Sturgis CHIROPRACTIC
Specific Chiropractic

Dr. Stuart Johnson
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PATIENT INFORMATION

Patient Name _____
Address _____
City _____ Zip _____ State _____
Home Phone _____
Cell Phone _____ Provider _____
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ☐ Breast ☐ Bottle ☐ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES & ILLNESSES

Has your child ever suffered from (check all that apply)?:

- ☐ Allergies
- ☐ Anemia
- ☐ Arm Problems
- ☐ Asthma
- ☐ Back Aches
- ☐ Bed Wetting
- ☐ Behavioral Problems
- ☐ Broken Bones
- ☐ Chronic Earaches
- ☐ Colds/Flu
- ☐ Colic
- ☐ Convulsions/Seizures
- ☐ Delayed Speech
- D Diabetes
- ☐ Digestive Issues (constipation/diarrhea)
- ☐ Dizziness
- ☐ Fainting
- D Headaches
- ☐ Heart Trouble
- ☐ Hyperactivity
- ☐ Hypertension
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Joint Problems
- ☐ Leg Problems
- ☐ Neck Problems
- ☐ Neuritis
- ☐ Orthopedic Problems
- ☐ Paralysis
- ☐ Poor Appetite
- ☐ Ruptures/Hernias
- ☐ Sinus Trouble
- ☐ Tuberculosis
- ☐ Walking Problems

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

MEDICATIONS (list)

SURGERIES (list)

FAMILY HISTORY (list)

SIBLINGS

How many children do you have? _____ Number of pregnancies: _____

Children's' Ages: _____ Are you currently pregnant? ☐ No ☐ Yes, I'm due: _____

Childrens' health concerns: _____ Health concerns regarding this pregnancy? _____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

Please READ AND INITIAL the following:

Acknowledgement of Receipt of Notice of Privacy Practices: I have read/acknowledged the Notice of Privacy Practices for Protected Health Information. Notice of Privacy Practices is available at the front desk upon request.

Initials ____

Payment Policy: I acknowledge I am financially responsible for all charges incurred at Sturgis Chiropractic, P.C. It is the policy of this office that payment be made at the time of service for all services rendered. If the incorrect insurance is provided at the time of service, these visits will be considered self-pay.

If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will NOT be submitted to insurance and the patient is responsible for the associated fees.

Initials _____

Insurance Assignment: I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. If the incorrect insurance is provided at the time of service, these visits will be considered self-pay.

If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will NOT be submitted to insurance and the patient is responsible for the associated fees.

Initials _____

Signature of Patient or Parent/Guardian _____ Date _____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations, various modes of physiotherapy, shockwave treatment, diagnostic x-rays, massage therapy, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Sturgis Chiropractic and /or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers, including those working at the clinic or office.

I will discuss with the Sturgis Chiropractic provider and/or with other office or clinic personnel the nature and purpose of the procedures, if I choose to do so.

I understand, as 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, 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, dislocation and sprains. I do not expect the Sturgis Chiropractic provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor/health care provider to exercise judgment during the procedure which the doctor/health care provider feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. 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.

I further understand that there are treatment options available for my condition, these treatment options include, but not limited to self-administered, over the counter analgesics, bracing, rest or medical care. I understand 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 will ask the doctor/health care provider questions about its consent if I have any, and by signing below I agree to the above-named procedures. I consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____

INSURANCE ABN

Advanced Beneficiary Notice

Deductible needs to be met before services are covered.

To use insurance, you must have a neuromusculoskeletal injury or problem.

Insurance companies will say you have so many visits a year, but unless it is for an injury, our contract with the insurance company states: **"Services to be billed must be medically necessary."**

***Insurance only covers visits that are medically necessary, no maintenance/wellness or corrective care.**

*Insurance pays for one chiropractic visit a day when covered.

***Covered visits must be in a treatment plan with a current diagnosis and visits must be used within a certain time frame.**

*Treatment plan must be reasonable within healthcare guidelines showing progress.

*It is fraudulent to continue billing insurance once treatment plan is finished.

*Progress exams are a required part of treatment plan and not covered by insurance.

***The Gonstead Chiropractor seeks the cause of dis-ease through the use of X-ray analysis to deliver a specific adjustment.**

Non-Covered Charges:

SELF PAY ADJUSTMENT $50
PROGRESS EXAM $40
SELF-PAY REHAB $20
EXTREMITY ADJUSTMENT $15
ELEC STIM $20
SHOCKWAVE $60
CERVICAL X-RAYS $100
THORACIC X-RAYS $120
LUMBAR X-RAYS $120
FULL SPINE X-RAYS $160

_____ _____

SIGNATURE **DATE**