Pediatric New Patient

melby chiropractic

Patient Information

Child's name _____ Today's Date ___/___/_____

Preferred name _____ Age _____ Birthdate ___/___/_____ Sex ☐M ☐F

Parent(s) names _____

Names of other Children _____

Street Address _____

City _____ State _____ Zip _____

Phone (_____)_____-_____ ☐Home ☐Work ☐Cell E-mail _____

How did you hear of Melby Chiropractic? _____

Health Information

Are you seeking treatment for ☐ Wellness checkup ☐ Specific condition _____

When did the symptoms begin? _____

Are the symptoms getting better or worse with time?_____

Has your child seen anyone else for this condition? Describe _____

Has your child ever seen a chiropractor before? ☐No ☐Yes Describe _____

Have you ever seen a chiropractor before? ☐No ☐Yes

Significant injuries or illnesses your child has had _____

_____

Who is your child's medical doctor? _____

Have there been any changes in the following habits:

☐ eating ☐ sleeping ☐ bowel ☐ bladder ☐ mood

Other/Explain: _____

Is your child currently taking any medication?

Medication Name	Dosage

Does your child have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

For Office Use Only

	4FS 3C 2T 2L CF&E Davis
	Norm N/CALL N/CE&X

Informed Consent for Chiropractic Care

Consent to Treat

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 treat 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 of 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 I 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 are 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 to 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.

Receipt of Privacy Policy

The Melby Chiropractic Privacy Notice includes a complete description of the uses and disclosures of my protected health information (PHI) necessary for the practice to provide treatment to me, and obtain payment for that treatment. It has been explained to me that the Privacy Notice will be available to me in the future at my request. Melby Chiropractic may use and/or disclose my PHI. I understand that I have a right to request that they restrict how my PHI is used; however, they are not required to agree to any restrictions that I request.

I understand that the office may need to contact me at times regarding office matters. I authorize the office to contact me in the following manner: by phone, email, or regular mail. Messages may be left on an answering device/voicemail, or with the person answering my phone.

I understand that this consent is valid for seven years. I further understand that I have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, Melby Chiropractic has the right to refuse to treat me. I understand that if I do not sign this consent evidencing my consent to the uses and disclosures contained in the Privacy Notice, then the practice will not treat me.

I have read and accept the Privacy Notice posted by Melby Chiropractic and authorize the use and/or disclosure of my health information in the manner described therein.

Electronic Health Records

I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Insurance Authorizations

I request that payment be made on my behalf to Melby Chiropractic for any services furnished to me. This is a direct assignment of my benefits under my policy. This authorization is in effect until I choose to revoke it.

I authorize the release of any and all pertinent information to any insurance company, adjuster or attorney involved in my case.

Signature of parent or guardian	Date
Printed name of parent or guardian	Relationship to patient
Signature of Doctor of Chiropractic: Jeffrey C. Melby, D.C.	Date