



LAKELAND
CHIROPRACTIC

CHILDREN'S SURVEY

CHILD'S NAME _____

D.O.B. _____ PHONE _____

PARENTS / GUARDIAN _____

ADDRESS _____

REGARDING YOUR CHILD:

- | | | |
|--|---------|--------|
| Were there any complications during your pregnancy or delivery? | ___ YES | ___ NO |
| Was your child born by Caesarean Section? | ___ YES | ___ NO |
| Did the doctor or midwife use forceps or other delivery devices? | ___ YES | ___ NO |
| Did your child have colic or other problems early in life? | ___ YES | ___ NO |
| Did (or does) your child have ear infections frequently? | ___ YES | ___ NO |
| Did your child have any injuries or falls that concerned you? | ___ YES | ___ NO |
| Does your child complain of headaches, neck pain or back pain? | ___ YES | ___ NO |
| Does your child have any allergies or intolerances? | ___ YES | ___ NO |
| Is (or has) your child been a bedwetter? | ___ YES | ___ NO |
| Does your child have difficulty in concentrating? | ___ YES | ___ NO |
| Does your child have frequent temper tantrums? | ___ YES | ___ NO |
| Are there any other health problems that concern you? | ___ YES | ___ NO |
| When was the last time your child's posture was examined? | _____ | _____ |

REGARDING YOUR RELATIONSHIP WITH YOUR CHILD:

- | | | |
|---|---------|--------|
| Do you miss work often due to your child's illnesses? | ___ YES | ___ NO |
| Do you miss sleep often due to your child's illnesses? | ___ YES | ___ NO |
| Do you worry often about your child's health? | ___ YES | ___ NO |
| Do you have health problems that affect your family? | ___ YES | ___ NO |
| Are aches/pains preventing you from taking part in family activities? | ___ YES | ___ NO |





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CONSENT TO CHIROPRACTIC CARE

Chiropractic care is recognized as being an effective and safe method of care for many conditions. However, you must recognize that there are risks associated with all health care procedures which you should be informed about. All practitioners who adjust the spine are required to warn patients of material risks and seek informed consent for chiropractic care.

- Chiropractic adjustments of the spine are internationally recognized as being far safer in dealing with neck and low back pain than medication and many other alternatives. -

[A Risk Assessment of Cervical Manipulation, JMPT, 1994, Magna Report, Ontario Ministry of Health, 1993]

Please read the following carefully:

1. I acknowledge there are rare risks associated with chiropractic care which include, but are not limited to, muscle strains, joint soreness, nausea and dizziness, fractures, disc injuries, strokes (or like episodes), and an exacerbation and/or aggravation of the underlying condition.
2. I acknowledge that I am aware of the potential risks. I appreciate that results are not guaranteed and that fees charged for services rendered are not subject to challenge with regard to perceived effectiveness of the procedure.
3. I do not expect the practitioner to be able to anticipate all potential risks and complications associated with the proposed care plan.
4. I hereby acknowledge my consent to chiropractic care by my primary Chiropractor at Lakeland Chiropractic or any other chiropractor working in this clinic. I understand that I may withdraw consent at any time and that it must be done in writing.

We have an "open door adjustment policy". If you prefer to have the door closed during adjustments, please notify a staff member or the doctor during your appointment. We will be happy to accommodate your request.

Patient Signature
(Parent or Guardian to sign for patient under 18)

Chiropractor's Signature

Patient Name [printed]

Date



**LAKELAND
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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, email address, and your clinical records to contact you with appointment reminders, inclement weather cancellations, information about care alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left by voicemail or with the person answering the phone. We may also contact you by e-mail or mobile text message. By signing this form, you are giving us authorization to contact you with these reminders & information and to leave messages by phone, text message, or with individuals at your home or place of employment.

In order to do these accurately, please list your current mobile phone number _____

And e-mail address _____.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to access your health information in our office if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone with access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the care we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have retained a copy of this authorization.

Patient Name Printed

Date

Patient Signature

Authorized Provider Representative

Personal Representative Printed

Personal Representative Signature



LAKELAND
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OFFICE POLICIES

APPOINTMENT POLICY

Office visits are scheduled according to the severity of your condition and the program of care that your doctor feels is best for you. Because your condition requires numerous appointments over the next few months, we have designated a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume responsibility of adherence to the appointment program as it is designed for optimum results.

If for any reason, you are unable to keep your appointment, we require that you telephone immediately to reschedule that visit. It is the patient's obligation to **make up a missed appointment within 7 days of any cancellation**. Also, this office reserves the right to charge for missed appointments and those appointments canceled without 24 hours' notice.

We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. We want to be respectful of your time, and put forth the utmost effort to run *on time*. Occasionally, unforeseen clinical circumstances may arise that cause us to run behind. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

FINANCIAL POLICY

As a courtesy to you, our office will assist you in filing your health care claim with your insurance carrier. We must have accurate and complete information at the time of service. Read your policy and know its provisions as well as its exclusions. If there are any changes in your policy or coverage, it is your responsibility to inform our office staff so we can file your claims properly.

You are personally responsible for all fees for services provided not covered by your insurance company. The insurance company has a contract with you (and/or your employer) and not with the doctor. We will verify your coverage as a courtesy to you, but this is not a guarantee of benefits.

Our practice is committed to providing the best care for our patients at a reasonable rate. We charge what is **usual and customary** for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary.

All insurance assignment patients must pay their deductibles in full and the co-payment at the time of service.

We offer "**payment at time of service**" **cash discounts** for those who care to participate. This is an individual financial agreement. We ask that this confidential contract be kept between yourself and our clinic.

- Due to the nature of these discounts, **payment is legally required at the time of service**.
- Patient balances may not exceed \$200 at any time.
- Returned checks and balances over 30 days may be subject to additional collection fees and interest.
- All accounts not paid within 90 days will be put through to collections.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES FOR PATIENTS.

Signature _____ Date _____