

## ABOUT THE CHILD PATIENT

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Gender  M  F  
 Significant Other's Name \_\_\_\_\_ Kid's Names and Ages \_\_\_\_\_  
 Your Employer \_\_\_\_\_ Type of Work \_\_\_\_\_  
 e-Mail Address \_\_\_\_\_ Have you been to a chiropractor before?  No  Yes  
 Emergency Contact \_\_\_\_\_ ph # \_\_\_\_\_  
 Name of Medical Doctor(s) \_\_\_\_\_

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Kiekhoefer Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? \_\_\_\_\_
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is:  Cash  Check  Credit Card  Car/Work Ins.

\_\_\_\_\_  
 Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

## REASON FOR SEEKING CARE

**PRESENT COMPLAINTS**

1. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

2. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

3. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

4. \_\_\_\_\_ How long has this been an issue? \_\_\_\_\_  
 Is it:  Dull  Sharp  Ache  Numb / Tingle  Stabbing  Constant  Occasional  Staying the same  Getting worse  
 Mild  Moderate  Severe  Worse in the morning  Worse in evening  Pain radiates to \_\_\_\_\_

5. Does your condition affect:  Sleep  Work  Daily Routine  Sitting  Driving

6. What makes it better? \_\_\_\_\_

7. What makes it worse? \_\_\_\_\_

8. What Doctor's have you seen for this? \_\_\_\_\_

9. Type of treatment: \_\_\_\_\_

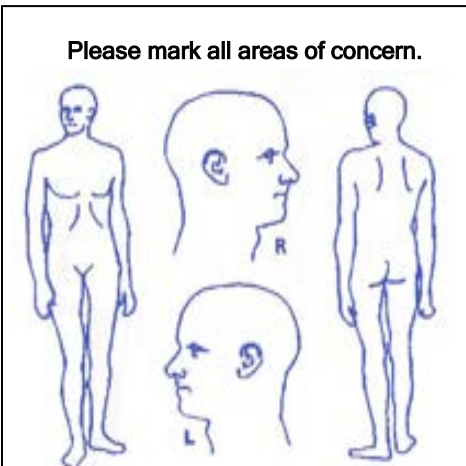
10. Results: \_\_\_\_\_

NOTES: \_\_\_\_\_

**Are you pregnant?**

Yes  No

Please mark all areas of concern.



## GENERAL HEALTH HISTORY-CHILD

Patient Name \_\_\_\_\_ *Mark the conditions that apply to you.*

**Past Present**

- Headaches
- Ear Infections
- Colic
- Allergies / Asthma
- Medication Side Effects
- Recurring Fevers
- Digestive problems
- Bed Wetting
- Chronic Colds/Sinus
- Other \_\_\_\_\_

**Past Present**

- Vision Problems
- Sleeping Problems
- Growing Pains
- Dental Problems
- Temper Tantrums
- ADHD
- Seizures
- Scoliosis
- Ever Needed Stitches

1. List any medications being taken: \_\_\_\_\_
2. Number of courses of Antibiotics child has taken in the last 6 mo. \_\_\_\_\_ Total during lifetime \_\_\_\_\_
3. Name of Pediatrician and Other Doctors: \_\_\_\_\_
4. Date of Last Visit \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Reason: \_\_\_\_\_
5. Name of Obstetrician/Midwife: \_\_\_\_\_
6. Location of Birth:  Hospital  Birthing Center  Home
7. Complications During Pregnancy:  No  Yes Explain: \_\_\_\_\_
8. Ultrasounds During Pregnancy:  No  Yes How Many: \_\_\_\_\_
9. Medication During Pregnancy / Delivery  No  Yes List: \_\_\_\_\_
10. Cigarette / Alcohol Use during Pregnancy:  No  Yes
11. Has any Doctor / Other Professional advised you to "Take the child to a Chiropractor ":  No  Yes, Name \_\_\_\_\_

## PAST HISTORY

12. List any past auto collisions: \_\_\_\_\_ Was any care received? \_\_\_\_\_
13. List any past falls bumps bruises: \_\_\_\_\_ Was any care received? \_\_\_\_\_
14. List any past sport, recreational, or home injuries: \_\_\_\_\_
15. Please describe any past conditions and treatment received: \_\_\_\_\_  
\_\_\_\_\_
16. Please list any past hospitalizations and surgeries: \_\_\_\_\_  
\_\_\_\_\_

## FAMILY HISTORY

- Father's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Mother's side:  Heart Disease  Cancer  Diabetes  Heavy Medication use  Arthritis  Other \_\_\_\_\_
- Is there any other family history you want us to know? \_\_\_\_\_



8619 West Point Douglas Rd., Suite 110  
Cottage Grove, MN 55016  
651-458-0094

#### Our Promise to You, Our Valued Patient

We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

#### Why a Privacy Policy?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of health information. This has challenged us to review not only how your information is used within our computers but also with the internet, phones, fax machines, and any device used to copy or transfer this data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our office adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that, without your written permission, your health information will not be used for any other purpose.

#### How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

#### To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

#### To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certifications, licensing, or credentialing activities.

#### Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with your patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as email (unless you tell us that you prefer not to receive reminders).

#### Public Health and National Security

As permitted or required by State or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

#### Family, Friends, and Caregivers

We may share your health information with those you tell us will be assisting you with your home care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

#### Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

#### Authorization to Use or Disclose Health Information

Other than what is stated above or where Federal, State, or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

#### Patient's Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and/or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003, and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed, and understand this policy.

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Legally Authorized Representative Signature

\_\_\_\_\_  
Print Name of Representative

\_\_\_\_\_  
Relationship to Patient

**I ACKNOWLEDGE THAT I DO NOT WISH TO OBTAIN A COPY OF THE HIPAA PRIVACY POLICY.**

\_\_\_\_\_  
Patient/Legally Authorized Representative Signature



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## Financial Policy

Welcome to our office! It is our mission to serve you to the best of our ability. Please read our financial policy, then sign and date it below. Thank you!

It is necessary for our office to have a copy of your insurance card(s) in your file. It is your responsibility to notify our office of any changes in your insurance carrier(s). We will verify your insurance coverage. However, insurance companies do make errors in reporting the coverage and benefits. They also have a disclaimer and state “this is not a guarantee of payment until we actually receive a claim”. We will file your claims with your insurance. However, it must be understood that your insurance contract is between you (the patient) and your insurance company.

**You are responsible for any amount not paid by your insurance company.**

Our office does not guarantee your insurance company will pay your claims. If you fail to respond to the insurance company’s request, you will be responsible for the full amount.

**Copays are due on the same date of service.** If this office needs to bill you for unpaid copays, you will be assessed an additional \$5.00 billing fee per monthly statement.

### Medicare Patients

Chiropractic Non-Covered Services	Reason Medicare May Not Pay	Estimated Cost
1. Chiropractic examinations	Items 1-5 are non-covered services and items under Medicare when delivered and/or ordered by a Doctor of Chiropractic	1. \$40-\$80
2. Chiropractic x-rays		2. \$60-\$120
3. Chiropractic extra-spinal adjustments		3. \$30
4. Therapy, such as ultrasound, electric stim., intersegmental traction, and rehab		4. \$20-\$30
5. Nutritional supplements, ice packs, pillows, and BioFreeze		5. \$1-\$100
6. Spinal manipulation	6. Medicare may construe your spinal manipulation to be maintenance care	6. \$45-\$80

**Delinquent accounts will be turned over to our Collection Agency.**

I have read the above policies and agree I am responsible for any amount not covered by my insurance company.

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE OR LEGAL GUARDIAN SIGNATURE



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### Insurance Information

#### *Patient Information*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F  
Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

#### *Responsible Party (if patient is a minor)*

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

#### *Insurance Information*

Primary Insurance Name (e.g. Blue Cross, UMR, etc.) \_\_\_\_\_  
ID # \_\_\_\_\_ Group Policy # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

If you have a digital copy of your ins. card, put the Provider service phone # on the back of your ins. card here:

\_\_\_\_\_

#### *Secondary Insurance Information*

Secondary Insurance Name \_\_\_\_\_  
ID # \_\_\_\_\_ Group Policy # \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

#### Assignment and Release

I hereby authorize payment of benefits be made directly to Kiekhoefer Chiropractic for services rendered to myself and/or dependents. I understand that I am responsible for any charges not paid by insurance. I authorize the release of any medical and billing information to my insurance company and the billing party named on behalf of me and/or my dependents.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If a minor, parent or guardian's signature \_\_\_\_\_

#### Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Kiekhoefer Chiropractic for any services furnished by this office. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my acceptance requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the approved claim form or electronically submitted claims, my acceptance authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services of this charge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_