PEDIATRIC HEALTH QUESTIONNAIRE

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ Birthdate: _____Age:_____
Weight: _____ Height: _____ Male or Female: _____ Purpose for your Visit? _____

Other Doctors Seen for this condition?: No ☐ Yes ☐ *(If yes):* Doctors' Names and Prior Treatments*:* _____
_____

Check any of the following Conditions Your Child Has Suffered from During the Past Six Months:

☐ Ear infections	☐ Scoliosis	☐ Seizures	☐ Chronic colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive problems	☐ ADHD	☐ Recurring fevers	☐ Growing / Back Pains
☐ Weight loss	☐ Autism	☐ Learning disabilities	☐ Speech delays	☐ Toe walking
☐ Colic	☐ Bed wetting	☐ Car accident	☐ Temper tantrums	☐ Other _____

Family History of Chronic Health Issues:
Family Member: _____Health Issue: _____
Family Member: _____Health Issue: _____
Family Member: _____Health Issue: _____

Previous Chiropractor: _____
Date of Last Visit: _____/_____/_____ Reason: _____

Name of Pediatrician/Family Doctor: _____
Date of Last Visit: _____/_____/_____ Reason: _____

Are You Satisfied With the Care Your Child has Received There? No ☐ Yes ☐

Number of Doses of Antibiotics Your Child has Taken:
During the past Six Months: _____, Total During His / Her Lifetime: _____ List: _____

Number of Doses of Other Prescription Medications Your Child Has Taken:
During the past Six Months: _____, Total During His / Her Lifetime: _____ List: _____

Is your child vaccinated? No ☐ Yes ☐ Alternate Schedule ☐

Did your child have any of the following reactions to vaccinations?

☐ None	☐ Fever	☐ Rash	☐ Pain at injection site
☐ Fatigue	☐ Excessive Crying	☐ Vomiting	☐ Developmental Delay or Regression
☐ Seizures	☐ Diarrhea	☐ Other _____	

Has your child contracted any childhood diseases? (i.e chickenpox, mumps, measles, etc.)
If so, please list_____

Prenatal History:

Name of Obstetrician/Midwife/Doula?: _ _____

Complications During Pregnancy? No ☐ Yes ☐ *(If Yes)* List: _____

Ultrasounds During Pregnancy? No ☐ Yes ☐ *(If Yes)* Number: _____

Medications During Pregnancy? No ☐ Yes ☐ *(If Yes)* List: _____

Cigarette / Alcohol Use During Pregnancy? No ☐ Yes ☐

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

How long were you in labor? _____

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Ceasarian Section ,Emergency or Planned? _____

☐ Epidural ☐ Ptocin ☐ Pain medication

Reasons for interventions: _____

Complications During Delivery? No ☐ Yes ☐ *(If Yes)* List: _____

Genetic Disorders or Disabilities? No ☐ Yes ☐ *(If Yes)* List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Nutritional and Activity History:

Breast Fed: No ☐ Yes ☐ *(If yes):* How Long? _____Any Difficulty? _____

Formula Fed: No ☐ Yes ☐ *(If Yes)* How Long? _____ Type: _____

Introduced to Solids at: _____months old, cows milk at _____ months/years

Food / Juice Allergies or intolerances: No ☐ Yes ☐ *(If Yes)* List: _____

_____

Does your child eat any of the following:

☐ Dairy ☐ Sugar ☐ Gluten/wheat ☐ Eggs

☐ Soy ☐ Caffeine

List your child's 3 favorite foods _____

Does your child drink water? _____How many glasses a day? _____

Does your child play outside?_____ List child's favorite activities_____

Does your child play sports?_____ Which ones?_____

Does your child watch TV?

☐ No ☐ Rarely ☐ Weekly ☐ Daily

How many hours of sleep does your child get each night?_____ Quality of sleep: Good Fair Poor

Does your child take naps? _____Length of naps _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spine nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fell head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? No ☐ Yes ☐

Is / Has your Child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)

No ☐ Yes ☐ *(If Yes)* List: _____

_____

Has Your Child Ever Been Involved in a Car Accident? No ☐ Yes ☐ *(If Yes)* List: _____

Has Your Child Ever Been Seen on an Emergency Basis? No ☐ Yes ☐ *(If Yes)* List: _____

Other Traumas Not Described Above? No ☐ Yes ☐ *(If Yes)* List: _____

Prior Surgery? No ☐ Yes ☐ *(If Yes)* List: _____

Menarche: No ☐ Yes ☐ Age: _____

Is there anything else you would like to discuss with us at this point? _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Patient Name: _____ Birthdate: _____Age:_____

Address: _____
 # Street *City* *State* *Zip Code*

Mother's Name_____ Father's Name: _____

Email:_____

Home Phone: _____ Work Phone: _____

Insurance Company: _____ ID#: _____
Name *Address*

Name of Insured: _____ Policy #: _____Ins. Co. Phone #: _____

Who may we thank for referring you to our office? _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Total Wellness of NJ and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all services rendered by this office.

_____ _____
(Parent/Guardian Printed Name) *(Parent/Guardian Signature)*

_____
(Date)

I authorize the release of any and all medical records or other information necessary to process claims. I also request payment of benefits be made directly to Total Wellness of NJ. I am consenting to signing an open sign-in sheet every visit on behalf of my son/daughter and I understand that anyone who enters the office will be able to view his/her name on this sheet. The statements made on this form are accurate to the best of my recollection.

_____ _____
(Parent/Guardian Signature) (*Date)*

Total Wellness
of New Jersey
Your Health, Our Passion

781 Rt. 15 South, Suite 102 ♦ Lake Hopatcong, NJ 07849 ♦ (973) 663-5633

OFFICE POLICIES

Welcome to our office! We are here to enhance your life, help correct the cause of your problems and restore your health. It is our policy to accept only those patients whom we believe we can help, and those who are willing to help themselves by actively participating in their care and following our recommendations. To help you receive the greatest benefits from your care here at our office, please comply with the following…

A) YOUR CARE PLAN: At your report of findings, the doctor will determine a care plan that best suits your spinal needs. Your office visits are scheduled according to this care plan. The frequency of your visitation schedule is of paramount importance to your results. As such, you must assume the responsibility of strict adherence to your care plan as it is designed for optimum results. Your commitment to keeping your appointments is your part in the correction of your problem and the restoration of your health.

B) MISSED/CANCELLED APPOINTMENTS: If for any reason, you are unable to keep an appointment, please call as soon as possible to reschedule that visit. It is best to make that appointment up within 24 hours to maintain optimal correction. If you have chosen not to schedule appointments, care will be delivered on a first come first serve basis after those with scheduled appointments. Please remember that it is the frequency of visits that counts, not the days on which you receive them.

C) HEALTHY LIVING WORKSHOP: The purpose of this workshop is to inform, inspire and empower you to take control of your life and health with 5 key wellness strategies. We have found that patients who attend respond better because they understand the cause of their problem and what we are attempting to do to correct it. Attendance is strongly recommended in order to get the most out of your care and our office.

D) INSURANCE: The privilege of insurance assignment begins when our office receives your insurance forms.
1. Deductible payments MUST be made prior to insurance submittal.
2. You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.
3. All co-payments are payable when services are rendered or at the end of each week.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balance due will become immediately payable in full, regardless of any claims submitted.
5. Our office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office.
6. Since we do not own your policy, and, occasionally, we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation.
7. Ultimately, it is your responsibility to see that your account is paid.

Lastly, it is our goal to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know.

WELCOME TO OUR PRACTICE!!!

I, _____ have read and understand the above policies and agree to abide by them.

_____ _____

Signature Date Effective 2/28/2017

Authorization to Use or Disclose Protected Health Information

Patient's Name_____ E-Mail address:_____

Patient's SS#:_____ Date of Birth:_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES TOTAL WELLNESS OF NJ TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITHTHE FOLLOWING:

Your authorization is requested for purposes of delivering your care in an open-door adjusting environment. In the course of your care in this environment, routine details of your condition may be inadvertently disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addresses and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization.

I give permission to Total Wellness of NJ to use my address, phone number and clinical records to contact me with the appointment reminders, missed appointment notification, birthday cards, holiday related cards, holiday promotions, information about treatment alternatives or other related information.

I give Total Wellness of NJ permission to contact me at my work number.

If Total Wellness of NJ contacts me by phone, I give them permission to leave a message on my answering machine or voice mail.

I give Total Wellness of NJ permission to display my name, photograph, or testimonial for internal office use.

I give Total Wellness of NJ authorization to use my name in the office's newsletter; i.e. congratulations or birthday wishes.

I give Total Wellness of NJ authorization to send me an e-mail newsletter on a monthly basis. I am aware that other patients may gain access to my e-mail address.

By signing this form you are giving Total Wellness of NJ permission to use and disclose your protected health information in accordance with the directives listed above.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this authorization, Total Wellness of NJ will not refuse to provide treatment. However, if you refuse to sign this AUTHORIZATION, any services rendered on this day will be paid in full at the time of service.

A copy of the signed authorization will be provided to you, the original will be maintained by this office.

Signature:_____ Date:_____

If you are a minor or if you are being represented by another party, please provide the appropriate person's :

Name:_____ Date:_____

Relation to Patient:_____ Signature:_____

EXPIRATION

The authorization shall expire on the following date:_____, 2020.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke the AUTHORIZION is not effective to the extent that we have provided services or taken action in the reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Total Wellness of NJ. The written notice must contain the following information: Your name, Social Security number, and Date of Birth; A clear statement of your intent to revoke this AUTHORIZATION; the date of your request and your signature. The revocation is not effective until it is received by the Privacy Official.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. 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.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: As adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of the chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustment to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis

_____ _____

Signature Date

Total Wellness
of New Jersey
Your Health, Our Passion

OUT OF NETWORK CONSENT FORM

Patient Name: _____
Insurance Company: _____
Policy #: _____ Group #: _____

I hereby instruct and direct my insurance company to pay the professional or medical benefits directly to *Total Wellness of New Jersey* as payment toward the total charges for the professional services rendered.

If my current policy prohibits direct payment to *Total Wellness of New Jersey,* I instruct and direct my insurance company to pay the professional or medical benefits to myself, I shall endorse and then mail as follows:

Total Wellness of New Jersey
781 Rt. 15 South, Suite 102
Lake Hopatcong, NJ 07849

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective as the original.

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

I authorize Total Wellness of New Jersey to initiate a complaint, reopening, appeal or Fair Hearing on my behalf to the insurance company for adjudication as necessary to acquire full payment of the services represented on the claim.

Payments to TWNJ are required within 2 weeks of insurance being processed. If payments are not received within 2 weeks, we will then debit the following credit card on file for the amount allowed by insurance.

Cardholder Name: _____ Type of card: _____

Account #: _____ Security code: _____

Expiration Date: _____/_____/_____

_____ _____
Patient/Policy Holder Signature DATE

_____ _____
Witness Signature DATE

(OVER)

DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES

The law of the State of NJ and NJ Department of Health and NJ Department of Banking & Insurance require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Our Practice Participates With: **Medicare of NJ** 7500 Security Blvd., Baltimore, MD 21244

Facilities Our Practice Is Associated With: **TWNJ** – 781 Rt. 15 South, Ste 102, Lake Hopatcong, NJ 07849

Licensed Assistant Healthcare Staff: Dr. Tami Hartman-Stappas/Dr. Bret Hartman – both locations above

The above licensed healthcare professionals may perform assistant services on the patient base upon the treatment plan and needs of the patient.

If the patient's health plan is not listed above, the physician and/or facilities providing services **DO NOT PARTICIPATE** with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

MANDATORY DISCLOSURES:

1. I understand that the health care professional that I am seeking healthcare services from is **"out-of-network"** with and does not participate with my health insurance plan: **Patient Initials: _____**

2. I understand that the amount or estimated amount the health care professional will bill me or the covered person for services is available upon request. **Patient Initials: _____**

3. I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided. **Patient Initials: _____**

4. I understand that I will have a financial responsibility applicable to health care services provided by an **out-of-network** professional, in excess of my in-network copayment, deductible, or coinsurance and that I may be responsible for any costs in excess of those allowed by my health benefits plan. **Patient Initials: _____**

5. I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs. **Patient Initials: _____**

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgment of Receipt of Disclosures: OUT-OF-NETWORK PATIENTS

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will:

BY: _____ **Print Name:** _____ **Date:** _____