COMPASS
CHIROPRACTIC & WELLNESS, LLC

2516 Forum Blvd., Suite 102
Columbia, MO 65203
www.compass-chiropractic.com
573-445-4444 phone
573-445-1888 fax

Patient ID: _____ Date: _____

# New Patient Forms - Pediatric

First Name (Print Please) _____ MI____Last Name_____

Address_____City/State_____Zip_____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____

Mother's Name: _____ Father's Name: _____

Address:_____ Address: _____

Phone: _____ Phone: _____

Pediatrician's Name: _____

Date of last Pediatric exam: _____

Who may we thank for referring you? _____

Present health challenge: _____

If child does not currently have a health challenge please indicate here with an "X" _____

If yes, please provide brief history: _____

_____

Is your child experiencing pain? _____

What makes it worse? _____ Better?_____

Other Health Care Professionals seen for this problem?

Chiropractor: _____

Medical Doctor: _____

Other: _____

Please list medications: _____

Were there complications during pregnancy? Y or N If yes, please list _____

_____

Did mom or dad smoke during the pregnancy? Y or N If so, who _____

Was the baby ever in breech presentation? _____

## Birth and Delivery

Where was the baby born? (Please circle) Home Hospital Birthing Center Other_____

Was delivery: Vaginal C-Section Were devices used? Y or N If yes, Forceps or Vacuum

How long was labor? _____ How long was delivery? _____

Was Oxytocin/Pitocin used? Yes or No Was an epidural administered? Yes or No

## Infancy

Was the child vaccinated? _____ Were there any prolonged use of medications or inhaler? _____

## Childhood Years

Did the child have childhood illnesses? _____ if yes, which? _____

Play Sports? _____ If yes, which? _____

Had surgery? _____ If yes, explain _____

Fallen from a height over 3 ft? _____ If yes, explain _____

Involved in car accident? _____If yes, explain _____

Prolonged use of meds? _____ If yes, explain_____

Emotional Traumas? _____ If yes, explain _____

Other information that may be helpful _____

_____

_____

## Payment/Billing Information

Insurance Self-Pay (Cash) Personal Injury/Auto Other _____

Responsible Party

Self/Other _____

Other than self

Name:_____

Address: _____

Phone:_____

## CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. _____ and whomever he/she may designate as his/her assistants to administer treatment as he/she so deems necessary to _____.

Printed name of person authorizing treatment: _____

Signature:_____Date:_____

Relationship to patient: _____

Witnessed: _____

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# PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand & agree with how your records will be used. 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.

1. The patient understand & agrees to allow Compass Chiropractic & Wellness to use their PHI for the purpose of treatment, payment, healthcare operations, & coordination of care. As an example, the patient agrees to allow his/her chiropractic office submit requested PHI to the Health Insurance Co. (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time & request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI, however; our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right of privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies & procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
8. Our office may contact you periodically regarding appointments, treatments, products, services or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at this time.
9. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
10. This notice is effective on the date stated below.

* Please list any persons that we are able to release information to. This information could include, but is not limited to scheduled appointments, financial, &/or health information.

**Family & Friends:**

1._____Relation:_____
2._____Relation:_____
3._____Relation:_____
4._____Relation:_____
5._____Relation:_____

**Physicians, Insurances, &/or Attorneys**

1._____
2._____
3._____
4._____
5._____

I have read & understand how my Patient Health Information will be used and I agree to these policies & procedures.

_____ _____
Name (Signature) Date

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# General Patient Information – Consent to Chiropractic Examination
# Acknowledgment of Financial Responsibility

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

## PATIENT'S RIGHTS

Compass Chiropractic & Wellness respects the unique differences of our patients, and will ensure that health care ethics are maintained for all patients. The following rights will be exercised on our patient's behalf.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to and is encouraged to obtain from his/her doctor relevant, current, and understandable information concerning diagnosis, treatment and prognosis.
3. The patient has the right to know the identity of their doctor and all office staff involved in their care.
4. The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the consequences of this action.
5. The patient has the right to every consideration of privacy.
6. The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases when reporting is permitted or required by law.
7. The patient has the right to expect reasonable continuity of care when appropriate and to be informed by the doctor and/or senior Intern of available and realistic patient care options.
8. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution.

## INFORMATION ABOUT CHIROPRACTIC MANIPULATION

The Nature of the Chiropractic Adjustment

The primary treatment used at Compass Chiropractic is spinal manipulative therapy. It is likely that spinal manipulative therapy will be used as part of your treatment. Spinal manipulative therapy includes use of the doctor's hands and mechanical instruments upon your body in such a way as to mobilize your joints. This movement may cause an audible "pop" or "click" such as experienced when you "crack" your knuckles. You may also feel a sense of movement.

## THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENT

All patient care, including chiropractic treatment, has the potential for negative effects. The risks associated with chiropractic treatments include, but are not limited to, dislocations and sprains, disc injuries, fractures, and strokes. These negative effects are very rare and will be fully explained to you by your doctor after the examination has been completed and a treatment plan has been developed. Your doctor will formulate a treatment plan and will recommend what they feel is in your best interest.

## THE PROBABILITY OF THOSE RISKS OCCURING

Fractures are rare occurrences and generally result from some underlying weakness of the bone which your doctor looks for during your initial consultation, your examination and while reviewing your x-rays. Stroke has been the subject of tremendous disagreement. The incidence of a stroke is exceedingly rare and is estimated to occur between one in one million and one in five million adjustments of the neck. The other complications are also generally described as rare.

## THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care & prescription drugs such as anti-inflammatory, muscle relaxants & pain-killers
- Physiotherapy
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care physician.

## THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED

Remaining untreated may allow the formation of adhesions and reduce mobility of your joints which may set up a pain reaction further reducing mobility. Over time this process may compromise your recovery making treatment more difficult and less effective the longer it is postponed.

## FINANCIAL RESPONSIBILITY – PAYMENT & INSURANCE

I understand and agree that the health and accident insurance policies are an arrangement between the Insurance carrier and me. This office 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 this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable

## MISSED NO SHOW APPOINTMENTS

**Chiropractic Appointments** - When we book your appointment, we are blocking time especially for you! We ask that you please call the office as soon as possible if you find you cannot make your appointment time. Repeat No-Show/No-Call offenses will be charged a fee of $25.

**Massage Appointments –** We ask for 24 hours' notice if you cannot make your massage appointment. Please note that if you miss your massage appointment, you will be charged for the massage – no exceptions.

## ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to issue payment check(s) directly to Compass Chiropractic & Wellness rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## THE CHIROPRACTIC EXAMINATION

Prior to establishing a treatment plan the doctor must perform a Chiropractic Examination in order to determine the exact cause of your complaint. During the examination the doctor will perform some procedures or maneuvers intended to reproduce your symptoms which will allow for a better understanding of the nature of your condition and for the development of an appropriate treatment regimen. There is a slight possibility that these maneuvers may temporarily aggravate your symptoms.

****DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BOX AND SIGN.**

I have read [ ] or have had read to me [ ] the above explanations of Compass Chiropractic & Wellness operations and the nature of chiropractic examination and treatment. I have discussed it with _____ (doctor's name) and have had my questions answered to my satisfaction

By signing below I state that I want to investigate how chiropractic care can help me (*or the patient listed below to whom I am the legal guardian*) and consent to a chiropractic examination. Once a treatment plan is established I will have the opportunity to discuss the treatment plan with my doctor and to consent to the proposed care. I intend the consent to cover any examinations for my present condition and for any future condition for which I seek treatment at Compass Chiropractic & Wellness (*for the condition(s) of the patient listed below for whom I am the legal guardian*).

_____ _____

Patient's Signature/Parent for Minor Date Doctor's Signature Date