Dr. Jennifer Finn
Dr. Krysten Schab
203 Greenwood Ave Unit 2
Clarks Summit, PA 18411
(570) 586-3440

PEDIATRIC/CHILD VITAL INFORMATION

Child 's Name _____Date _____

Address_____

Date of Birth_____ Age_____ Sex at birth _____ Gender_____

Any other siblings? If so, how many _____

	Name of Parent/Guardian A (Main Contact)	**Name of Parent/Guardian B**
Name:		
Relationship:		
Cell Phone:		
Employer:		
Email:		

ADDITIONAL INFORMATION

Can we leave a detailed message on **Parent A** cell phone? _____ If alternate # please indicate _____

Can ***we leave appointment related info*** with anyone answering your phone? _____

Would you like to receive a text appointment reminder? _____

Do you give permission for the doctor to text you? _____

Would you like to receive *email updates* from the office and staff: _____ We promise not to spam!

How would you like to *receive bills for balances* on your account? *If you opt for email/text, you can submit payment online with a credit card. If you opt for mail, you will need to mail a payment back.
Check one of the following: ____Email ____Text ____Mail

How did you hear about Finn Chiropractic Center? _____If you were referred by someone, please let us know! We are grateful for referrals and would like to thank them personally!

PEDIATRIC/CHILD CASE HISTORY

Child 's Name _____

Reason for Seeking Chiropractic Care

Has your child ever received chiropractic care? _____ If so, date of last visit_____

Please **check** reason for care:
____ Wellness Focused ____ Problem Focused

If problem focused, please explain: _____
When was this problem first noticed? _____
How did the problem begin? _____
Problem is: ____getting better ____ getting worse ____staying the same

Please **check** any of the following conditions or concerns:

___ Ear Infections	___ Nursing Concerns	___Headaches	___ Pain
___ Reflux	___Digestive Concerns	___ADHD/Attention	___ Bedwetting
___ Colic	___ Behavioral Concerns	___Autism/Spectrum	___ Skin Conditions
___ Allergies	___ Seep Issues	___ Sports/Exercise	___ Asthma
___Constipation	___Diarrhea	___Communication	___ Dizziness

___Other: _____

If your child is complaining of **pain**, please indicate pain location: _____
Does the pain travel?_____ If yes, where? _____ What makes the pain better?
_____ What makes it worse? _____

Pregnancy & Birth History

Weeks pregnant at time of delivery _____Approximately how long did labor last? _____
Height _____ Weight_____ APGAR Scores _____
Name of Pediatrician_____ Date of last visit_____

Please **check** any of the following:
Artificially induced into labor? _____
Ultrasounds during pregnancy? _____
Any medications taken during pregnancy? _____ If yes, please list _____
Cigarette, Alcohol, Illicit/Recreational Drugs? ___ If yes, please list _____
Any Illness, Trauma, or other Complications during pregnancy/delivery? ___ If yes, explain _____

Check birth location **AND** if any of the following were administered during labor or birth?

___ Home Birth	___ Emergency Caesarean	___ Forceps	___Epidural
___ Birth Center	___ Planned Caesarean	___Vacuum Extraction	___Pitocin
___ Hospital Birth	___ Vaginal Delivery	___Episiotomy	___ Other _____

Feeding History

Please **check** any of the following:
Breastfed? ___ If so, for how long _____ Bottle Fed ___ If so, for how long _____
Formula Use? ___ If so, for how long **and** type _____
Introduced to solid foods at _____months Introduced to Cow's Milk at _____months
Allergies/intolerances to food?___ If yes, please list_____
Typical Diet:_____

Physical Stress

Please **check** any of the following:

___ Accident Prone	___ Surgery	___Bone Fracture or Dislocation
___ Incoordination	___Automobile Accident	___ Sports/Exercise

Explain any of the above: _____

Chemical Stress

Please list any current medications and/or supplements
_____
_____

Please indicate any vaccinations **and** whether vaccinations are up to date or on a delayed schedule

_____

_____ If vaccinated, please describe if any and all reactions:

_____

Please **check** any of the following:

___Exposure to secondhand smoke

___ History of antibiotic usage If so, what kind _____

___ Allergies If so, explain _____

Emotional Stress

Please **check** any of the following:

___ Loss of Loved One ___ Bullying ___ Relocation ___Academic Performance

___ Loss of Pet ___ Parent's Divorce ___ Birth of Sibling ___Other: _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the chiropractor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such chiropractic care to a third-party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

(Signature of Parent or Guardian)

FINN CHIROPRACTIC CENTER

INFORMED CONSENT TO CHIRPROACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other procedures including various modes of physical therapy, if necessary. I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here, **Dr. Jennifer Jaffe Finn, Dr. Krysten Schab** and/or other licensed Physicians of Chiropractic who may treat me now or in the future in this office.

The Nature of Chiropractic Treatment: The doctor will use her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, and others, may also be used.

Possible Risks: I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment. In the rare event there are specific risks pertaining to my individual case, the doctor will address these with me directly. The risks of complications due to chiropractic treatment have been described as "rare, about as often as complications are seen from the taking of a single aspirin tablet.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I intend to receive the recommended treatment, and hereby give my full consent to treatment.

To be completed by the patient's representative if necessary (if the patient is a minor or is physically or mentally incapacitated)

_____	_____	_____
Patient Name	**Signature**	**Date**
_____	_____	_____
Printed Name of Guardian Or Representative	**Signature**	**Date**

FINN CHIROPRACTIC CENTER

Consent for Use and Disclosure of Health Information

Date of Consent: _____

Patient Name: _____
Date of Birth: _____

By signing this form, I give this clinic, consent to use and/or disclose my protected health information (PHI) to carry out treatment, payment or health care operations.

I have the right not to sign this consent. If I refuse to sign this consent, this clinic may refuse to not provide me with treatment until I consent.

This clinic has provided me with a copy of its Notice of Privacy Practices which describes how this clinic may use and disclose my health information. I have the right to review this Notice before signing this consent.

This clinic may change the Notice of Privacy Practices as needed. I may obtain a current copy of this clinic's Notice of Privacy Practices by contacting this clinic's Privacy Officer.

I have the right to withdraw this consent at any time. I must do this in writing to this clinic. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then this clinic, by law, is unable to provide to me further treatment or follow-up, other than required emergency services.

This consent is good unless and until I withdraw it in writing.

_____

Signature of Patient or Legal Representative *Date*

FINN CHIROPRACTIC CENTER

Acknowledgment of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

_____

Name of Patient or Legal Representative *Date*

_____

Signature of Patient or Legal Representative *Date*

INSURANCE ASSIGNMENT POLICY STATEMENT

Dear Patient:

You have selected “INSURANCE ASSIGNMENT” as the method of choice to take care of your financial obligation with this office.

It is important that you realize that in this office we offer the option of ‘’INSURANCE ASSIGNMENT” strictly as a courtesy to our patients, and as a result, patients must understand and agree to the following:

1. That you are considered a” cash “patient until you bring in a current insurance card and this office qualifies and accepts your coverage.
2. That you are ultimately responsible for full payment of any and all services rendered.
3. That you must pay all deductibles in full.
4. That co-insurance and co-pays must be paid at the time of service, or at the end of each week if you are coming several times a week. You may pay with cash, check or credit card (except American Express). We also accept HRA Spending Account credit cards.
5. That if your carrier has not paid a claim within 60 days of submission, you are responsible for taking an active part in the recovery for your claim, and that after 90 days you will be responsible for payment in full of any outstanding balance.
6. If you have an outstanding balance on your account, we will bill you via mail. Any bills not paid within 60 days are subject to a $10 late fee. Any bills not paid within 90 days will be forwarded to a collection agency.

This insurance assignment policy must be followed, and we ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it, and you accept full responsibility.

Date: _____

Patient’s Name: _____

Patient’s Signature: _____

Witness: _____

FINN CHIROPRACTIC CENTER

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize **Dr. Jennifer Finn and/or Dr. Krysten Schab**, to administer chiropractic care as she deems necessary to my dependent minor child.

Child's Name: _____

Your Relationship to Child: _____

As of today's date, I have the legal right to select and authorize health care service for the minor child named above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office. I understand that if I am a legal guardian, I may be asked to provide proof of guardianship prior to treatment being rendered.

_____ _____

Date Phone

_____ _____

Parent/Guardian Signature Parent/Guardian Printed Name

Special Instructions:

This facility follows state guidelines regarding the treatment of minors. This state permits a minor to present for treatment without parent/guardian attendance, only with the consent of a parent/guardian.

List the name and relationship of individual(s) that may also bring my child in for care (grandparents, older siblings, etc):

Name	Relationship

In some instances, older minor children may present for care without a parent or other representation. This occurs commonly with students of driving age. Though it is required that a parent/guardian make the appointment for the minor, this facility must have permission to present for care at the scheduled appointment time without the responsible party (parent/guardian) present. By office policy, in this event, any treatment outside of what would be considered routine, the responsible party (parent/guardian) will be contacted and notified prior to the rendering of such service(s).

By signing below, I authorize my minor child to present for treatment without a parent/guardian present. I understand that myself or another parent/guardian are responsible for scheduling the minor child's appointment so as to confirm that I am aware the child is being treated.

I understand that I may make changes to this consent at any time, and to update or change the terms of this agreement, it is my responsibility to notify the front desk and request an updated consent form.

_____ _____

Parent/Guardian Signature Date

Consent for Use and Disclosure of Health Information to Family, Friends and Others Involved in Your Care

Patient Name: _____

Date of Birth: _____ Date of Consent: _____

By signing this form, I give **FINN CHIROPRACTIC CENTER** consent to use and/or disclose my protected health information (PHI) to my family, close friends, or others involved in my care and/or payment of my care pertaining to health information and treatment, appointments, and financial agreements. Please list the names and relationship of those individuals you would like us to share information with, as well as any restrictions.

Name	Relationship	Restrictions

I have the right to withdraw this consent at any time. I must do this in writing to **Finn Chiropractic Center**. This consent is good unless and until I withdraw it in writing.

_____

Signature of Patient or Legal Representative *Date*