

Name of Parent _____	Name of Child _____ Date _____
Address _____	Address/Phone (if different from parent) _____
City/State/Zip _____	_____
Phone # (Work) _____ (Hours ___ to ___)	_____
Home # _____ Cell # _____	Phone # _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F
E-mail _____	Date of Birth _____ Age _____
Insurance Company _____	Medical Doctor _____
Policy ID# _____ Group # _____	Date of Last Visit _____

During pregnancy, were you on medication? Did you smoke or consume any alcoholic beverages?  Yes  No

If so, what? \_\_\_\_\_

Was there back pain?  Yes  No \_\_\_\_\_

Approximately how long was labor? \_\_\_\_\_

\_\_\_\_\_

Were you physically ill? (Colds, flu, allergies, German measles, anything like that?)  Yes  No

If so, what? \_\_\_\_\_

**Regarding Labor:**

Was it chemically induced?  Yes  No

Doctor assisted?  Yes  No

Was a C-Section performed?  Yes  No

Were forceps used?  Yes  No

Did doctor have hands on the infant?  Yes  No

Were you lying down?  Yes  No

Was family member present?  Yes  No

If so, who? \_\_\_\_\_

(95% of all infants were born with hands on or forceps)

Was the baby premature?  Yes  No

If so, what was his/her age and weight? \_\_\_\_\_

Has your child been vaccinated?  Yes  No

Was your child breastfed?  Yes  No If yes, for how long? \_\_\_\_\_

**Did your child suffer any health problems, such as:**

- Headaches  Yes  No
- Allergies  Yes  No
- Ear Problems  Yes  No
- Sleeping Disorders  Yes  No
- Breathing Problems  Yes  No
- Fatigue  Yes  No
- Irritability  Yes  No
- Hyperactivity  Yes  No
- Frequent Colds  Yes  No
- Flu  Yes  No
- Bloody Noses  Yes  No

- Meningitis  Yes  No
- Diarrhea  Yes  No
- Constipation  Yes  No
- Colic  Yes  No
- Rashes  Yes  No
- Milk or Lactose Intolerance  Yes  No
- Bed Wetting  Yes  No
- Digestive Problems  Yes  No
- Latching Difficulty  Yes  No

Other: \_\_\_\_\_  
\_\_\_\_\_

**Regarding your child today:**

- Is your child accident prone?  Yes  No
- Has the child had any falls down steps?  
 Yes  No
- Has your child ever fallen from heights over 2 feet?  
 Yes  No
- Has your child ever been involved in a motor vehicle accident?  
 Yes  No
- Has your child ever been hospitalized or had surgery?  
 Yes  No
- Does your child suffer from:
  - Allergies  Yes  No
  - Asthma  Yes  No
  - Headaches  Yes  No
- Has your child ever had any broken bones or sprain injuries?  
 Yes  No
- Is your child on any medication?  Yes  No
- If so, what? \_\_\_\_\_

- Has your child had a scoliosis examination by an approved Scoliosis determination procedures clinic?  Yes  No
- Is your child hyperactive?  Yes  No
- Have learning disorders?  Yes  No
- Sleeping difficulty?  Yes  No
- Poor posture?  Yes  No
- Does your child have any problem associating with friends?  
 Yes  No
- Is your child nervous, or has anyone suggested that your child was nervous?  Yes  No
- Does your child show any signs of nervousness, twitching or excessive talking to themselves?  Yes  No
- If you could improve one aspect of your child's health or behavior, what would it be? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION

I, \_\_\_\_\_, certify that Dr. Teresa Melton does not claim to cure any illness or disease. I understand that I am to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I hereby give permission to Dr. Teresa Melton to release any private health information necessary in treatment, payment or health care operations. I authorize the use of my signature on all insurance claim submissions. I understand I may revoke this release only in writing. I understand that this office does leave voicemail messages if they are unable to contact patients, unless instructed in writing not to do so.

I hereby understand that payment is expected when services are rendered unless other arrangements are made in advance. I also understand that I am responsible for all bills and any collection expenses incurred at this office.

I, the undersigned, assign directly to Dr. Teresa Melton all insurance benefits, if any, otherwise payable to me for services rendered.

I fully understand and agree that the insurance policies are an arrangement between an insurance carrier and myself. I understand I am financially responsible for all charges whether or not they are paid by insurance, and I may be billed if necessary for additional costs incurred in the collection of these accounts. I understand that it is ultimately my responsibility to know and understand my insurance plan.

I also understand that insurance benefits are not a guarantee of insurance coverage.

I hereby give permission to the doctor to administer treatment and perform such general procedures as she deem necessary in the treatment of my condition.

The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I certify that I have read and understand the above information and that it is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

**Patient's/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

***PLEASE PRESENT YOUR INSURANCE CARD AND A PHOTO ID***

*A copy will become part of your medical record.*

## FINANCIAL POLICY

Communication with our clients regarding our financial policy assists us in providing the best possible service to you. Please read the following. Your initials and signature are required. Thank you.

- \_\_\_\_\_ Private Pay/Cash Patient – (clients without BC/BS insurance) Full payment is required when services are rendered to continue treatment OR payment arrangements need to be agreed upon.
- \_\_\_\_\_ Insurance Reimbursement – Clients are required to contact their insurance company to verify their deductible status and the amount of coverage for chiropractic, acupuncture and massage therapy available to them. We will also be contacting your insurance company to verify your coverage. It is important to remember that what the insurance tells us is not a GUARANTEE of payment from them.
- \_\_\_\_\_ Deductible and Co-payment - If you have not met your deductible, you will be required to pay the full amount of each visit until you have met it. We require your co-payment or co-insurance at the time of service. If you do not know what your co-insurance is, a minimum of 20% is due at the time of service. Any charges that your insurance company does not pay for or denies will be the patient's responsibility.
- \_\_\_\_\_ Purchasing Products – Payment for all products is the patient's responsibility. Payment for products is due at the time of purchase. As a courtesy to you, we will bill your insurance company. If your insurance company does pay for the product, we will credit/refund your account.

## AGREEMENT TO PAY

I understand that the agreement with my health insurance is an agreement between them and me. I take full responsibility for payment of all charges for professional services rendered. I understand the financial policy detailed above. I understand that I am responsible for all charges regardless of my existing medical coverage. NSF check will be charged a \$25.00 fee.

Consent for Treatment/Release of Insurance Assignment Medical Information.

YES\_\_\_\_ NO\_\_\_\_ I authorize any and all therapy services that the provider feels necessary.

YES\_\_\_\_ NO\_\_\_\_ I assign payment of medical benefits directly to Allergies, Aches & Pains.

YES\_\_\_\_ NO\_\_\_\_ I authorize Allergies, Aches & Pains to leave voicemail messages regarding my appointments. Should I decide that I no longer wish to have messages left, I understand that a written request must be made.

YES \_\_\_\_ NO \_\_\_\_ I hereby authorize Allergies, Aches & Pains to release to my insurance company, health plan, or insurance group, any medical records or information concerning the treatment to obtain reimbursement on my behalf for the treatment or service provided by Allergies, Aches & Pains. I understand that I may revoke the consent to release information to third parties at any time and that the provision of services is not conditional on my agreement to disclose information to the parties. If I revoke my consent, I will be responsible for paying for all services rendered by Allergies, Aches, & Pains.

I have read , understand and agree to this financial agreement.

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SIGNATURE

DATE