GREATER ROCHESTER CHIROPRACTIC

LISTEN KNOW HEAL PROTECT

BRIGHTON Leslie W. Lange, DC
Samuel W. Ascioti, DC
E. Daniel Quatro, DC
Jason T. Swinton, DC
Megan A. Tuzzo, DC
WEBSTER Amy E. Kochersberger, DC
Samuel W. Ascioti, DC

Pediatric Patient Information (Birth to Age 5)

Patient's Name: _____ Today's Date: _____

Gender: ___M ___F Date of Birth: _____ /_____ /_____ Age: _____ Social Security #: _____

Address/City/State/Zip: _____

Pediatrician's Name: _____

Pediatrician's Address/Phone:_____

Whom may we thank for referring your child to our practice? _____

Parent's Name(s):_____

Parent's Phone Number(s):_____

Parent's Email Address (optional-for appointment reminders):_____

Siblings (names and ages):_____

Pregnancy/Birth History

(If your child is adopted, please answer to the best of your ability.)

What was your child's gestational age (weeks/days) at delivery? _____

During pregnancy, was your child ever diagnosed with IUGR? If yes, what was the cause of the growth restriction (if known)? _____

Type of delivery: ___Vaginal ___VBAC ___C-Section

What interventions were used during delivery (induction, medications/epidural, fetal monitor, forceps, vacuum, other)? _____

Were there any problems or significant events during the birthing process? If yes, please describe:

_____

_____

_____

Where was your child born? _____

Delivering OB/Midwife: _____

After your child was born, did he/she ever require an evaluation or stay in the Special Care Nursery or NICU? If yes, please describe why: _____

_____

_____

If it applies to your family, are you currently feeding your child by any of the following?

___nursing ___exclusive pumping ___donor milk ___formula ___combination

Do you currently have, or have you in the past had concerns about your child's feeding abilities? _____

Description of Condition

Describe the reason(s) for your visit today: _____

When did the symptoms begin? How did they start? _____

What seems to make the symptoms better? _____

What seems to make the symptoms worse? _____

What, if any, are the effects of the problem on body function and daily activities? _____

Have you seen another doctor or health care provider for these symptoms? If Yes, please indicate the name and type of provider(s): _____

Is there any additional information about the reason for this visit that you would like the doctor to know?

Current Health and Wellness

Does your child have any ongoing diagnoses, health problems, or do you have any concerns about their health (in addition to the reason you brought them in today)? _____

Please list any medications/supplements your child is currently taking, including over-the-counter medications: _____

_____

Has your child met age appropriate growth and developmental milestones? ___Yes ___No

If No, is your child receiving support (where) or needing support? _____

_____

How does your child sleep at night? _____

Has your child been immunized? ___Yes ___Delayed Schedule ___No ___Declined

If Yes, are the immunizations up to date? _____

Have you noticed any reactions to immunizations? If Yes, please describe: _____

_____

Please list any illnesses, surgeries, or hospital visits with reasons and approximate dates: _____

_____

_____

Does your child have any allergies you are aware of? If Yes, please list:_____

_____

_____

Has your child had any ear infections? ___Yes ___No If Yes, at what age(s)? _____

Date of last physical examination: _____

Has your child had previous chiropractic care: ___Yes ___No

Consent to Treat a Minor

I hereby authorize the doctors at Greater Rochester Chiropractic to evaluate and administer chiropractic care as deemed necessary to my child at this and future visits. I understand I am welcome and encouraged to ask questions at any point before, during, or after treatment(s). I acknowledge that I am financially responsible for any and all fees charged by Greater Rochester Chiropractic and the payment will be made as soon as services are provided.

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Guardian: _____

Relationship: _____

Date: _____

Witness (office staff):_____

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Office Guidelines and Fee Policy

Patient's Name: _____ Today's Date: _____

Please initial <u>EACH</u> line in this section.

<u>I UNDERSTAND AND AGREE TO THE FOLLOWING:</u>

____ **As per my health insurance contract and the Office Fee Policy, <u>my payment is due at the time of service</u> for any Self-pay, Co-Pay, Co-Insurance, and/or Deductible amounts (except for No Fault cases).**

***** *If full payment is not an option, please speak to the Office Manager* ***prior*** *to your treatment to request a payment plan or discount due to a financial hardship. You will be required to provide documentation such as income statements or proof of Medicaid insurance in order for a discount to be considered.* ***If a payment plan is not arranged <u>prior to receiving your treatment</u>, you may be ineligible for a payment plan for that treatment.***

____ **If my account becomes 90 days delinquent,** the office has the right to deem it a collection item and it will be turned over to a collection agency.

____ **A $20.00 fee will be added to my account for any check that is returned by the bank for "Insufficient Funds."**

____ **I may be charged a $50.00 Missed Appointment Fee,** if I fail to give 24 hours' notice when canceling an appointment, or if I fail to show up for a scheduled appointment.

____ **If I do not follow this agreement, Greater Rochester Chiropractic reserves the right to cancel or not schedule future appointments.**

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Please initial <u>ONE</u> line in this section.

<u>I UNDERSTAND AND AGREE TO THE FOLLOWING:</u>

____ **I have health insurance:** I am ultimately responsible for determining my health insurance policy's chiropractic coverage, including but not limited to the following: co-payments, co-insurances, deductible amounts, limits on number of visits, referral requirements, maximum reimbursements available for chiropractic services, and verifying that my doctor participates with my insurance plan. I am responsible for paying any charges that are NOT covered or are DENIED by my health insurance plan.

- ***** *Please contact your insurance company at the Customer Service phone number printed on your insurance card if you have questions pertaining to your coverage and benefits and/or questions about how your insurance company processed your claim.*
- ***** *Please be aware that health insurance companies provide quotes, but **<u>will not guarantee</u>** your coverage and benefits based on a quote. **<u>Your insurance company will process the claims we submit and make a final determination of your coverage.</u>***

____ **I have Medicaid:** Medicaid does not provide any coverage for chiropractic treatment. I will provide proof of continued Medicaid coverage each month and I will Self-pay.

____ **My doctor does not participate with my insurance company or specific insurance plan:** I will Self-pay for my treatment.

- ***** *We submit claims to the insurance companies and plans that our doctors participate with. If your doctor does not participate with your insurance company or your insurance plan, we will provide a detailed receipt for you to submit for possible reimbursement. As previously stated, your payment to our office will be due at the time of service.*

____ **My insurance does not cover chiropractic treatment:** I will Self-pay for my treatment.

____ **I do not have health insurance:** I will Self-pay for my treatment.

____ **My injury occurred at work (Workers' Compensation):** **<u>Choose ONE of the following options.</u>**

_____I am being treated by Samuel W. Ascioti, DC, who participates with the NYS Workers' Compensation Board. I am responsible for filing an injury report with my employer and will provide this office with all necessary information related to the case. Claims will be billed to my employer's Workers' Compensation insurance carrier and payment will be made directly to the doctor.

_____I am being treated by a doctor who does not participate with the NYS Workers' Compensation Board and I will Self-pay. My personal health insurance company is not responsible for and cannot be billed for any treatment of injuries that occurred at work, regardless of whether I file a Workers' Compensation claim through my employer or not.

____ **I was involved in a Motor Vehicle Accident/No-Fault (NF):**

I am responsible for filing an accident report with the automobile insurance carrier and providing this office with all necessary information related to the case. Claims will be billed to the insurance carrier and payment will be made directly to the doctor. If my NF or PI carrier deny payment for my case, I will owe payment for the services rendered.

- ***** *Please be aware that <u>some auto policies have a Medical Deductible</u> that must be paid by you before payments will be made by the insurance company. You must complete any paperwork your insurance carrier requests and attend any examinations they require. If you do not follow the insurance company's guidelines they could deny payment, making you fully responsible for payment.*

_____ _____

Printed Name of Patient or that of Legal Representative *Patient's Signature or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, indicate relationship*

Witness: _____ *(office staff)*

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Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

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

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Greater Rochester Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Greater Rochester Chiropractic and informs me of my rights with respect to my protected health information.

_____ _____

Printed Name of Patient or that of Legal Representative *Patient's Signature or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, indicate relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ Other (please specify):_____

_____ _____

Employee Name *Today's Date*