VITALITY CHIROPRACTIC & FAMILY WELLNESS

Your Child's Facts

1

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____ **Apartment #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Cell #:** _____

Email: _____

How did you find us? Patient *(who)*: _____ Doctor *(who)*: _____ Staff *(who)*: _____

(circle one) Promotion/Event Internet Newspaper Signage Business Insurance Other: _____

Your preferred method of communication for patient appointment reminders (*circle one*): Email Text Message No Reminder

If you'd like text message reminders please circle your provider: AT&T Verizon Sprint T-Mobile Other: _____

Do you know your child's height and weight? (height): _____ (weight): _____

Child's Date of Birth: ____/____/____ **Gender of Child** (*circle one*): Male Female

Employer: _____ **Work #:** _____ **Ext:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Care Physician (PCP): _____ **Phone #** (PCP): _____

Race (*circle one*): White (Caucasian) Black or African American Asian American Indian or Alaska Native

Native Hawaiian or Pacific Islander I Decline to Answer Other: _____

Ethnicity *(circle one):* Hispanic or Latino Not Hispanic or Latino I Decline to Answer

Is your child currently taking any medications?

Medication Name	Dosage and Frequency

Does your child have any medication allergies?

Medication	Reaction

(913) 962-7408 (office) | (913) 962-7416 (fax) | 7410 Switzer, Shawnee, KS 66203 | vitalitychiropractickc@gmail.com | www.vitalitychiropracitckc.com

VITALITY CHIROPRACTIC & FAMILY WELLNESS

Your Child's History

2

Name: _____ **Date of Birth:** _____ **Date:** _____

Health History

Issues
Mark those that apply:

- Back pain ☐
- Neck pain ☐
- Leg pain ☐
- Arm pain ☐
- Torticollis ☐
- Headaches ☐
- Ear infections ☐
- Tubes in ears ☐
- Recurring respiratory infections ☐
- Colic as an infant ☐
- Asthma ☐
- Allergies ☐
- Constipation ☐
- Bed-wetting ☐
- Skin problems (eczema, rashes) ☐
- Childhood diseases ☐
- Other ☐

List: _____

Trauma
Mark those that apply:

- Fall from bike, scooter ☐
- Fall down stairs ☐
- Fall from significant height ☐
- Motor vehicle accident ☐
- Trips and falls easily ☐
- Injuries (fracture, burn) ☐
- Other: _____

Nutritional
Mark those that apply:

- Is a good eater ☐
- Likes all food ☐
- Has food allergies ☐
- Takes vitamin supplements ☐
- Is/was breast feed ☐
  - Length of time: _____
- Drinks cow's milk ☐
- Three favorite foods: _____

Emotional
Mark those that apply:

- Sleeps well at night ☐
- Takes daytime naps ☐
- Has nightmares ☐
- Sleep walks ☐
- Frequent temper tantrums ☐
- Cries a lot ☐
- Other: _____

Developmental
Mark those that apply:

- Sit up unassisted ☐
  - (age) _____
- Rolls over ☐
  - (age) _____
- Crawls ☐
  - (age) _____
- Walks ☐
  - (age) _____

Environmental
Mark those that apply:

- Goes to day care ☐
- Smoker in household ☐

Immunizations
Mark those that apply:

- Has been immunized ☐
- Has had a reaction to immunization ☐

Is your child under medical care for a specific condition? ☐ Yes ☐ No Please list the condition and care received. _____

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Your Child's Life

Name: _____ **Date of Birth:** _____ **Date:** _____

Mother's Health at Birth:

- Morning sickness ☐
- Indigestion ☐
- High or low blood pressure ☐
- Swollen ankles ☐
- Back pain ☐
- Groin pain ☐
- Diabetes ☐
- Anemia ☐
- Abnormal bleeding ☐
- Trauma/fall/vehicle accident ☐
- Hospitalized during pregnancy ☐
- Prescribed bed rest ☐
- Smoked ☐
- Consumed alcohol ☐
- Used over the counter drugs ☐

List: _____

_____

- Used prescription medication ☐

List: _____

_____

Birth to 3 Months:

Mark those that apply to your child as an infant.

- Medicated at birth ☐
- Vaccinated at birth ☐
- Formula fed ☐
- Other source ☐

List:

_____

_____

_____

- Nursing difficulties ☐

List:

_____

_____

_____

- One side feeding preference ☐
- Frequent spit-up after feeding ☐
- Smoker in household ☐
- Sleeps easily ☐
- Preferred sleeping position ☐
- Excessive crying/colic ☐
- Intestinal gas ☐
- Trauma, fall, accident ☐
- Noise when breathing ☐

4 Months and Up:

Mark those that apply to your child to age 2 years.

- Digestive problems ☐
- Food allergies ☐
- Takes vitamin supplements ☐
- Frequent respiratory infections ☐
- Tubes in ears ☐
- Frequent nightmares ☐
- Sleep walking ☐
- Trauma, fall, accident ☐
- Injuries, fractures, burns ☐
- Trips, falls easily ☐
- Medications ☐

List:

_____

_____

_____

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_____

Birth History:

Check if you had any of the following.

- Hospital birth ☐
- Home birth ☐
- Planned C-section ☐
- Emergency C-section ☐
- Induced birth (Pitocin) ☐
- Forceps used ☐
- Vacuum extraction used ☐
- Epidural anesthesia ☐
- Other painkillers ☐

_____

Infant Presentation

- Head ☐
- Face ☐
- Breech ☐
- Full term ☐
- Premature ☐

Weight: _____

Length: _____

Conditions:

List conditions in order of concern:

_____

_____

_____

_____

_____

_____

_____

_____

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VITALITY CHIROPRACTIC & FAMILY WELLNESS

Our Financial Policy

4.1

It is the policy of this office that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments, regardless of whether or not this office accepts insurance assignment.

PATIENTS WITHOUT INSURANCE OR SELF PAY: If you are not insured OR not insured by a plan we participate with, **payment is expected in FULL at each visit.** If you are seeing our doctors on an "out of network" basis you may request a "Superbill" so that you may submit it to your insurance company for out-of-network reimbursement.

PATIENTS WITH INSURANCE: Vitality Chiropractic and Family Wellness, LLC (VCFW) participates with Blue Cross Blue Shield and Unitedhealthcare. Knowing your chiropractic insurance benefits is your responsibility. **All co-payments and deductibles must be paid at the time of service.**

PATIENT BILLING & BALANCES DUE: Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. In the event that you do not pay your co-payment or deductible payment at the time of service OR your insurance carrier assigns any additional patient responsibility amounts after the claim is processed, **we will charge the credit card on file for such patient responsibility, co-payment or deductible amount to the following extent:**

1. **If the balance due is less than $100 your card will be charged automatically.**
2. **If the balance due is greater than $100, we will contact you 72 hours prior to your card being charged.** Should you decide to use an alternate method of payment OR set up a payment plan, please **alert our office within 72 hours of our contact,** and our contact shall include a voice message from us to you if we are unable to reach you.
3. Payment plans ARE available upon request.
4. **A $10 late fee per month may** be charged to your account if your balance is unpaid 90 days after your last visit until balance is paid in full.
5. If we do not receive payment in full for the balance due, or you have not set up an automatic payment plan **after 6 months of an unpaid balance your account may be forwarded to collections,** and you hereby agree that if VCFW, LLC places your account with an agency or attorney for collection, you will pay VCFW, LLC all of its costs and expenses in collecting monies owed by you to the extent allowed by applicable law.
6. If your credit/debit card on file expires or otherwise becomes uncollectible, we will expect you to promptly provide a new credit or debit card.
7. **A $25 returned check fee will** apply towards your account for checks returned for insufficient funds.

Please check one box:

☐ Run my card I have swiped & saved in secure system. Signature still needed on next page.

or

☐ Run my card information provided in the box below.

CREDIT CARD INFO

Credit Card # _____ **Card Type:** VISA MASTERCARD DISCOVER AMEX

Expiration Date: _____ **3-digit Security Code:** _____

Name on Card: _____

...our financial policly is continued on the next page...

VITALITY CHIROPRACTIC & FAMILY WELLNESS

Our Financial Policy *(continued...)*

4.2

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible for payment of these services.

ASSIGNMENT OF BENEFITS: I, the undersigned certify that I (or my dependent) have coverage with my insurance as presented and assign directly to VCFW, LLC all insurance benefits, payable to me for services rendered, I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services, I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I acknowledge and understand that it is my responsibility to inform the doctor's office if there is a change in my health insurance information.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I consent to the use or disclosure of my medical information by Vitality Chiropractic and Family Wellness, LLC and/or the affiliate practioners that operate within Your Wellness Connection, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of VCFW. I understand that diagnosis or treatment of me by VCFW may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my medical information is used or disclosed to carry out treatment, payment or health care operations of the practice. VCFW is not required to agree to the restrictions that I may request. However, if VCFW agrees to a restriction that I request, the restriction is binding on VCFW. I have the right to revoke this consent, in writing, at any time, except to the extent VCFW has taken action in reliance on
this consent.

My "medical information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This medical information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review VCFW's Notice of Privacy Practices prior to signing this document. A current copy is posted in the lobby of Your Wellness Connection.

The Notice of Privacy Practices describes the types of uses and disclosures of my medical information that will occur in my treatment, payment of my bills or in the performance of health care operations of VCFW. This Notice of Privacy Practices also describes my rights and the duties of VCFW with respect to my medical information. VCFW reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I hereby authorize VCFW, LLC to charge my credit, debit, or HSA card on file for the full amount owed by me for all services and/or treatment rendered by VCFW, LLC in accordance with the terms above. Effective until revoked by you in writing.

_____ **Today's Date:** ____/____/____

Signature of Patient/Parent/Guardian

_____

Printed name of Patient/Parent/Guardian

_____

Other family members covered by this agreement.

Consent to Treatment of Minor Child

6

Name: _____ **Date of Birth:** _____ **Date:** _____

I, (*print parent/guardian name*) _____

hereby authorize: Dr. Stacy Jimenez

and whomever she may designate in assistance to administer treatment as deemed necessary to my son/daughter

(*print child's name*) _____

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

Witnessed: _____

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VITALITY CHIROPRACTIC & FAMILY WELLNESS

Chiropractic Informed Consent

5

Name: _____ **Date of Birth:** ____/____/____ **Today's Date:** ____/____/____

Chiropractic evaluation and treatment involves certain inherent risks. There are several benefits associated with performing an evaluation. They include: working diagnosis of present condition, qualifying physical abilities and comparing performance results with the physical demands of a specific job category or classification. There are also expected benefits associated with participation in a treatment program. They include: increased flexibility, decreased pain, decreased inflammation, better circulation; all combining to improve function in activities of daily living.

Today's treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, active or passive stretching, instrument-assistant soft tissue manipulation (IASTM), massage techniques (including but not limited to effleurage, petrissage, compression, and tapotement) and the application of kinesiology tape. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, disc injury, reddening of the skin and/or development of petechiae (small broken capillaries in the skin's surface), bruising, itching and/or blistering of the skin, muscle, ligament, or joint injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability to ensure the maximum improvements. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to Dr. Jimenez by calling 913-962-7408.

Adjustment – Spinal manipulation that involves precise impulses in a specific direction to restore normal motion and position of individual vertebrae.

Interferential Current Therapy – Small electrical impulses are used to stimulate muscles and relieve tension by reducing nerve irritation. This current promotes the secretion of natural painkillers (endorphins).

Intersegmental Traction Therapy – This therapy utilizes rollers that slowly travel the length of the spine. By stretching individual joints, it promotes increased mobility and blood flow that leads to faster healing.

Active or Passive Stretching – Areas of the body taken through active or passive range of motions to encourage stretching and lengthening of the muscles and increased circulation.

Instrument-Assisted Soft Tissue Release (IASTM) – A treatment to break up adhesions or scar tissue detected by the stainless steel instrument in the area of complaint to increase range of motion, decrease pain, improve circulation, encourage healing, and prevent the formation of the development of scar tissue.

Massage Techniques – Including but not limited to effleurage, petrissage, compression, and tapotement techniques to encourage muscle relaxation, stretching and lengthening of the muscles and increase circulation.

Kinesiology Taping – The application of elastic adhesive tape to the area of complaint to help eliminate pain, aid in proper muscle and joint function, provide support and neuromuscular re-education.

Risk factors have been reduced to the best of our ability. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatments.

By signing this form you consent to disclose any and all relevant medical health conditions (i.e. cardiovascular, neurological, skin, muscle or joint conditions) that could be a contraindication to treatment to Dr. Jimenez.

DO NOT RECEIVE TREATMENT IF YOU HAVE ANY OF THE FOLLOWING: AN INFECTIOUS OR CONTAGIOUS SKIN DISEASE, OR INFLAMMATORY CONDITION AFFECTED BY INCREASED BLOOD CIRCULATION.

Signature: _____ **Today's Date:** ____/____/____

Printed Name: _____

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