VITALITY CHIROPRACTIC & FAMILY WELLNESS

# Your Child's Facts

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**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 height and weight?** (height): _____ (weight): _____

**Date of Birth:** ____/____/____ **Gender** (*circle one*): Male Female **Marital Status** (*circle one*): M D W S

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

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

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

**Smoking Status** (*circle one*): Never Former Occasional Every Day **Smoking Start Date**: ____/____/____

**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

**Are you currently taking any medications?**

| Medication Name | Dosage and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Do you have any medication allergies?**

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

☐ **I choose to decline receipt of my clinical summary after every visit.** *(These are often blank as a result of the nature/frequency of chiropractic care)*



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**Are you currently taking any supplements?**

| Supplement Name | Dosage and Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Please list your major health goals:**



## FOR OFFICE USE ONLY

**Height:**_____ **Weight:**_____ **Blood Pressure:**_____/_____

**Documentation** (*circle all that apply*): ☐ Scanned In ☐ Demo Entered ☐ Meds Entered ☐ Ins. Entered

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

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.

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

**Patient or Personal Representative Signature:**

_____

**Printed Name of Patient or Personal Representative:**

VITALITY CHIROPRACTIC & FAMILY WELLNESS

# 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:

_____

_____

_____

_____

_____

_____

_____

## 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

# Your Child's History



**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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VITALITY CHIROPRACTIC & FAMILY WELLNESS

# Consent to Treatment of Minor Child

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**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

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

Treatment may involve adjustments, interferential current therapy, intersegmental traction therapy, and exercises. Risks may include but are not limited to cardiovascular, muscle, ligament, joint, or disc injury. Symptomatic aggravation of the condition is also possible. Risk factors have been reduced to the best of our ability. However, any increase in the current level of discomfort, or any other change in symptoms should be immediately reported to a staff member.

**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.

**Exercise:** The entire body benefits from this therapy, both physically and psychologically. Exercise improves digestion, increases energy levels and promotes the reduction of stress.

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 treatment program.

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

**Printed Name:** _____



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# Our Financial Policy

7.1

Thank you for choosing our office for your wellness care. We are committed to providing you with high quality health care. The services provided by our office are services you have elected to receive which may imply a financial responsibility on your part. 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.

**SELF PAY:** If you are not insured by a plan we participate with OR choose to self pay, payment in FULL is expected at each visit.

**INSURANCE:** Vitality Chiropractic participates with Blue Cross Blue Shield and Unitedhealthcare. **Knowing your chiropractic insurance benefits is your responsibility.** As a courtesy we verify your insurance information and benefits for chiropractic services only. It is the policy of this office to extend to our clients the courtesy of assigning chiropractic insurance benefits directly to you. We are happy to extend this credit to you so that you can follow through with all the care necessary. The following are important points of consideration to be aware of:

1. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company and we are required by law to collect co-payments and deductible payments at the time of service. Please assist us in compliance with our obliga tions by paying your co-payment and deductible payment at each visit. In the event that you do not pay your co-payment or deductible payment at the time of service, we will charge the credit card on file for such co-payment or deductible amount.
2. If you are seeing our doctors on an "out of network" basis, you will be subject to out of network rates. In this event, you may request a "Super bill" so that you may submit it to your insurance company for out-of-network reimbursement.
3. Patients whose treatment visitation schedule is once per month or less, may no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous wellness plans to allow you to continue needed care.

BALANCES DUE:Your insurance plan is required to send you an Explanation of Benefits (EOB), which will state any balance remaining to be paid by you. **Beginning May 1, 2017,** if your insurance carrier assigns any additional patient responsibility amounts after the claim is processed; **we will use your credit card on file for this payment. Please take note of the following:**

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 your contact shall include a voice message from us to you if we are unable to reach you.
3. If your credit/debit card on file expires or otherwise becomes uncollectible, we will expect you to promptly provide a new credit/debit card.
4. If for any reason we are unable to collect payment in full via credit/debit card on file you will receive notice requiring immediate payment for services. If we do no receive payment in full for the balance due, a second and last notice will be provided. **If after the second and last notice we do not receive payment in full for the balance due, your account may be forwarded to collections,** and you hereby agree that if Vitality Chiropractic and Family Wellness, LLC places your account with an agency or attorney for collection, you will pay Vitality Chiropractic and Family Wellness, LLC all of its costs and expenses in collecting monies owed by you to the extent allowed by applicable law.

**PATIENT BILLING:** You will receive a receipt of all charges upon request. By executing this Financial Policy and Patient Authorization, you hereby guarantee payment of all charges from Vitality Chiropractic and Family Wellness, LLC for medical services and treatment provided.

1. **We accept the following payment methods: Cash, Check, VISA/MasterCard, Discover and American Express.**
2. **An additional $25.00 will be added to your account if a check is returned for insufficient funds.**
3. In the event that your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.
4. If after insurance has processed and your account acquires a credit and no outstanding services are pending, a refund check will be mailed with a receipt to you to confirm your payment.

**CLAIM SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

*...continued on next page...*

VITALITY CHIROPRACTIC & FAMILY WELLNESS

# Insurance Data Collection



**Last Name:** _____ **First Name:** _____

**Date of Birth:** ____/____/____

## Insurace Verification: FOR OFFICE USE ONLY

**Date:** ____/____/____ **Ins. Contact Name:** _____ **Eff. Date of Coverage:** ____/____/____

**Deductibles: In Net:** _____ **How much met?** _____ **How much remains?** _____

**Co-Pay(s):** _____ **Coinsurance %:** _____ **Max Benefits / Year:** _____

*Photocopy/scan the front and back of the insurance card in the area below.*

# Notice of Patient Privacy Practices



We are committed to preserving the privacy of your medical information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

**HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.**

We may require your written consent before we use or disclose to others your medical information for purposes of diagnosing or providing treatment to you, obtaining payment for your health care bills or to conduct health care operations of Your Wellness Connection (YWC).

***Treatment** includes activities performed by a practitioner, chiropractic assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers.

***Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

***Health Care Operations** includes the necessary administrative and business functions of our office.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you nconfidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. This Notice is posted in our lobby. We may revise our Notice from time to time. The effective date at the lower left-hand side of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our Privacy Officer at (913) 962-7408.

VITALITY CHIROPRACTIC & FAMILY WELLNESS

# Our Financial Policy *(continued...)*

7.2

**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.

**PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice of Privacy Practices and agree to its terms.

**ASSIGNMENT OF BENEFITS:** I, the undersigned certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Vitality Chiropractic and Family Wellness, 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.

**AUTHORIZATIONS:** I hereby acknowledge that I have read the above policy regarding my financial responsibility to Vitality Chiropractic and Family Wellness, LLC for medical services and treatment provided and I agree to pay Vitality Chiropractic and Family Wellness, LLC any balance unpaid by my insurance carrier for myself or the below named person

**I hereby authorize Vitality Chiropractic and Family Wellness, LLC to charge my credit card or debit card on file for the full amount owed by me for all services and/or treatment rendered by Vitality Chiropractic and Family Wellness, LLC in accordance with the terms above.**

This authorization shall remain effective unless and until it is revoked by you in writing and delivered to the office of Vitality Chiropractic and Family Wellness, LLC 7410 Switzer Rd., Shawnee, KS 66203

The goal of this office is to provide you with the finest quality of care available. If you have any questions with regard to your health care or any of our policies, please let us know.

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

**Printed Name:** _____

*Credit Card Info*

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

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

**Name on Card:** _____


*This form is in compliance with requirements for the government EHR incentive program.*