

The Back & Body CLINIC

www.backbodyclinic.com
info@backbodyclinic.com

487 Crockett Drive, Lewisville Texas 75057

Phone: 972-436-9785
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CHILDREN'S HEALTH HISTORY FORM (to be filled out by parent)

(This form is designed for children 12 years old and younger)

Date: _____

Patient's Name: _____ SS#: _____ Age: _____ Birth Date: _____

Race: African American American Indian Asian White Other _____ Ethnicity: African American Hispanic Indian Other _____

Child's Home Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Mother's Information

Father's Information

Name	Name
Phone Number	Phone Number
Occupation	Occupation
Employer	Employer
E-mail Address	E-mail Address

Parent's Marital Status: Married Divorced Widowed Single Names and Ages of siblings: _____

Has your child been treated by a Chiropractor before? Yes No If yes, please give details (such as the doctor's name, last adjustment and any treatment information) _____

Emergency Contact Name and Number: _____

HISTORY OF PRESENT ILLNESS:

Major symptom(s) or purpose of this appointment and date it appeared: _____

Which describes the pain? Achy Burning Dull Sharp Stiff Throbbing Tingling Numbness Sore Other _____

How would you rate your child's pain level? 0 1 2 3 4 5 6 7 8 9 10

How frequent is your child's pain? Constant Frequent Intermittent Occasionally

What does this prevent your child from doing or enjoying? _____

What makes the problem worse? _____

What helps relieve the problem? _____

Has your child ever had the same or a similar condition? Yes No If yes, when was the first time you noticed the problem and how did it originally occur? _____

Are there any other current conditions that may be related to your child's major symptom? _____

TELL US WHERE YOU HURT

PLEASE READ CAREFULLY: Mark the areas on your body where you feel your problem. Include all affected areas. If your symptoms radiate, draw an arrow from where they start to where they stop. Please extend the arrow as far as the problem travels. Use the appropriate symbol(s) listed below.

Ache: >>>>

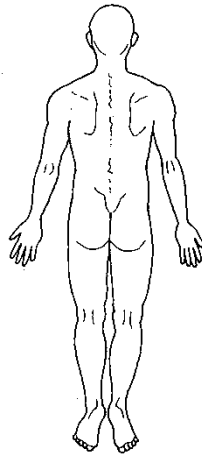
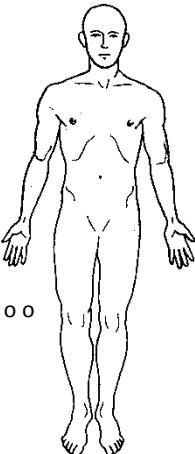
Numbness: =====

Burning: x x x x

Stabbing: /////

Throbbing: #####

Pins & Needles: o o o o



FOR OFFICE USE ONLY		
BP	O2	
H/W	BMI	
P	%	

PAST MEDICAL HISTORY

Please check those that apply to your child's birth

<input type="checkbox"/>	Mother Smoked In Pregnancy	<input type="checkbox"/>	Premature	<input type="checkbox"/>	Forceps/Vacuum Delivery	<input type="checkbox"/>	Epidural/Meds in Labor
<input type="checkbox"/>	Mother Drank In Pregnancy	<input type="checkbox"/>	Overdue	<input type="checkbox"/>	Breech Delivery	<input type="checkbox"/>	Very Short Labor
<input type="checkbox"/>	Mother Did Drugs In Pregnancy	<input type="checkbox"/>	Labor Induced	<input type="checkbox"/>	C-Section Delivery	<input type="checkbox"/>	Very Long Labor

Has your child ever been diagnosed as having or have suffered from? (Mark **P** for past and **C** for current)

<input type="checkbox"/>	Broken/Fractured Bones	<input type="checkbox"/>	Congenital Disease	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	Excessive Bleeding
<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Ruptures
<input type="checkbox"/>	Constipation/Diarrhea	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	Hernias

Has your child had any major illnesses, injuries, falls, auto accidents, or surgeries (include dates):

Has your child been treated for any health condition by a physician in the last year? Yes No If yes, describe _____

What medications or nutritional supplements is your child currently taking?

NAME	STRENGTH	FREQUENCY	NAME	STRENGTH	FREQUENCY

Does your child have any medicinal, environmental, or food allergies? Yes No If yes, describe: _____

Please list any other health problems your child has, no matter how insignificant they may be: _____

Who is your family medical doctor? _____ When doctors work together, it benefits you. May we have your permission to update your doctor regarding your care at this office? Yes No

FAMILY HISTORY

Has your family ever been diagnosed by these diseases?

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Diabetes 1 or 2	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Thyroid Disorder
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Tuberculosis

I, _____ give the doctors at The Back & Body Clinic authorization to examine, diagnose, and/or treat
(Parent/Guardian's name)

my child _____ with or without _____ present.
(Child's name) (Person's name)

Parent/Guardian's Signature: _____ Date: _____

Witness Signature: _____



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OFFICE POLICY

Welcome to The Back & Body Clinic. We appreciate the confidence you have shown by allowing us to be involved with your healthcare. It is our goal to do everything possible to make your care here as trouble-free as possible.

Because everyone prefers to “know the rules” in the beginning, we have attempted to set forth guidelines in regard to payment procedures. If you have any questions **at any time** in regard to your account, please do not hesitate to ask.

- **Payment in full is required** at the time services are rendered unless other arrangements are made
- There is a **\$25.00 fee for returned checks**
- Copies of **medical records require an advance notice of 3-5 business days** and **pre-payment is required**
 - Please note that these are usually requested by the insurance company and/or attorneys, and they are usually the ones to pay for these services. Any additional forms required from your insurance company (i.e. disability reports, questionnaires, etc.) or requests for medical records by other entities not directly related to the coordination of care will be charged as follows:
 - 1st form- Free
 - Any additional forms: \$25 + €50/page over 20
- **No refunds on credit balances are issued until all treatments are completed** and the patient has been released for care, unless other arrangements are made with the billing department.
- Any changes in address, phone numbers, employment, and/or insurance needs to be given to the front desk so that our records may be kept current. It is the **patient’s responsibility to notify us of any changes**, and the patient agrees to be responsible for any balances that may be incurred due to these changes.

PATIENT TYPE

Insurance:

Patients who have insurance coverage will be expected to pay their co-payment or co-insurance in full every visit, unless prior arrangements are made with the billing department. Please remember that the insurance contract is between the insured and his/her insurance company. If payment has not been received from the insurance company within **60 days**, the patient will be responsible for the unpaid balance and will be given any necessary paperwork for him/her to obtain reimbursement from the insurance company.

Time of Service Discount:

Patients who do not have insurance coverage, or choose not to use their insurance will be considered time of service discount patients. Payment is expected in full every visit, unless prior arrangements are made with the billing department

Medicare:

We accept Medicare assignment and are a participating provider. **Government policy requires all offices to file claims** for any services rendered to a Medicare patient. The services covered by Medicare and the supplementary or secondary insurance benefits vary. Our staff will be happy to verify coverage and discuss any specific information.

Personal Injury:

Whenever personal injury protection (PIP) is available, we will file claims to the patient’s auto insurance. If the PIP benefits have been exhausted, we will file claims to the patient’s major medical insurance, or the patient will pay cash and seek any reimbursement available from the insurance company/companies. We typically do not accept 3rd party insurance as a form of payment, but consider it on a case by case basis.

Veterans:

We are in network with the veterans choice program and accept authorizations from TriWest. Visits that are not covered by your authorizations will be charged to you with our time of service discount, or billed to your private insurance company.

Workman’s compensation- Effective March 01, 2005, we no longer accept Worker’s Compensation cases. If you feel your injury may be work-related in any way, please let us know so that we may refer accordingly.

FINANCIAL POLICY

All financial arrangements must be made through the billing department. I understand, agree and acknowledge that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this chiropractic 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 upon receipt. **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, any fees for professional services rendered to me will be immediately due and payable. Furthermore, balances that are outstanding for >90 days may be turned over to a collection agency. If your account is turned over to collections, an additional administration fee will be added to your balance.

Due to the complexities of nature, no doctor can promise you specific results. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Because of this, **I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment even if I am not satisfied with the results of my care.**

Some insurance companies have recently begun to determine that some charges (including manipulations) are not "medically necessary". They have done this in spite of the fact that benefits were correctly verified and even after payment has been issued on these same services for prior dates of service. Therefore, we have found it necessary to add the following statement to our office policy. Please be aware that should this happen, you will be charged the time of service rate for these charges, and we will work with you any way that we can.

"Should my insurance company determine that any treatment I receive at this office is not medically necessary or not covered by my policy and states in writing before the service or supply was given, I hereby agree to be financially responsible for those charges."

I do understand that the above referenced office will release my Protected Health Information to insurance carriers and other health care providers for the purpose of treatment, payment and/or health care operations. This document shall act as my written authorization for this act of disclosure of my Protected Health Information. Without written authorization, information may be disclosed according to Texas law that overrides HIPPA rules regarding: child abuse, neglect, domestic violence, or other accidents under Texas law, workers compensation cases, or an emergency.

I further authorize Matthew W. Gilbert, D.C. and/or The Back & Body Clinic, its authorized agents and employees to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and the said office of The Back & Body Clinic at the request or within the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Please sign and date below acknowledging that you have read, understand, and agree with the policies stated above.

Parent/Guardian Signature

Date

Witness Signature

Date



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INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialties of chiropractic, osteopathy, and medicine. Chiropractic healthcare seeks to resolve health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic healthcare services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative power. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS, and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

In coming to the doctor of chiropractic, a patient gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or healthcare if he is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through healthcare procedures the condition from which he is suffering: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regimen.

PREGNANCY WAIVER

In the event that X-Rays are needed, I hereby acknowledge that The Back & Body Clinic has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy. I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions that do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

I have read and understand the foregoing. I hereby authorize and release the doctor and whomever he may designate as his assistants to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I further authorize the doctor to disclose all or any part of my patient records to any person or corporation which is or may be liable under a contract to the office, the patient or to a family member or employer of the patient for all or part of the clinic's charges, including and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.

Signature

Date



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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 and 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 PHI we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (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 or her own health records at any time and 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. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only to be obtained one time for all subsequent care given 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 to 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 and 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.

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

Patient Signature

Date



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ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay The Back & Body Clinic as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

Patient Signature

Date