GREATER ROCHESTER
CHIROPRACTIC
COLLABORATIVE SPINE CARE

30 ALLENS CREEK RD, ROCHESTER, NY 14618
GRCHEALTH.COM
585-442-3220 T
585-442-1017 F

Pediatric Patient Information (Age 6 to 12)

Name:	Date	
Address/City/State/ZIP:		
Date of Birth:	Age:	Gender:
Pediatrician Name:		
Pediatrician Address/Phone:		
Referred by:		

Parent Name(s):
Parent Phone Number(s):
Parent Email Address (optional for appointment reminders):
Siblings (names and ages):

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?

____

____

GREATER ROCHESTER CHIROPRACTIC
30 ALLENS CREEK RD, ROCHESTER, NY 14618
WWW.GRCHEALTH.COM
(585) 442-3220

Have you seen another doctor or healthcare 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, where does/is your child needing/receiving support? ______________________________

____

How does your child sleep at night? ______________________________

____

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

Has your child been immunized (circle one)? Yes Delayed Schedule No Declined
If yes, are the immunizations up to date? ______________________________

Have you noticed any reactions to immunizations and if so please describe: ______________

____

____

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

____

____

____

GREATER ROCHESTER CHIROPRACTIC
30 ALLENS CREEK RD, ROCHESTER, NY 14618
WWW.GRCHEALTH.COM
(585) 442-3220

Were there any problems or significant events in your pregnancy or your child's labor/birth that may be contributing (If yes, please describe. If your child is adopted please answer to the best of your ability.)? ______________________________

____

____

Does your child have any allergies you are aware of (if yes, please list)? ______________

____

____

Has your child had any ear infections? (circle one) Yes No
If Yes, at what age(s): ______________________________

____

____

Date of last physical examination: ______________________________

Has your child had previous chiropractic care? (circle one) 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): ______________________________

GREATER ROCHESTER
CHIROPRACTIC
COLLABORATIVE SPINE CARE

30 ALLENS CREEK RD, ROCHESTER, NY 14618
GRCHEALTH.COM
585-442-3220 T
585-442-1017 F

Office Guidelines & Fee Policy

Patient Name:	Date

Please initial EACH line in this section.

I understand and agree to the following:

_____ As per my health insurance contract and the Office Fee Policy, **my personal payment is due at the time of service for any Self-pay, Co-pay, Co-Insurance, and/or Deductible amount**s (except for No Fault or Worker's Compensations 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 prior to receiving your treatment, you may be ineligible for a payment plan for that day's treatment.*

_____ If my personal account becomes 90 days delinquent, **Greater Rochester Chiropractic** 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.

continued on next page >

Office Guidelines & Fee Policy continued

GREATER ROCHESTER CHIROPRACTIC
30 ALLENS CREEK RD, ROCHESTER, NY 14618
WWW.GRCHEALTH.COM
(585) 442-3220

Please initial ONE line in this section.

I understand and agree to the following:

_____ **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, <u>but 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 my specific insurance plan: I will Self-pay for my treatment.**

** We submit claims to the insurance companies and plans with which our doctors participate. 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 Greater Rochester Chiropractic 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)**: Choose ONE of the following options:

_____I am being treated by Mitchell J. Long, DC, MS, E. Daniel Quatro, DC, or Megan A. Stavalone, DC, who participate with the NYS Workers' Compensation Board. I am responsible for filing an injury report with my employer and will provide Greater Rochester Chiropractic 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 Greater Rochester Chiropractic.

_____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 denies payment for my case, I will owe payment for the services rendered.

** Please be aware that <u>some auto policies have a Medical Deductible that must be paid by you</u> 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

____ Witness Signature (GRC office staff)

____ If Legal Representative, indicate relationship

_________________________ Today's Date

GREATER ROCHESTER
CHIROPRACTIC
COLLABORATIVE SPINE CARE

30 ALLENS CREEK RD, ROCHESTER, NY 14618
GRCHEALTH.COM
585-442-3220 T
585-442-1017 F

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's 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**