Springtime CHIROPRACTIC

Putting the spring back in your step.

PEDIATRIC NEW PATIENT INFORMATION

Date: _____

PATIENT INFORMATION

Child's Name: _____ Child's Nickname: _____
Sex: M / F Date of Birth: _____ Age: ____ Child's SS#: _____
Child's Home Phone #: ___ _____
Child's Home Address: _____
City: _____ State: _____ Zip: _____
Reason for visit:_____

FAMILY INFORMATION

Parent's name(s): _____
Home Phone #: _____ Home Phone #: _____
Work Phone #: _____ Work Phone #: _____
List Ages of Other Children in Family: _____
Predominant language used at home: _____

INSURANCE INFORMATION

Policy Holder's Name: _____
Policy Holder's ID#: _____ Group #: _____
Policy Holder's Birth Date:_____ Insurance Company Name: _____
Policy Holder's Employer: _____

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CONSENT TO TREAT

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic treatment.

According to a study by the Rand Corporation, a serious adverse reaction from a neck adjustment occurs once in 1 million manipulations. In contrast, the journal of the American Medical Association found that more than 2 million Americans become seriously ill each year from reactions to currently prescribed drugs. 106,000 of those people die from the side effects.

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter named _____
As the examining / treating doctor deems necessary.

I understand the remote possibility of an injury to my child from a chiropractic treatment and elect him/her to receive the recommended treatment.

Parent's/Guardian Name: _____
Signature_____ Date: _____

Birth History

Today's Date:_____ Patient's Name: _____
Sex: M F Date of birth:_____ Age: ____

Labor and Delivery

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

How long was the 2nd stage (the pushing phase) of the labor? _____hours

	Yes	No	
Hospital birth	O	O	_____
Home Birth	O	O	_____
Midwife assisted	O	O	_____
Vaginal Delivery	O	O	_____
Planned C-section	O	O	_____
Emergency C-section	O	O	_____
Was birth induced (Pitocin)	O	O	_____
Forceps Delivery	O	O	_____
Vacuum Extraction	O	O	_____
Anesthesia administered	O	O	_____
Fetal Distress	O	O	_____
Meconium staining	O	O	_____
Head presentation	O	O	_____
Face presentation	O	O	_____
Breech presentation	O	O	_____

Birth weight: ____lbs/ kgs Birth Length: ____ins/cm Baby home on day: ____

Baby's Condition immediately after birth:

Apgar Scores: At 1 minute: ___ / 10 At 5 minutes: ___ / 10

Baby's Crying: Baby cried immediately after birth ___
Cried Strongly:____ Weak cry ___ Did not cry for ___ minutes

Baby's Color: Pink all over ____ Blue Face(Cyanosis)?_ ___ Blue hands/ feet ___
Jaundice(Yellow)?_____

Baby's activity: Arms and legs actively moving ____ Floppy baby ____

Congenital Anomalies/ Defects?_____
If yes, please explain:_____

Intensive Care: Was required ____ Days in neonatal Intensive Care Unit ___

Medication given at birth? _____

Vaccines administered? _____

Pregnancy History

Today's Date: _____Child's Name: _____ Sex: M F

Date of birth:_____ Age: ____ Mother's Name: _____

How many children do you have?___ What was the term of your pregnancy? _____wks

During your pregnancy, did you have any of the following:

	Yes	No	
Falls?	O	O	_____
Motor Vehicle Accidents?	O	O	_____
Near- miss MVA?	O	O	_____
High BP?	O	O	_____
Diabetes?	O	O	_____
Anemia?	O	O	_____
Morning Sickness?	O	O	_____
Indigestion?	O	O	_____
Seizures?	O	O	_____
Swollen ankles?	O	O	_____
Thyroid Problems?	O	O	_____
Heart Problems?	O	O	_____
Back Pain?	O	O	_____
Abnormal Bleeding?	O	O	_____
Were you hospitalized?	O	O	_____
Any other illnesses?	O	O	_____

During your pregnancy, did you use any of the following?

	Yes	No	
Tobacco?	O	O	_____
Alcohol?	O	O	_____
Non-prescribed drugs?	O	O	_____
Prescription Medications?	O	O	_____

Medications:_____ Reason:_____

Over-the counter meds? O O _____

Medications:_____ Reason:_____

Third Trimester Presentation: Vertex ____ Breech____ Transverse_____ Face/ Brow_____

Other Problems during pregnancy?_____

Problems during labor and delivery?_____

Pre-school History: 3 years to 5 years

Today's Date:_____ Patient's Name: _____ Sex: M F

Date of birth:_____ Age: ____ Current weight:_____ Current Length: _____

Obstetrician/ Midwife:_____ Pediatrician/ Family MD:_____

Date of Last Visit:_____ Purpose:_____

Has your child ever been treated on an emergency basis? __If yes, please explain: _____

Previous Chiropractor:_____ Date of Last Visit: _____ Purpose: _____

Purpose of this appointment: _____

The following questions are designed to help the doctor provide the best possible spinal care for your child.

Yes No

O O Does your child complain of pain or discomfort? If yes, when did this occur?_____

Was the onset: Sudden? O or Gradual? O Is the problem: Constant? O or Intermittent? O

O O Has your child ever had this problem before? _____

Health History

Yes No

O O Does your child ever complain of neck or back pain?_____

O O Does your child ever complain of pains in the legs or arms? _____

O O Does your ever complain of headaches? _____

O O Has your child had asthma? _____

O O Is your child allergic to anything? _____

O O Are there any smokers in the child's home? _____

O O Has you child had any earaches?____ At what age did the 1st earache occur?

O O Do your child's earaches tend to occur in the same ear? Right/ Left/ Both? _____

O O Is your child presently taking any prescribed mediation? _____

O O Has your child had any other illnesses? (List with dates)_____

O O Has your child ever been to a hospital or emergency room for evaluation or treatment?

_____

O O Has your child been recently vaccinated? _____

O O Do you have any other concerns about your child's health? _____

Number of hours sleeping per night? _____ Quality of sleep: Good ___ Fair____ Poor ____

***Has the child ever suffered from*:**

O Headaches	O dizziness	O fainting	O seizures/ convulsions	O heart trouble
O asthma	O colic	O scoliosis	O neck problems	O chronic earaches
O colds/flu	O backaches	O reflux	O joint problems	O orthopedic problems
O diabetes	O anemia	O constipation	O leg problems	O arm problems
O ADD/ADHD	O diarrhea	O digestive disorders	O sinus trouble	O Hypertension
O Muscle Pain		O walking trouble	O poor posture	O bed wetting
O stomach aches		O broken bones	O Growing Pains	O Ruptures/ Hernia
O poor appetite		O behavioral problems		

• Springtime Chiropractic •1001 S. Whitney Way • Madison, WI • 53711 •(608)274–6200•

Pre-school History: 3 years to 5 years

Today's Date:_____ Patient's Name: _____ Sex: M F

Nutrition

Yes No

O O Do you have any concerns of your child's diet? _____

O O Does your child have any digestive disturbances? _____

O O Does your child eliminate stools each day? _____

O O Does your child have any food allergies?_____

O O Does your child have any persistent or intermittent skin rashes?_____

O O Is your child receiving any vitamin supplements?_____

For how many months was your child breast-fed?_____

What does your child usually eat for breakfast?_____

What does your child usually eat for lunch? _____

What does your child usually eat for dinner? _____

What does your child usually eat for snacks/ desserts? _____

How much cow's milk does your child drink each day? _____

What is your child's favorite food? _____

What types of fast foods does your child like to eat? _____

Trauma

Yes No

O O Has child had any falls? _____

Circle one if child has had a fall from:

baby walker bed/couch crib highchair changing table swing slide bicycle monkey bars skateboard/ skates down stairs

If yes, describe the trauma and the date it occurred:_____

O O Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades or similar?

O O Has your child ever fallen down stairs or any height?_____

O O Has your child ever been in a motor vehicle accident or near miss? _____

O O Has your child ever had a bone fracture or joint dislocation?_____

O O Has your child had any other trauma or injuries?_____

O O Does your child ever bang his/ her head repeatedly against a wall, bed, or other object?

Number of doses of antibiotics your child has taken: Last 6 months? ____ During his/her lifetime? ____

Present History:

_____

_____ Immunization

History: _____

Surgery: _____

Medications: _____

Family History :_____ Page 2

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1001 South Whitney Way, Madison, WI 53711

PAYMENT POLICY

If your insurance policy provides for chiropractic services, this is our payment plan.

LIMITED ASSIGNEMENT: We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15th of the month. **Copays are due at time of service or a $10.00 surcharge will be added.**

If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) If you require an appointment after hours, there is a $50.00 emergency charge that is not covered by your insurance company. **Payment is expected at the time of service.**

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Springtime Chiropractic. It is therefore important that **you** contact your insurance company to know your specific chiropractic benefits.

Any charges not paid are considered delinquent. Delinquent charges will be assessed an interest rate of (10%) ten percent monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of $27.00 will be charged for any returned checks.

NO SHOW POLICY

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of $20.00 for the missed appointment.

Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy. Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

_____ _____

Patient or Guardian Signature Date

DR. JAMIE LENZ, DC, CCSP, CACCP
1001 S WHITNEY WAY
MADISON WI 53711
(608) 274-6200

NOTICE OF PRIVACY PRACTICES (HIPPA)

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or facility if it is necessary to refer you to them for diagnosis, assessment, or treatment of your heath condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder a message will be left on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization it will not affect the treatment 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.

Permitted uses and disclosures without your consent or authorization

Under federal law we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use or disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful purpose.
6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health and safety of a person or the public.
8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

10) We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Wisconsin's workers compensation laws.

Other than the circumstances described in the preceding examples, any other use of disclosure of your health information will only be made with your written authorization.

Marketing

Your Chiropractor and members of the practice staff may need to use your health information including your name, address, phone number and your clinical records for the purpose of marketing products and service to you. We are specifically requesting authorization to market the following products and/or services to you:

We may contact you by phone, mail, e-mail, fax, or other forms of electronic communication:

1) for appointment reminders and/or recall activities
2) with coupons for discounted services and/or products
3) announcing events, classes, or new products/services at our office

We may display inside our office:

1) pictures, cards, letters, drawings, artwork, recipes, jokes, testimonials, and/or things given to us by our patients or their families
2) acknowledgement of new patients, birthdays, anniversary's, and/or thank you for referrals.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or status of your account. We will do our best to accommodate any reasonable request if you would like receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. Your request to inspect and/or copy your health information must be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1) Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2) Those disclosures made to you.
3) Those disclosures we are permitted to make without your consent or authorization as described above.
4) Those disclosures made based on an authorization you signed.
5) Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6) Those disclosures for national security or intelligence purposes.
7) Those disclosures made to correctional officers or law enforcement officers.
8) Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw of modify your request.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notice. If we make a change to the terms of our privacy agreement we will notify you in writing when you when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will take any action against you if you do so. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

Dr Jamie Lenz
1001 S Whitney Way Madison WI 53711
Ph: (608) 274-6200 Fax: (608) 278-4586

This notice is effective as of September 9, 2009. This notice will expire seven years after the date upon which the record was created.

_____ _____
Patient Name (Printed) Date

_____ _____
Patient (or Representative) Signature Authorized Provider Signature

_____
Description of personal representative's authority to act for the patient

PEDIATRIC PATIENT HISTORY

Today's Date:_____ Patient's Name: _____ Sex: M F

Developmental History

Does or did your child have any of the following:

- □ Difficulty with crawling (on all fours)
- □ Did not crawl on all fours
- □ Difficulty learning to ride a bike
- □ Appears clumsy
- □ Difficulty learning to read
- □ Difficulty with writing
- □ Difficulty using utensils
- □ Difficulty buttoning clothing
- □ Difficulty tying shoes
- □ Difficulty or awkward with walking/running
- □ Poor hand-eye coordination
- □ Difficulty sitting still or paying attention

At what age did your child start to walk unassisted: _____

Comments:_____

_____

_____

Neurological/Other

Has your child ever been diagnosed by a medical professional with any of the following, if yes, by whom:

- □ Hearing loss or impairment
- □ Visual impairment
- □ Neurological disorders
- □ Anxiety/Depression
- □ Obsessive Compulsive Disorder (OCD)
- □ Autism/Autism Spectrum Disorder
- □ ADD/ADHD
- □ Tourette's Syndrome
- □ Dyslexia
- □ Other _____

Current/Past Medications and Treatment

List any medications that your child is taking:

_____

List names, dosage, frequency _____

_____

List any special dietary needs that your child has:

_____

_____

List any supplements that your child takes:

_____

List any treatment that your child is currently undergoing with any health professional:

_____

_____

List any special services that your child is currently receiving at school or privately: medications, or other medical treatment:

_____

List any previous chiropractic treatment, that your child has undergone:

Comments:_____

_____

_____

_____