Galloway Wellness New Pediatric Patient File # _____

New Pediatric Intake (only fill out if patient is 5 years old or under):

Child's Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Gender: M / F / Other Date of Birth: _____/_____/_____ Age: _____

Height: _____ Weight: _____ Blood Type: A / AB / B / O Rh: + / -

Does child live with: Mother / Father / Both / Legal Guardian

Parent's/Guardian's Names: _____

Physician's Name: _____ Phone: _____

May we communicate with your family doctor regarding your child's care if necessary? Yes / No

Prenatal History:

Did you receive Chiropractic Care during pregnancy? Y / N

How stressful would you rate your pregnancy on a scale of 1-10 (10 being greatest stress)? _____

Complications during pregnancy: Y / N Please describe: _____

Ultrasounds during pregnancy: Y / N If so, how many? _____

Exposure to alcohol, cigarettes or second hand smoke during pregnancy: Y / N Which: _____

Did you take prenatal vitamins? Y / N If yes, approximate start? _____

If yes, please list name of vitamins, medications and reason for taking:

Name	Reason

Birthing History:

How many weeks' gestation was the baby at birth: _____Wk. _____D

Birth Weight: _____ lbs. _____ oz. Birth Length: _____ in.

Medications during labor / delivery? (including IV antibiotics) Y / N Please List: _____

Was Pitocin used to induce / speed up labor: Y / N

Were your membranes ruptured by a medical professional: Y / N

Was your child at any time during your pregnancy in an intra-uterine constraining position: Y / N / Unsure

If yes, please describe: Breech / Transverse / Face /Brow Presentation / Other: _____

Delivery: Vaginal / C-section If it was a C-section: Planned / Emergency

If it was vaginal, was the baby presented: Head / Face / Breech

Were any of the following interventions used during delivery? Forceps / Vacuum / Extraction / Other: _____

Were there any complications during delivery? Y / N If yes, please specify: _____

Was the baby born with any purple markings / bruising on their face or head? Y / N

Any concerns about misshapen head at birth? Y / N

Was the baby ever administered to Neonatal Intensive Care? Y / N

If yes, for how long and why? _____

Was any medication given to the baby at birth? Y / N / Unsure

If yes, what medication and why? _____

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Print: _____ Date: _____

Galloway Wellness New Pediatric Patient File # _____

Has your child received previous Chiropractic Care? Y / N

Purpose of Appointment: (What are you hoping to gain from this experience?)

Do you have a specific concern that brings you in: Y/ N If yes, please explain: _____

If yes, please answer the following questions:

Does your child appear to be in pain or discomfort? Y / N

How would your child rate their pain/discomfort:

How long has your child been experiencing this? _____

Is the condition getting: Better / Worse / Staying the same Onset: Sudden / Gradual

What makes the situation worse? _____

What makes the situation better? _____

Has your child had x-rays in relation to the current complaint: Y/ N

Have you seen other health professionals for this complaint? (Specialist, Naturopathic Doctor, Physiotherapist, Massage Therapist, etc)

Name of Practitioner	Treatment Used and/or Medications Taken

What signals has your child's body been communicating?

Current	Previous		Current	Previous		Current	Previous	
		Asthma			Frequent Diarrhea			Failure to Thrive / Slow Weight Gain
		Respiratory Tract Infections			Constipation			Slow or Absent Reflexes
		Sinus Problems			Flatulence			Asymmetrical Crawling or Gait
		Ear Infections			Headaches / Migraines			Weight Challenges
		Tonsillitis			Neck Pain			Bed Wetting
		Strep Throat			Torticollis / Head Tilt			Sleep Problems
		Frequent Colds / Croup			Trouble Feeding on One Side			Night Terrors
		Recurrent Fevers			Back Pain			Tip Toe Walking
		Eczema			Growing Pains			Regression of Milestones
		Rashes			Scoliosis			Seizures
		Allergies			Red, Swollen, Painful Joint			Tremors / Shaking
		Food Sensitivities			Colic			ADD / ADHD
		Digestive Problems			Frequent Crying Spells			Autism / PPD

Please include any additional information you may feel is pertinent for the doctor to know about your child.

My signature confirms that this information of complete and true to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Print: _____ Date: _____

Galloway Wellness New Pediatric Patient File # _____

Financial Policies

METHOD OF PAYMENT:

Payment is due at the time or service. The amount due for services will depend on whether you have insurance, are self-pay, or are going through a Third Party Administrator. See below for further information regarding insurance, self-pay and Third Party Administrator. The accompanying adult to a minor patient is responsible for payment. For your convenience we accept Credit card, cash, and personal checks.

CHECK RETURN FEE:

There is a $25 charge for checks returned due to insufficient funds.

CANCELLATION/NO SHOW FEE:

While some cancellations are inevitable, cancellations with less than 24-hour notice or missed appointments (no-shows) have unfortunately become a great expense to our organization. If you call with less than 24 hours' notice or if you don't call at all, we reserve the right to bill you for the time we saved for you. No shows, missed appointments or changes in appointments made with less than a 24-hour notice will be charged a $25 fee for chiropractic treatment and $50 for chiropractic examinations, nutritional consults, new patient visits, and massage visits.

INSURANCE:

Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. We will bill your insurance plan and will collect any copay, co-insurance, or deductible due by you at the time or service. Any non-covered service fees will also be collected at the time of service. If your health plan determines a service to be "**not covered**" or is **not an eligible expense under your plan**. You will be responsible for the complete charge or remaining balance of the non-covered service(s). Payment is due upon receipt of that statement from your insurance company. It is uncommon, but pre-authorization from your insurance company may be required for chiropractic care in order to receive full benefit coverage. If you are not sure pre-authorization is required for your plan, please contact our office or your insurance company to verify your plan benefits. If required, an authorization must be received by our office prior to your visit. Failure to provide Galloway Chiropractic with proper authorization may result in delay or rescheduling your appointment. You will also be financially responsible for all services related to your visit.

SELF PAY (No Insurance):

We do offer **Cash** patients a 20% discount if balance is paid in full at time of service.

PERSONAL INJURY/AUTO INJURY

Please advise our office on your first visit whenever you have one of the above claims. We will work with any insurance companies/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party. If you, your attorney or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.
WE **DO NOT** accept *Third Party* Insurance on PI/MVA. You will need to pay cash and we will provide your receipts for you to file.
We also **DO NOT** accept *Worker's Comp.*

MEDICARE:

Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will ONLY cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes

and files the forms for Medicare at no charge. As a courtesy to you, we will bill your secondary insurance after Medicare pays.

SECONDARY INSURANCES:

Our Office does not file Secondary Insurances.

BALANCES:

Failure to pay any balance due may result in your account being turned over to an outside collection agency. This action will not compromise your care.

I have read and understand the financial policy set forth by Galloway Chiropractic Clinic, LLC, and I agree to be bound by its terms. I also understand and agree that such terms may be amended periodically by the practice.

Signature of Patient/Legal Guardian: _____ **Date: _____**

Relationship to Patient: _____ **Date**: _____

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Insurance Assignment and Authorization:

I hereby direct my insurance company, _____ to pay Galloway Chiropractic Clinic LLC the sum of the proceeds payable under the terms of my insurance policy for dates of services seen in association with Galloway Chiropractic Clinic LLC.

I specifically authorize that this assignment may be paid from disability benefits, medical payments or from any benefits due me under this claim.

I also authorize Galloway Chiropractic Clinic LLC to release any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature of Patient/Legal Guardian: _____ Date: _____

Relationship to Patient: _____ **Date**: _____

Witness: _____ Date: _____

Fax and E-mail Authorization Form

In order to communicate with you by fax or e-mail, Galloway Chiropractic LLC requires the following information. All information is kept strictly confidential and is used only for our purposes.

Fax Number: _____

E-mail Address: _____

I understand that fax and e-mail communications are not secure forms of communication and that confidentiality of any e-mail or fax cannot be ensured.

I authorize Galloway Chiropractic LLC to Fax and E-mail correspondence, request for information and other documents to me whenever possible.

Signature of Patient/Legal Guardian: _____ Date: _____

Relationship to Patient: _____ **Date**: _____

Galloway Wellness New Pediatric Patient File # _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____

Address: _____

Telephone: _____ E-mail: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to Galloway Chiropractic Clinic LLC's use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Persons Authorized to Use or Disclose Information: Information will be used by or disclosed by:

1. Galloway Chiropractic Clinic LLC
2. Name: _____

Who can we release information to / speak to about your care?

Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

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Authorization and Consent to Treat

The following is provided so that we might have a common understanding of our rights and roles in professional therapeutic relationship. Please read and sign this agreement indicating that you understand and agree to the following. Please ask any questions if you would like further information about any of the following.

1. Information revealed during counseling and treatment sessions is confidential. Exceptions to this confidentiality include disclosure by your regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the legal authorities compel us to do so.
2. Each procedure or treatment carries with it both risks and benefits. There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment.
3. Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Please let the doctor know if you are being treated by other healthcare providers (physicians, counselors, therapists, etc.). It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments between visits.
4. Physical examination, chiropractic treatment, and neuro-muscular therapy involves physical contact and may be uncomfortable for some persons. If you are uncomfortable with physical contact or unfamiliar with chiropractic please let the doctor know so that they can assist you and help you find an alternative that is more comfortable for you.
5. You are welcome to bring a friend or relative to your visits if such companionship is comfortable for you.
6. You are encouraged to ask questions on any health-related topic and to take an active role in your health care. This office offers a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyle that can help you attain you highest level of health.
7. The doctor may not be available at all times. If you have a serious health problem that requires immediate attention, you should call your other doctors, call 911, or have someone take you to the nearest hospital or emergency room. If you notice an adverse effect from one of the components of your health plan, you should discontinue it and contact the doctor and relate what has occurred as soon as possible.
8. It may become necessary at various times to contact you by phone, mail, or e-mail. By signing this form, you are giving us your permission to contact you by one of the above methods.

The new patient information, health history, and other information that I provided on my intake form are complete and accurate. I understand and agree to the information on this page. My questions, if any, were answered to my satisfaction.

Signature of Patient / Legal Representative: _____

Relationship to patient: _____ **Date:** _____

Consent for Minor: I acknowledge that I have read and understand the above consent to treat information and authorize and give consent to the doctor(s), staff, and doctor assistants of Chiropractic Works to treat my minor child. As of today's date, I have the legal right to select and authorize health care service for the minor child named below. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of spouse, former spouse or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Print Child's Name: _____

Relationship to Child: _____

Parent/Guardian Print & Sign Name: _____ **Date**: _____