Schmidt Chiropractic Center

PEDIATRIC PATIENT INTRODUCTION

Child's Name______________________ DOB __________ Mother' Name ______________________

Address______________________________________Father's Name______________________

City/Town______________State__________ Zip__________Home Phone ______________________

Mother's Work Phone______________ Mother's Cell Phone______________ Mother's Email______________

Father's Work Phone ______________Father's Cell Phone______________ Father's Email ______________

Referred by ____

Child's Birth Date__________ Age__________ Sex__________ Number of Siblings______________

Birth Weight __________ Birth Length__________Current Weight__________ Current Length __________

Third Trimester Presentation: (check box) ☐ Vertex ☐ Breech ☐ Transverse ☐ Face/Brow

Type of Birth: (check box) ☐ Normal Vaginal ☐ Forceps ☐ Cesarean ☐ Suction Cap or Vacuum

Location: (check box) ☐ Home ☐ Birthing Center ☐ Hospital

Problems During Pregnancy ____

Problems During Labor/Delivery ____

Apgar Scores: ______ _______ Was There Presence at Birth of: (check box) ☐ Jaundice (Yellow) ☐ Cyanosis (Blue)

Congenital Anomalies/Defects? ☐ Yes ☐ No If Yes, Please Explain ______________________

Infant Feeding: ☐ Breast ☐ Bottle If Bottle, Which Formula? ______________________

Number of Hours Sleeping Per Night: ______________Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Obstetrician/Midwife ____

Pediatrician/Family MD ____

Date of Last Visit ______________ Purpose ______________________________

Immunization ____

Number of Doses of Antibiotics Your Child Has Taken: During Past Six Months _______ During His/Her Lifetime______

Previous Chiropractor: ____

Date of Last Visit ______________Purpose ______________________________

Has Your Child Ever Been Treated On An Emergency Basis? ☐ Yes ☐ No If Yes, Please Explain ______________

Purpose Of This Appointment ____

Delivery/Birth History: ____

____

____

At What Age Did the Child:

Respond to Sound ______________ Follow An Object With His/Her Eyes ________ Hold Head Up ______________

Sit Alone ______________ Crawl ______________ Stand ______________ Walk Alone ______________

At What Age, If Ever, Did This Child Suffer From The Following Childhood Diseases?

Chickenpox ____________________ Mumps _____________ Measles ____________________ Rubella _____________

Rubeola ________________ Whooping Cough ____________ Other ______________ Other _______________________

Has the Child Ever Suffered From:

☐ Headache	☐ Orthopedic Problems	☐ Digestive Disorders	☐ Behavioral Problems
☐ Dizziness	☐ Neck Problems	☐ Poor Appetite	☐ ADD/ADHD
☐ Fainting	☐ Arm Problems	☐ Stomach Aches	☐ Ruptures/Hernia
☐ Seizures/Convulsions	☐ Leg Problems	☐ Reflux	☐ Muscle Pain
☐ Heart Trouble	☐ Joint Problems	☐ Constipation	☐ Growing Pains
☐ Chronic Earaches	☐ Backaches	☐ Diarrhea	☐ Allergies to:________
☐ Sinus Trouble	☐ Poor Posture	☐ Diabetes	☐ Allergies to:________
☐ Asthma	☐ Scoliosis	☐ Hypertension	☐ Allergies to:________
☐ Colds/Flu	☐ Walking Trouble	☐ Anemia	☐ Other _____________
☐ Colic	☐ Broken Bones	☐ Bed Wetting	☐ Other _____________

Has This Child Ever Suffered The Following Spinal Traumas?

☐ Fall in Baby Walker	☐ Fall From Bed or Couch	☐ Fall Off Skateboard or Skates
☐ Fall From Crib	☐ Fall Off Swing	☐ Fall Off Bicycle
☐ Fall From Highchair	☐ Fall Off Slide	☐ Fall Down Stairs
☐ Fall From Changing Table	☐ Fall Off Monkey Bars	☐ Other __________________________

Has This Child Ever Sustained An Injury Playing Organized Sports? ____________If Yes, Please Explain: _______

____

Has This Child Ever Sustained Injuries In An Auto Accident? ____________If Yes, Please Explain: ______________

____

Present History____

____

Hospitalization/Surgeries____

Medications ____

Accidents ____

Family History____

____

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AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Schmidt Chiropractic Center and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

SIGNED:___________________________ WITNESSED: _____________________________ DATE: ____________________

I realize that I am responsible for all fees charged by this office and I agree to pay for all services provided. X-Rays remain the property of this office.

SIGNED: __________________________________DATE: ____________________________

Schmidt Chiropractic Center

320 E Hill St, PO Box 215
Norwood Young America, MN 55368

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

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 your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment.

The nature of chiropractic adjustment: The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your own knuckles. You may also feel a sense of movement.

Examination and Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Orthopedic testing
- Range of motion testing
- Basic neurological exam
- Muscle strength testing
- Ultrasound
- Radiographic studies
- Rehabilitation/core strengthening
- Nutritional therapy
- Mechanical traction/flexion distraction
- Other_______________________________

We will explain these procedures to you and answer any questions you have about them.

The material risks inherent in chiropractic adjustment: Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

The probability of risks occurring:

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.
Fracture: Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient.
Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.
TIA/Stroke: According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.
Other complications: These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.
The availability of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants, and pain killers
- Hospitalization
- Surgery

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

The risks and dangers associated with remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Notices of Privacy Practices: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Consent to Release of Information:

- In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.
- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.
- I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.
- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: ________________________

I, ____, have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. **BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.** I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

I also grant permission to communicate my personal health information to others involved in my care for the purpose of treatment, results of tests and medical care at the following numbers.
Please specify your contact preference:
_____Home Phone:__________________________________
_____Cell phone:____________________________________ Text: Yes or No
_____Email:____

_________________ _____________________________________ _______________________________________

Date | Signature of patient or authorized person | Authority to act on behalf of patient (Proof Required)

Schmidt Chiropractic Center

320 E Hill St, PO Box 215 - Norwood Young America, MN 55368

www.schmidtchiro.net P: (952)467-2505 F: (952)467-9104

Dr. Julie Schmidt, DC & Dr. Nick Heckmann, DC GTS

Financial Policy

Participating Health Insurance

This clinic is a participating provider with the following insurances (these are subject to change at any time, and may include other healthcare plans):

- Blue Cross Blue Shield of Minnesota
- Preferred One Products & Select Care/Laborcare
- Medica, Principal Financial Group, United Health Care, Great-West Healthcare (Including Senior Plans)
- HealthPartners, Ucare, Cigna Health Care, Patient Choice (Including Senior Plans)

It is the responsibility of the patient to verify insurance coverage for chiropractic care. Benefits quoted are a general outline and are not a guarantee of payment. As a provider, the clinic cannot hold a patient responsible for any usual and customary provider reductions. Depending upon your plan, you may be responsible for a percentage, copay and or deductible at each visit. Services that are not covered by your healthcare plan's chiropractic benefits, and are not eligible for reimbursement, are your financial responsibility. Copays are due at time of service. If patient account is 90 days delinquent, the account will be turned over to a credit agency.

☐ I choose to have the clinic submit my chiropractic treatments to my health insurance.

____

Patient Signature Date

____

Printed Name

Time Of Service Discount- Cash Rate

Patients without medical insurance, or those who have insurance and choose not to utilize their insurance benefits, are required to pay for their chiropractic treatment the same day that treatment was received at this clinic. By paying same day, you will be eligible for a ***Time of Service*** discounted rate of $52.00 per treatment. By law, our clinic is also required to administer an initial exam. The cash rate for this one time initial exam service is $100.00. You may also be responsible for services including, but not limited to: soft tissue massage prior to treatment and the spinal/extraspinal adjustments. Time of Service cash rates do not apply toward your annual out-of-pocket spending limits or yearly deductible. Cash, checks, all major credit cards or HSA/Flex spending cards are all forms of cash payments. If patient account is 90 days delinquent, account will be turned over to a credit agency.

Please note: Time of Service discounted rate fees will not be submitted to any insurance.

☐ I choose to pay the *Time of Service Rate* of $52.00 for my chiropractic treatments.

____

Patient Signature Date

____

Printed Name