Great Lakes Chiropractic of St. Michael
116 Central Ave East St. Michael, MN 55376
PH: 763-515-6650 | FAX: 763-777-9186

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:

___ Illness accompanied by a high fever
___ Headaches (occasional or frequent)
___ Seizures/Convulsions
___ Ear infections/earaches (if so, how many) ________
___ Head injury
___ Serious fall or repetitive falls
___ Epilepsy
___ Meningitis
___ Allergies to foods
___ Environmental allergies
___ Chemical insensitivities
___ Is child vaccinated?
___ Have you declined any vaccines?
___ Adverse reaction to any vaccinations (even if mild)
If yes, please explain: ________________________

___ Dizziness
___ Diabetes
___ Hypoglycemia (low blood sugar)
___ Trouble with bladder control
___ Fainting
___ High/Low blood pressure
___ Heart Disease
___ Asthma
___ Sinus problems
___ Constipation
___ Digestive disorders
___ Rheumatic Fever
___ Neck or back problems
___ Joint or muscle problems

NEUROLOGICAL/OTHER:

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

___ Hearing loss or impairment
___ Neurological disorders
___ Obsessive Compulsive Disorder (OCD)
___ ADD/ADHD
___ Dyslexia

___ Visual impairment
___ Anxiety/Depression
___ Autism/Autism Spectrum Disorder
___ Tourette's Syndrome
___ 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?

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

Labor and Delivery History

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

___ Hospital birth
___ Long and/or difficult labor
___ Placenta Previa
___ Forceps or vacuum
___ Fetal distress
___ Elective C-section
___ Home birth
___ The delivery was rapid
___ Breech birth
___ Cord around neck
___ Emergency C-section
___ The child was premature (2+ weeks)
___ The child was a "blue baby"
___ Labor was induced. If yes, reason? ____
___ 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?

___ Required resuscitation/oxygen
___ Jaundice
___ Poor sleeper
___ Colic
___ Immunizations in hospital
If yes, specify vaccine: ______________________
___ Distorted skull
___ Difficulty latching/sucking
___ Formula fed
___ Feeding (___ breast or ___ bottle)
If breast fed, how long _____________

Developmental History

Does your child have any of the following?

___ Difficulty with crawling (on all fours)
___ Difficulty learning to ride a bike
___ Difficulty learning to read
___ Difficulty using utensils
___ Difficulty tying shoes
___ Poor hand-eye coordination
___ Did not crawl on all fours
___ Appears clumsy
___ Difficulty with writing
___ Difficulty buttoning clothing
___ Difficulty or awkward with walking/running
___ 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 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 agrees 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

____

WHO HAS FINANCIAL RESPONSIBLE FOR THIS PATIENT RELATIONSHIP TO PATIENT

COPAYS: Co-payments 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
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

______________________________ 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