Bahnemann Family Chiropractic, PC: Pediatric Registration and History

Child's Name_______________________________________ Parent(s) Name____________________________________

Child's Date of Birth__________________ Age__________ M / F Height_________ Weight_____________

Address____ Home Phone (______) __________________

Parent's cell (_____) _________________Child's pediatrician and location____

Who told you about our office___________________________ Reason for today's visit_____________________________

Insurance Company Name: _____________________________ Insurance ID #: ___________________________________

BIRTH MOTHER'S PREGNANCY

Did the mother have any injuries during the pregnancy (accidents, falls, etc.)_______________________________________

Any treatment required during the pregnancy (chiro., PT, massage, etc.) ____

Any health problems during the pregnancy (diabetes, pre-eclampsia, bed rest, etc.)_________________________________

Any medications or drugs taken during the pregnancy__________________________________ Did the mother smoke_____

LABOR AND DELIVERY

Problems during labor and delivery____

Type of birth: Vaginal______ C-Section_____ Forceps_____ Vacuum Extraction_____ Home Birth______

Name of Hospital/Delivery Center_______________________________________ Was a Midwife or Doula used______

Length of labor______________________ Was labor induced_______________ Did the mother have an epidural_______

Baby's birth weight____________ Birth length___________ APGAR Scores__________ Length of Hospital stay_____

Problems with the baby after delivery____

CHILD'S HEALTH HISTORY

Health problems with the child now or in the past____

Accidents or injuries to the child (falls, car, sports, broken bones)____

According to the National Safety Council, approximately 50% of children fall head first from a high place during their 1st year of life (i.e. a bed, changing table, down stairs, etc.). Was this the case with your child? No Yes

Was the child breast fed____ If so, for how long_________ Was the child bottle fed____ For how long__________

Current milk: Breast____ Formula/Type_______________ Cow's milk-what %__________ Soy milk___ Rice milk___

Frequency of eating____________________________ Current food/snacks______________________________________

Any known food or environmental allergies/intolerances____

Current medications________________________________ Current behavior___________________________________

Number of hours of sleep per night_________ Quality of sleep: Good______ Fair________ Poor________

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

GENERAL SYMPTOMS Check symptoms the child currently has or has had in the past year

GENERAL
__ADD/ADHD
__Allergies
__Autism/Asperger's
__ Anemia
__Bed Wetting
__Behavioral Problems
__Bladder Infection
__ Broken Bones
__Cancer/Tumors
__Depression
__Diabetes
__Difficulty Sleeping
__Dizziness
__Dyslexia
__Epilepsy
__Fainting
__Growing Pains
__Heart Problems
__Hodgkin's Lymphoma
__Hyperactivity
__Juvenile Arthritis
__Nightmares
__Night Sweats
__Paralysis
__PDD
__Seizures
__Sensory Processing Challenges
__Speech Problems
__Stroke

EYE, EAR, NOSE & THROAT
__Pink Eye
__Vision Problems
__ Dizziness
__ "Crossed" Eyes
__Ringing in Ears
__Hearing Loss
__Earache
__Ear Infections
__Nose Bleeds
__Sinus Problems
__Bad Breath
__Colds-Flu
__Frequent Runny Nose

RESPIRATORY
__Asthma
__Bronchitis
__Pneumonia
__Mononucleosis
__Shortness of Breath
__Cough/Wheeze
__Repeated infections/colds

GASTRO-INTESTINAL
__Poor Appetite
__Excessive Appetite
__Bloating/Gas
__Indigestion
__Nausea
__Reflux
__Constipation
__Diarrhea
__Colitis/IBS
__Hernia

HEAD, NECK and SPINE
__Headaches
__Neck Pain
__Neck Stiffness
__Torticollis
__Midback Pain
__Low back Pain
__Back Spasms
__Scoliosis
__Muscle/joint pain

ARMS and HANDS
__Shoulder Pain
__Broken Collar Bone
__Erb's Palsy
__Elbow Pain
__Dislocated Elbow
__ "Little League Elbow"
__Wrist or Hand Pain
__Numbness or Tingling in arms

HIPS, LEGS and FEET
__Buttocks Pain
__Hip Pain
__Congenital Hip Dysplasia
__Knee Pain
__Ankle or Foot Pain
__Feet/Toes turn in or out
__Bow Legs or KnockKnee
__Walks on Toes
__Flat Feet
__Limp

SKIN
__Cradle Cap
__Baby Acne
__Eczema
__Psoriasis
__Hives
__Rash
__Bumps on back of arms or legs
__Dark circles under eyes or puffiness

CHILDHOOD ILLNESSES
__Chicken Pox
__Colic
__Croup
__Diptheria
__Measles
__Mumps
__RSV
__Rubella
__Tetanus
__Whooping Cough

OTHER:
____
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Authorization for care of a minor: I hereby authorize Bahnemann Family Chiropractic PC and its doctors to administer care as they deem necessary to my son/daughter/ward. I accept responsibility for payment for services rendered. The patient information given is true and complete to my knowledge. I authorize the doctor to take progress photos of my child to be kept in their medical chart.

Signature__________________________________ Relationship______________ Date___________

Witnessed____ Date_________________

Bahnemann Family Chiropractic PC
CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.
There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. ***The possibility of such injuries resulting from cervical spine manipulation is extremely remote***

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with
Kerri Bahnemann, DC and Bahnemann Family Chiropractic PC
(health care providers name).

Dated this________day of_________ 20

____ ____

Print Patient Name ***Print Witness Name***

____ ____

Patient signature (or Legal guardian) ***Signature of Witness***

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 consent form stating that you understand and agree with how your records will be used.

1. The patient 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 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.
8. From time to time we may send you birthday cards or letters use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.

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

____________________________________ ________________________

Patient Name Date

____

Patient / Legal Guardian Signature

Bahnemann Family Chiropractic PC

2024

PATIENT FINANCIAL POLICY

BAHNEMANN FAMILY CHIROPRACTIC, PC

Patient Name / Family: ______________________

Date completed: ___________________________

Thank you for choosing Bahnemann Family Chiropractic PC as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

The patient is expected to present an insurance card at their initial visit, and any time there are changes to their insurance company. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with us. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, ***it is the insurance company that makes the final determination of your eligibility and benefits***. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Participating Insurances

- **Blue Shield Federal Plans**
- **Blue Shield of CO & PPO Plans**
- **Medicare Part B**
- **TriWest VA authorized beneficiaries**

Non-Participating Medicare plans accepted

- **Humana**
- **Aetna**
- **Cigna**
- **United Healthcare**

Participating Insurances

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your insurance claims. If you have out of network benefits, they may pay a portion of your billed charges; however, you are ultimately responsible for any charges you incur while under care in our office.

Referrals and Preauthorizations

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. It is always the patients' responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Self-pay patients will be required to pay for their initial telemedicine history, in-office examination and treatment at the initial appointment. Payment arrangements are available if needed, and discounts are available ***when paid at time of service***. Please ask to speak with Dr. Bahnemann to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Motor Vehicle Accident (MVA) and Third Party Billing

We will bill your automobile insurance company for bodily injury care. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to report your injury to your insurance to open a medical payment claim. They may send you an accident questionnaire form to be completed by you. If the questionnaire is not returned to your insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

CANCELLATION OF APPOINTMENTS

If it is necessary to cancel a scheduled appointment, we require at least 3 hours advance notice.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 3 hour advance notice.

No-shows: a no-show is when a patient misses an appointment with no notice ***or shows up too late to the appointment to be seen***.

A **$40.00 fee** will be billed to your account for late cancellations and for no-shows.

Repeatedly missing visits jeopardizes your care. For this reason ***after an ESTABLISHED patient has two (2) late cancellations and/or no-shows or a NEW PATIENT has one (1) cancellation or no-show, they will be discharged from the practice.***

Extenuating circumstances will be considered in making this decision when clearly communicated to our office.

COMPLETION OF FORMS POLICY

In order for us to better serve you, we request that you are aware of the following:

Your insurance company will not be billed as insurance companies do not reimburse for the time and judgment that are required to complete these forms. **Please allow 7 business days for completion of forms.**

Payment is required prior to completion of all form(s)

The fee for completion of forms varies from **$20 to $40** depending on time and complexity. This includes summary of care, FMLA paperwork, or disability determinations.

- **Returned Checks**
  The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

  Medical Record Copies
  Patients or attorneys requesting copies of medical records will be charged:
  - $18.53 for the first ten pages (1-10)
  - $0.85 per page for the next 30 pages (11-40)
  - $0.57 per page for pages 41 and above (41+)
  - $10.00 additional fee for certification of medical records
  - Cost of portable media supplies, if applicable, i.e. CD or flash drive

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I understand the above-written financial policies and have had opportunity to discuss my concerns or questions, if I had any, to my satisfaction. Furthermore, I agree to abide by these financial policies for any services rendered to me at Bahnemann Family Chiropractic, PC.

______________________________ ______________________

Patient or legal guardian Signature *Date*

email: ______________________________ Cell/Home phone: ____________________

BAHNEMANN FAMILY CHIROPRACTIC, PC RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS AGREEMENT AT ANY TIME.
PATIENTS WILL BE LIABLE FOR THE TERMS OF THEIR MOST RECENTLY SIGNED AGREEMENT.