

PLEASE PRINT

Child's Full Name: _____ Date: _____

My Child Identifies Their Gender As _____ Preferred Pronouns _____

Parent #1 Name: _____ Parent #2 Name: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Parent #1 Phone Work and/or Cell: _____

Parent #2 Phone Work and/or Cell: _____

Parent Email Address(es): _____

Birth Date _____ Sex _____ Birth Weight _____ Birth Length _____ Current Age of Child _____

Type of Birth: Vaginal ___ Forceps ___ Breech ___ Cesarean ___ Home ___ Birthing Center ___ Hospital ___

Medication taken during pregnancy? _____ Epidural: YES NO

Any problems during pregnancy and/or labor? There is more space on next page for additional information. _____

Apgar Scores: _____ Jaundice (yellow) at Birth? _____ Cyanosis (blue)? _____

Congenital Anomalies/Defects: _____

Infant Feeding: Breast ___ Bottle ___ Formula ___ Other Food or Drink Information: _____

No. of Hours Child Sleeps Daily _____ Quality of Sleep: Good ___ Fair ___ Poor ___

Explain: _____

Number of Siblings _____ Siblings Name, Age and Sex _____

Child's Age When Adopted _____ Date of Adoption _____

Known Health History of Child _____

Obstetrician and/or Midwife Name: _____ Location: _____

Pediatrician and/or Family MD Name: _____ Location: _____

Date of Last Visit to Dr: _____ Purpose of that Visit: _____

Immunization History: _____

Has your child ever been treated on an emergency basis? _____ Please Describe: _____

Purpose of the appointment today with the Chiropractor: _____

Pregnancy History: _____

Delivery/Birth History: _____

Developmental History – At What Age Did the Child: Childhood Diseases – Age of the Child When Occurred:

Respond to Sound _____
Crawl _____
Follow an Object with their Eyes _____
Hold Head Up _____
Stand _____
Sit Alone _____
Walk Alone _____

Chicken Pox _____
Rubella _____
Rubeola _____
Whooping Cough _____
Mumps _____
Measles _____
Other _____

Has this child ever suffered from (please check any that apply):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Backaches | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Allergies | <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Sugar Concentration | <input type="checkbox"/> Headaches | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Leg Problems |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Joint Problems |
| <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Chronic Earaches | <input type="checkbox"/> Colds/Flu |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Muscle Jerking | <input type="checkbox"/> Ruptures/Hernias | <input type="checkbox"/> "Growing Pains" |
| <input type="checkbox"/> Any Other Problem _____ | | | |

Present Health History or Additional Information: _____

Surgery Information: _____

Medications: _____

Accidents: _____

Family Health History: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices (posted in the office) and I have been provided an opportunity to review it. This document states that your medical information will not be given to anyone without your written permission.

Name: _____ Birth Date: _____

Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treats me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in the improvement of symptoms, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, prorated fees for unused, prepaid treatments will be refunded if you wish to cancel the treatment.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to self-administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants, and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name: _____

Patient Signature: _____ Date signed: _____

TO BE COMPLETED BY PATIENT S REPRESENTATIVE
IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient s Name: Name of Representative: _____

Date signed: _____ Signature of Representative: _____

Relationship or Authority of Patient's Representative: _____

LICENSED DOCTOR
Dr. Jessica Paige, B.S., D.C. DC-29172
1620 Westwood Drive, Suite D
San Jose, CA 95125
408-385-1849

Financial Guidelines

Thank you for choosing our office for your health care. Our office is dedicated to providing the finest quality health care with the best possible service available to you. Our financial guidelines are based on an open and honest discussion of our fees. Please read and sign this document.

Payment: We accept Cash, Checks, Visa and MasterCard. Payment for treatment is due **AT THE TIME SERVICES** are rendered. We do not send bills.

Initial _____

Financial Consent: The patient (guardian) agrees to be fully responsible for the total payment of the treatment performed in this office.

Initial _____

Minors: Payment for services of the treatment of minors is the responsibility of the adult accompanying the minor.

Initial _____

Missed Appointments: Your appointment time has been reserved specifically for you. If you choose to **CANCEL** or **RESCHEDULE** an appointment with **LESS THAN 24 hours notice**, by phone, online (Setmore) or email, or if you fail to appear for an appointment, **you will be CHARGED \$80** for that appointment. **We cannot make special circumstances for every individual therefore the policy pertains to all cash and insurance paying patients.** Insurance **WILL NOT** be billed for the missed visit. Both the Wellness Plans and Visit Plans have their own specific missed appointment policy (see them for 24 hour policy).

Initial _____

Late Arrival For Your Appointment: The office strives to maintain a punctual schedule. If you arrive **10 minutes** or more after your scheduled appointment time we CANNOT guarantee you will be seen at that time. **You will be rescheduled according to availability and subject to the 24 hour missed appointment policy.**

Initial _____

Past Due Charges: An interest charge of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be applied to your account if over 90 days past due. Any accounts which are over 120 days past due may be referred to our collection agency. Interest does not occur on the outstanding insurance portion as a courtesy to you. A charge of \$35.00 will occur for returned checks.

Initial _____

Collection Fees: Fees incurred to collect payment will be billed to and is payable by the patient.

Initial _____

I, the undersigned, have read the above financial guidelines, and agree to abide by these policies.

Sign and Print Name: _____

Date: _____

Insurance Acknowledgement Form

As a service to our patients, we will bill some insurance companies. As a reminder, your insurance policy is a contract between **YOU** and **YOUR INSURANCE COMPANY**. As a healthcare provider, **we are not a part of that agreement.**

*****Please verify your benefits with your insurance company, what they tell us is NOT a guarantee of coverage.**

In-Network Policy:

- In-network with ONLY Blue Shield of California PPO and Medicare (depending on which plan)

***As a courtesy to you, we will collect your **estimated** patient's portion at the time of your visit and bill your insurance company for the balance.

*****If your insurance company does not pay as expected, or delays payment beyond 90 days, you are responsible for the balance.**

***We are always available to answer your questions regarding this matter. If your insurance company adjusts our fees, the resulting balance will be your responsibility.

***Our goal is to help you achieve and maintain optimum health, which is not necessarily the goal of your healthcare insurance company.

***Medicare requires a separate ABN to be signed by card holders

Out-of-Network Policy:

- All other insurances are considered out-of-network
- We will provide a statement for you to submit directly to your insurance company
- Your insurance will reimburse you directly at the specific rate stated in your contract

*****Please notify our staff ahead of time if you are going to require the insurance specific statements for insurance reimbursement.**

I, the undersigned, have read the above insurance acknowledgement form, and agree to abide by this policy.

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Sign and Print Name: _____

Date: _____

Dr. Jessica Paige 1620 Westwood Drive, Suite D, San Jose CA 95125 (408) 385-1849 www.drjessicapaige.com

COVID-19 INFORMED CONSENT TO TREAT

1. COMPLETE TESTING, HEALTH and VACCINATION INFORMATION

- Patient Name: _____
- Have you ever tested positive for COVID-19? Yes No *If Yes:* Date diagnosed: _____ Hospitalized? Yes No
- Are you experiencing any of the following potential symptoms of COVID-19: 1) Fever, 2) Dry Cough, 3) Shortness of Breath, 4) Runny Nose, 5) Sore Throat, 6) Loss of Taste or Smell? Yes No
- Have you received a COVID-19 Vaccination: Yes No
If Yes, which Vaccine: _____ *Date(s):* 1st Dose: _____ 2nd Dose(if applicable): _____

2. REVIEW, CONFIRM UNDERSTANDING, CONSENT TO CARE - Initial in 4 places, Sign and Date

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my healthcare. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of healthcare during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. For example, I understand that given the nature of care, simply being in a healthcare office, where frequent patient appointments occur, may elevate the risk of contracting COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I knowingly and willingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic. I confirm all of my questions were answered to my satisfaction.

I have read, or have had read to me, the above COVID-19 risk informed consent to treat. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient
Signature: _____
[Parent or Guardian Signature if applicable]

Name: _____

Date: _____

Witness
Signature: _____
Witness

Name: _____

Date: _____