Kowalski Chiropractic Health & Performance

4010 6th Ave. Suite A Kearney, NE 68845 & 316 Grand Ave. Ravenna, NE 68869
Kearney Ph: 308-455-1410 (Fax: 308-455-1411) **/ Ravenna Ph: 308-452-4500**
www.KearneyDC.com

Pediatric Member Information

Child's Name: _____ Date of Birth: _____ Age: _____ Sex: (M / F)

Parent's/Guardian's Names: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Parent's Cell Phone: _____ Parent's Work Phone: _____

Parent's Email: _____ (For newsletters and clinic updates)

Insurance Carrier: _____

Whom may we thank for referring you to our office? _____

Height (of child) _____ Weight (of child) _____ Siblings and ages: _____

Has your child received previous Chiropractic Care? (NO / YES)

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Family Doctor

Name: _____ Professional Designation: _____ Clinic Name: _____

Date and reason of last visit: _____ May we communicate with your family doctor regarding your child's care of necessary? (NO / YES)

What signals has your child's body been communicating?

__ Asthma
__ Respiratory Tract Infections
__ Sinus Problems
__ Ear Infections
__ Tonsillitis
__ Strep Throat
__ Frequent Colds/Croup
__ Recurrent Fevers
__ Colic
__ Tremors/ Shaking
__ Eczema
__ Rashes
__ Allergies
__ Food Sensitivities
__ Digestive Problems
__ Frequent Diarrhea
__ Constipation
__ Flatulence
__ Frequent Crying Spells
__ ADD/ADHD
__ Headaches/Migraines
__ Neck Pain
__ Torticollis
__ Trouble Feeding on One Side
__ Back Pain
__ Growing Pains
__ Scoliosis
__ Red, Swollen, Painful Joint
__ Failure to Thrive/ Slow Weight Gain
__ Autism
__ Slow or Absent Reflexes
__ Asymmetrical Crawling or Gain
__ Weight Challenges
__ Bed Wetting
__ Sleep Problems
__ Night Terrors
__ Tip Toe Walking
__ Regression of Milestones
__ Seizures

Do you have any specific concern that brings you in?

__ No, I am interested in having my child's nervous system assessed to achieve optimal health and functioning.

__ Yes: _____

*If **yes**, please answer the following questions:*

Does your child appear to be in pain or discomfort? _____ How long has your child been experiencing this? _____

Is it getting better, worse, or staying the same? _____ Was the onset sudden or gradual? _____

Have you seen other health professionals regarding this complaint? (NO / YES)

*If **yes**, whom*? _____

What treatments did they use? _____

Has your child taken any medication for this complaint? __ NO __ YES: _____

Has your child ever experienced this complaint before? __ NO __ YES: _____

Did they receive any treatment at the time? __ NO __ YES: _____

Has your child had x-rays in relation to the current complaint? __ NO __ YES: _____

Prenatal Profile

__ Adopted __ Prenatal history unknown __ Birth history unknown

Complications during pregnancy: __ NO __ YES (brief description): _____

Ultrasounds during pregnancy: __ NO __ YES (If so, how many)? _____

Medications during pregnancy: __ NO __ YES (If so, which ones and how often? Include OTC): _____

_____

Exposure to alcohol, cigarettes, or second-hand smoke during pregnancy: __ NO __ YES: _____

Birth Experience

Location of Birth: __ Home __ Hospital __ Birthing Center __ Other: _____

Birth Attendants: __ Doula __ Midwife __ GP __ OB __ Other: _____

Medications during labor/delivery? (Including IV antibiotics) __ NO __ YES: _____

Was Pitocin used to induce/speed up labor? (NO / YES)

Were your membranes ruptured by a medical professional? (NO / YES)

Was your child, at anytime during your pregnancy, in an intrauterine constraining position? __ NO __ YES __ UNSURE
*If **yes**, please describe*: __ Breech __ Transverse __ Face / Brow presentation

Type of delivery? (vaginal / cesarean section) If the delivery was **cesarean**, it was (planned / emergency)

If the delivery was **vaginal**, was the baby presented: __ Head __ Face __ Breech

Were any of the following interventions used during delivery? __ Forceps __ Vacuum Extraction __ Other: _____

Were there any complications during delivery? (NO / YES)
*If **yes**, please specify*: _____

How long was the labor from the first regular contractions to the birth? _____

How long was the second stage (*the pushing phase*) of the labor? _____

Was the baby born with any purple markings / bruising on their face of head? (NO / YES)

Any concerns about misshapen head at birth? (NO / YES)

Post Natal History

How many weeks gestation was the baby at birth? ___ weeks ___ days / Birth Weight: __ lbs. __ oz. / Birth Length: ___ inches

If known, APGAR scored at 1 minute: _____/10 5 minutes: _____/10

Was the baby ever administered to Neonatal Intensive Care? (NO / YES)
*If **yes**, for how long and why?* _____

Was any medication given to the baby at birth? (NO / YES / UNSURE)
*If **yes**, what medication and why?* _____

Child Health History (*answer only those which are applicable*)

How many hours does your baby sleep between feedings? _____ Day _____ Night

Does your child have a preferred sleeping position? (NO / YES): _____

Does your child have any feeding difficulties? (NO / YES): _____

Is your child currently being breastfed? ___ Yes (exclusively) ___ Formula Supplemented ___ No
*If **no**, how long was the baby breastfeed?* _____ weeks/months

Does your child have a one-sided breast preference? (NO / YES) if **yes**, they prefer (LEFT / RIGHT)

Does your child frequently spit up after feeding? (NO / YES)

Does your child cry often? (NO / YES) if **yes**, approximately how many hours per day? _____

Does your child pass a lot of gas? (NO / YES)

Does your child frequently arch his/her head and neck backwards? (NO / YES)

Has your child shown any sensitivities to foods either in your diet or their own? (NO / YES) _____

Is your child exposed to cow's milk/dairy? ___ No ___ Yes, formula ___ Yes, directly ___ Yes, I drink it and breastfeed

Has your child been exposed to antibiotics? (NO / YES)

Our goals are to provide a detailed assessment of your child's current health status and provide you the resources for a highly engaged and healthy child whose body is functioning at its absolute peak potential while they grow. Essential to this healthy growth is a nervous system functioning free from interference called subluxations, or spinal misalignments. You have taken an important step for your child's future through a chiropractic evaluation!

Consent to Evaluation of a Minor Child

I _____ being the parent or legal guardian of _____,
(print name of consenting adult) (print name of minor)

Hereby grant permission for my child to receive a chiropractic evaluation including history, spinal scan, examination, and x-rays if warranted. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date

KOWALSKI CHIROPRACTIC HEALTH & PERFORMANCE, LLC

Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days of receipt of the bill.**
- **In the event a bill is disputed, you must notify us within 30 days.** If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 18% per annum.** In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.
- All balances remaining **unpaid after 30 days may be reported to a credit bureau** and affect your credit rating.

Returned Checks

- It is our policy to collect **$25.00** for checks that are returned to us. This is to cover any fees that apply from the transaction

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding your account at any time. Please direct accounting questions to our front desk.

HIPPA Privacy Policy

- Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.
- By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.
- I authorize this office to allow family and friends looking for me to be given information as to my arrival or departure of the premises, and or leave a message for me if I have not arrived or am in with the doctor.

Designation of Authorized Representative

I do hereby designate Kowalski Chiropractic Health & Performance, LLC to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Kowalski Chiropractic Health & Performance, LLC. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make direct payment to you of settlement proceeds.
3. I hereby assign and transfer to you the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your service. I authorize you to prosecute said action either in my name. I further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance companies, whether it be all or part of what was due, I personally owe to you.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to Kowalski Chiropractic Health & Performance, LLC is paid in full.

_____ _____

Patient Signature **Date**

_____ _____

Doctor's Signature **Date**