Baldwin CHIROPRACTIC
Compassionate Service with Purpose

10700 SE 208th ST, Suite 207
Kent, Washington 98031
Tel: (253) 854-3185
Fax: (253)854-3185

CHILD CONFIDENTIAL PATIENT INFORMATION

Date:_____ Name _____

Parents Name (s): _____

Address _____

City _____ State _____ Zip code _____

Home Phone (___)___-_____ Cell Phone (___)___-_____ Work Phone (___)___-_____

Parents E-mail _____ Sex: M F Date of Birth ____/____/___

Preferred Language: _____ Height:_____ Weight:_____

Appointment Reminders?: (circle one) None / Email / Text Wireless Provider_____

Emergency Contact Name _____ Relationship to patient _____

Emergency Phone (_____)_____-_____ Primary Care Provider's Name _____

Primary Care Provider's Location or address _____

PERSONAL INSURANCE INFORMATION

Primary Insurance Company_____ Policy or Group _____

Name of Insured _____Relation to Patient _____

THIS OFFICE VISIT IS DUE TO

Describe the purpose of this visit: _____

When/How did this condition begin?:_____

Has this problem gotten ☐ worse ☐ better ☐ stayed the same?

Does this condition interfere with ☐ Sleep ☐ daily routine? ☐ other activities

Explain_____

Has this condition occurred before ☐ Yes ☐ No Has your child seen other doctors for this condition? ☐ Yes ☐ No

If yes who? _____ Type of treatment? _____ Results_____

HEALTH HISTORY

Please note if Father, Mother, Sibling, have any diagnosed conditions: _____

_____

_____

Please check each condition that the child has now or had in the past:

☐ Vision Problems	☐ Irritability	☐ Breathing Problems	☐ Constipation
☐ Headaches	☐ Skin problems	☐ Asthma	☐ Bedwetting
☐ Sleeping Disorders	☐ Allergies	☐ Hyperactivity	☐ Pink eye

Child's Current Health Status

Is your child accident prone? □ Yes □ No

Has your child : □ been hospitalized? □ had a severe fall? □ been in a car accident?

Has your child ever taken antibiotics? □ Yes □ No

Is your child currently taking any medications? □ Yes □ No If yes what?_____

Does your child have any difficulty interacting with schoolmates or friends? □ Yes □ No

Does your child ever exhibit nervousness, twitches, shakes or rocking behavior? □ Yes □ No

What changes (if any) in your child's health or behavior would you like accomplished? _____

_____

Mother's Pregnancy & Labor

During pregnancy did the mother take any medication? □ Yes □ No Explain:_____

Smoke □ Yes □ No Consume alcohol? □ Yes □ No Experience any illness? □ Yes □ No Explain_____

How long did labor last? _____ Was the child premature? □ Yes □ No If yes how early? _____

Was labor □ induced? □ C-section? □ Forceps or vacuum extraction used?

Did the child experience any of the following immediately after birth?

Did the child experience any of these?

□ Jaundice □ Respiratory Problems Explain:_____

□ Feeding Problems □ Displaced or broken joints

Notice Of the Possibility of Insurance Denial

Your insurance company will only pay for services it determines to be reasonably necessary. If your insurance company determines that a particular service, although it would otherwise be covered, is not reasonably necessary under its program standards your insurance company will deny payment for that service. The following services may not be covered:

Some or all x-rays, Re-examinations, Supplies such as ice packs, pillows, exercise balls, orthotics, supplements, etc., Manual traction/mechanical traction, Office visits deemed "not medically necessary" by your insurance company, Massage therapy, Spinal rehabilitation and exercises

As a courtesy to you, we will bill your insurance company directly. Please note that if we bill the insurance for your services, you **will not** be eligible for our **"paid at the time of service"** discount. This discount does not include durable medical equipment.

To take advantage of this discount, pay the discounted price at the time of service. We will supply you with a "Super Bill" that you send to your insurance for reimbursement of that charge.

PRODUCT RETURN POLICY

We do not accept returns of any complimentary products purchased at Baldwin Chiropractic. This will include any pillows, supports, ice packs, nutritional supplements etc.

I have been informed by my doctor or his staff that in my case, my insurance company may deny payment for some future services. If my insurance company denies payment, I agree to be personally and fully responsible for payment of these services. I understand that I could choose to pay discounted fee at the time of service, but, at this time, would like to bill my insurance.

Consent to treatment of Minor Child

I hereby authorize the doctors of Baldwin Chiropractic and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my child.

Parent or Guardians Signature: _____ Date_____

INFORMED CONSENT TO CHIROPRACTIC CARE

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae.

Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (broken rib), disc injuries, strokes, dislocations, strains, and sprains.

With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. These options may include, but are not limited to: medical care with prescription drugs, physical therapy and surgery.

Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:_____

Witness Name: _____ Signature: _____ Date:_____

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Parent and/or Guardian Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**