RIVER CITY CHIROPRACTIC

Welcome!

River City Chiropractic extends a warm and personal welcome to you on behalf of the doctor and staff. Our goal is to provide you with the finest health care as well as offer you many informative and entertaining educational opportunities.

CONFIDENTIAL PATIENT INFORMATION			Date: / /
Child's Name:		Parent/Guardian Name(s):	
Address:	City	State:	Zip Code:
Phone:		Other Phone:	
DOB:	Sex: M F	How did you hear about us?	
Who is your primary care physician?			
Is your child receiving care from any other health professional? ☐ Yes ☐ No -If yes, please name them and their specialty:			
Please list any drugs/medications/vitamins/herbs/other that your child is taking:			

CURRENT HEALTH CONDITIONS					
What health condition(s) bring your child to be evaluated by a chiropractor?					
When did the condition first begin? How did the problem start? Suddenly Gradually Post-Injury					
Has your child ever received care for this condition before? ☐ Yes ☐ No					
Is this condition: (Mark all that apply) ☐ Getting worse	☐ Improving	☐ Intermittent	☐ Constant	☐ Unsure	
What makes the problem better?		What makes the problem worse?			

Health Goals For Your Child	
What are your top three health goals for your child? 1. _____ 2. _____ 3. _____	What would you like to gain from chiropractic care? ☐ Resolving existing condition ☐ Overall wellness ☐ Both

Growth & Development History

Child's birth was: Natural vaginal birth Scheduled C-section Emergency C-section
How many week's your child born?

Please circle any applicable interventions or complications:
Breech Induction Pain meds Epidural Episiotomy Vacuum extraction Forceps
Other:_____

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ☐ Yes ☐ No
If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ☐ Yes ☐ No
-if yes, please explain:

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and /or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ☐ No ☐ Yes, on a delayed or selective schedule ☐ Yes, on schedule
- If yes, please list any vaccination reactions:

Night terrors or difficulty sleeping? ☐ Yes ☐ No
-If yes, please explain:

Behavioral, social or emotional issues? ☐ Yes ☐ No
-If yes, please explain:

Acknowledgement & Consent

Patient Signature: _____ Date: _____

River City Chiropractic
1109 E. Polston Ave.
Post Falls, ID 83854

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Guardian Financial Policy

River City Chiropractic

1109 E Polston Ave

Post Falls, Idaho 83854

208-777-4000

In the interest of good communication and our continued commitment to provide high quality Chiropractic care, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choice for your care.

We are committed to support you in understanding your spinal health and will always present you with the best recommendations to treat your personal situation. To make these services affordable we are pleased to offer you the following payment options.

1. Check or Cash
2. Visa, Mastercard, Discover, American Express
3. Payment Plan

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office—this includes any treatment that is not a benefit of any chiropractic insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received.

Please make your questions and concerns known to our Billing Manger who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party) _____ Date_____

Patient Health information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this.

1. The patients understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke a consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature (responsible party) Date