT ILLNESS:

REASON FOR YOUR VISIT TODAY

HOW LONG HAS YOUR CHILD HAD THIS PROBLEM

WHAT CAUSED IT

HAVE THEY EVER HAD THE SAME OR A SIMILAR CONDITION? YES OR NO. IF YES, WHEN AND DESCRIBE:

HEALTH HISTORY:

Has your child ever experienced the following or been diagnosed as having any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Illness accompanied by a high fever | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches (occasional or frequent) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Hypoglycemia (low blood sugar) |
| <input type="checkbox"/> Ear infections/earaches (if so, how many) _____ | <input type="checkbox"/> Trouble with bladder control |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Serious fall or repetitive falls | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Allergies to foods | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Chemical insensitivities | <input type="checkbox"/> Digestive disorders |
| <input type="checkbox"/> Is child vaccinated? | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Have you declined any vaccines? | <input type="checkbox"/> Neck or back problems |
| <input type="checkbox"/> Adverse reaction to any vaccinations (even if mild) | <input type="checkbox"/> Joint or muscle problems |
| <input type="checkbox"/> If yes, please explain: _____ | |

NEUROLOGICAL/OTHER:

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- | | |
|--|--|
| <input type="checkbox"/> Hearing loss or impairment | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Obsessive Compulsive Disorder (OCD) | <input type="checkbox"/> Autism/Autism Spectrum Disorder |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Tourette's Syndrome |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Other _____ |



SURGERIES that your child has had, include dates _____

MEDICATIONS that your child is taking or has taken in the past. Names, dosage, frequency.

NUTRITIONAL SUPPLEMENTS your child takes. Vitamins, herbs, naturopathic remedies, etc.

SPECIAL SERVICES that your child is currently receiving at school or privately _____

SPECIAL NEEDS your child has _____

OTHER TREATMENT that your child is currently undergoing with any health professional _____

FAMILY HISTORY: Any health conditions of mother/father _____

ACTIVITIES: Activities/sports does your child participate in and how frequently



**** THIS PAGE FOR CHILDREN AGES 0 – 12 ONLY ****

Pregnancy History (Mother)

(If the child is adopted, answer to the best of your ability)

Did you ever experience any of the following during your pregnancy?

- | | |
|--|--|
| <input type="checkbox"/> Severe viral infection during the first trimester | <input type="checkbox"/> Alcohol consumption and/or drug use |
| <input type="checkbox"/> Breech position during pregnancy | <input type="checkbox"/> Radiation exposure |
| <input type="checkbox"/> Accident or infections | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Severe stress | <input type="checkbox"/> Uncontrolled Diabetes |
| <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Toxemia |

Labor and Delivery History

Did you and/or the child experience any of the following during the labor/delivery:

- | | |
|--|---|
| <input type="checkbox"/> Hospital birth | <input type="checkbox"/> Home birth |
| <input type="checkbox"/> Long and/or difficult labor | <input type="checkbox"/> The delivery was rapid |
| <input type="checkbox"/> Placenta Previa | <input type="checkbox"/> Breech birth |
| <input type="checkbox"/> Forceps or vacuum | <input type="checkbox"/> Cord around neck |
| <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Emergency C-section |
| <input type="checkbox"/> Elective C-section | <input type="checkbox"/> The child was premature (2+ weeks) |
| <input type="checkbox"/> The child was a "blue baby" | |
| <input type="checkbox"/> Labor was induced. If yes, reason? _____ | |
| <input type="checkbox"/> Medications during delivery. If yes, list (i.e. Epidural) _____ | |

Comments: _____

Newborn History

Weight at birth: _____ Length at birth: _____

Did the child experience any of the following as a newborn?

- | | |
|--|---|
| <input type="checkbox"/> Required resuscitation/oxygen | <input type="checkbox"/> Distorted skull |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Difficulty latching/sucking |
| <input type="checkbox"/> Poor sleeper | <input type="checkbox"/> Formula fed |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Feeding (____ breast or ____ bottle) |
| <input type="checkbox"/> Immunizations in hospital | <input type="checkbox"/> If breast fed, how long _____ |
| If yes, specify vaccine: _____ | |

Developmental History

Does your child have any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Difficulty with crawling (on all fours) | <input type="checkbox"/> Did not crawl on all fours |
| <input type="checkbox"/> Difficulty learning to ride a bike | <input type="checkbox"/> Appears clumsy |
| <input type="checkbox"/> Difficulty learning to read | <input type="checkbox"/> Difficulty with writing |
| <input type="checkbox"/> Difficulty using utensils | <input type="checkbox"/> Difficulty buttoning clothing |
| <input type="checkbox"/> Difficulty tying shoes | <input type="checkbox"/> Difficulty or awkward with walking/running |
| <input type="checkbox"/> Poor hand-eye coordination | <input type="checkbox"/> Difficulty sitting still or paying attention |

Age of child when he/she sat _____ crawled _____

How long did your child crawl (in months): _____

At what age did your child start to walk unassisted: _____



STANDARD CONSENT

When a patient seeks Chiropractic health care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a Chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for these findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's natural ability toward self-healing. Our only method is specific adjusting to correct vertebral subluxations.

Any procedure intended to help may also do harm. While chiropractic procedures done in this office are usually considered remarkably safe and effective, please understand there are occasional and rare complications which have been documented. While the chances of experiencing these complications are extremely small, it is the practice of this office to fully inform and educate all of our patients about them. Cervical manipulations have rarely caused injuries to the small blood vessels that go to and from the upper neck to the brain. The risk of this occurring is thought to be one in three million to one in fourteen million, according to several studies. These other complications include but are not limited to:

- | | | | |
|--------------------|----------|-----------|-----------------|
| pain | burns | swelling | sensory changes |
| soft tissue injury | bruising | bleeding | stroke(CVA) |
| discoloration | fracture | dizziness | inflammation |
| disc injury | nausea | weakness | soreness |

By signing below, I understand that there is no guarantee or warranty of a specific cure or result. I understand that I can request specific additional information from the doctor regarding treatment risk. Given this information, I consent to care.

SIGNATURE OF PARENT OR GUARDIAN

DATE



AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize the doctors at Great Lakes Chiropractic to evaluate and treat my son/daughter as they deem necessary.

I understand and agree to allow Great Lakes Chiropractic to use Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

 SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING CARE

 DATE

 WITNESS

 DATE

AUTHORIZED PEOPLE WHO HAVE ACCESS TO MY INFORMATION

I authorize Great Lakes Chiropractic of St. Michael to share my account information including TREATMENT DETAILS, ACCOUNT INFORMATION, PAYMENT DETAILS, AND APPOINTMENT TIMES with the following people. (spouse, parent, children)

 NAME

 RELATIONSHIP TO PATEINT

 NAME

 RELATIONSHIP TO PATEINT

 NAME

 RELATIONSHIP TO PATEINT

Please do NOT allow anyone to access my information

This is valid until revoked or changed by written communication.

 SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR)

 DATE



FINANCIAL POLICY

MISSED APPOINTMENT: Your time is important, as is ours. A \$50.00 fee will be charged to all accounts that miss an appointment without 24-hour notice. All cancellations and reschedules must be made by calling or texting. NO emails. This is not a fee that can be submitted to your insurance.

INSURANCE: Current insurance MUST be present at the time of service. All claims will be submitted to your insurance carrier unless otherwise specified. Great Lakes Chiropractic will not go back to correct claims processing because of missing or invalid insurance for primary or secondary policies. We will not quote coverage or benefit levels or guarantee that your insurance company will cover the services we have provided. If you have questions, please call your insurance carrier directly.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Great Lakes Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Great Lakes Chiropractic will be credited to my account. However, I agree that I am personally responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

In the event your insurance does not process a claim, or they reverse previously processed claims for any reason, we will not go back more than 90 days to re-submit claims. You will be financially responsible for the self-pay office visit rate for all appointments older than 90 days.

INSURANCE POLICY HOLDER'S FIRST AND LAST NAME	RELATIONSHIP TO PATIENT	POLICY HOLDER'S DOB
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WHO HAS FINANCIAL RESPONSIBLE FOR THIS PATIENT	RELATIONSHIP TO PATIENT
---	--------------------------------

COPAYS AND BALANCES: Co-payments AND/OR any balance on your account are due on the day of your appointment.

SECONDARY/SUPPLEMENTAL INSURANCE: Please inform us of any secondary insurance you may have.

MEDICARE: We do accept Medicare. Medicare covers manual manipulation of the spine *only*. All other services are NOT covered. These services include, but are not limited to x-rays, examinations and therapies. You are required to pay any deductible and remaining balance after Medicare processes your claim.

WORKER'S COMPENSATION/PERSONAL INJURY: Please inform us immediately if you are injured on the job or are involved in an accident. We will work with you to manage your care and submit your fees.

SELF-PAY RATE/NO INSURANCE: For patients who carry insurance in which we are not in-network or for patients who do not wish to submit claims to their insurance company, we offer a self-pay office visit. This charge will be due at the time of your appointment.

CARD-ON-FILE: All accounts are required to have a credit card on file to cover fees, co-pays, co-insurance and deductibles. See separate form.

COLLECTIONS: Unpaid balances of five months or more will incur an 8% of the outstanding balance late fee per month. After nine months, the account will be turned over to a collection agency.

I have read and understand the Financial Policy of Great Lakes Chiropractic of St. Michael. I understand that I am responsible for all services not paid for by my insurance including deductibles, copayments, or non-covered services. I am also responsible for any fees incurred.

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR)

DATE



AUTHORIZED CARD-ON-FILE

I am providing Great Lakes Chiropractic of St. Michael with a credit card to be stored securely and used for all fees, co-pays, and/or co-insurance or deductibles after insurance has processed my claims. The card on file can be changed or removed at any time by contacting Great Lakes Chiropractic of St. Michael.

_____ The card-on-file will only be used in these situations:

(Initial)

- a) when authorized by you in-office to pay your balance**
- b) automatically when you have a past due balance of over 60 days**
- c) automatically for a missed appointment fee**
- d) automatically when you cancel/reschedule an appointment with less than 24-hour notice**

I agree to respond promptly when Great Lakes Chiropractic of St. Michael notifies me that my card-on-file does not work or has expired.

This card-on-file can be used for the following people or family members:

_____ Name

_____ Relationship

_____ Name

_____ Relationship

_____ Name

_____ Relationship

_____ Name

_____ Relationship

_____ Name

_____ Relationship

_____ **SIGNATURE**

_____ **TODAY'S DATE**

*Security note from Rectangle Health, the credit card processing software vendor:
 "All cards are electronically stored and encrypted in the payment portal software, such that no direct staff at Great Lakes Chiropractic or support staff at Rectangle Health can view your information at any point, beyond the last 4 digits. Once imbedded into the software the information is encrypted and stored.*



AUTHORIZATION TO CONSENT TO TREATMENT

Dear Parent(s): State law requires that you consent to most medical treatments for your minor child. If an adult other than your child's parent or legal guardian accompanies him/her to office visits or your child is of legal driving age and will be coming to appointments without you, we will be unable to provide treatment without your written authorization, except in emergency situations. To authorize an adult other than your child's parent or legal guardian to consent to medical treatment for your child or for your child to attend visits without you, please complete the sections below. By completing this authorization, you consent to the sharing of your child's protected health information with this individual as outlined in our Notice of Privacy Practices.

PART I. MINOR CAN BE TREATED WITH CONSENT FROM OTHER ADULT

I authorize the following individual(s):

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

to consent to medical treatment for my minor child(ren) listed below:

Name: _____ Date of birth: _____

PART II. MINOR CAN BE TREATED WITHOUT PARENT PRESENT

I authorize my child(ren) of legal driving age to attend appointments on their own. Consent for care is still required by a legal guardian.

Name: _____ Date of birth: _____

PART IV. SIGNATURE

Printed Name of Parent or Legal Guardian

Signature of Parent or Legal Guardian

Date