

PEDIATRIC CASE HISTORY

(Ages 0-12 years old)

PERSONAL INFORMATION

Name: _____ Date: _____

Date of Birth: ___/___/___ Age: _____ Sex: Male Female

Ethnicity: Hispanic Non-Hispanic Choose not to specify Race: White Other _____

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

Social Security Number: _____ - _____ - _____ Home Phone: (_____) _____

Cell Phone: (_____) _____ E-mail: _____

Information provided by: _____ Relationship to patient: _____

PHYSICAL STRESSORS

Did the mother experience any significant falls/traumas during the pregnancy? Yes No Unsure

List any evidence of birth trauma: None Bruising Cord around neck Fast or slow birth
 Odd-shaped head Respiratory depression Stuck in birth canal
 Unknown

Does the child wear a backpack? Yes No

Does the child participate in sports/exercise activities? Yes No

Explain: _____

Does the child engage in any hobbies or activities that require prolonged, awkward or repetitive postures (violin, gymnastics, ballet, etc.)? Yes No

CHEMICAL STRESSORS

As an infant, was the child breastfed? Yes, until _____ months Yes, still breast feeding No

Was formula introduced? Yes, at _____ months No

Was cow's milk introduced? Yes, at _____ months No

Have solid foods been introduced? Yes, at _____ months No

Does the child have any food, liquid or juice intolerances or allergies? Yes No

During pregnancy, did the mother smoke? Yes No

During pregnancy, did the mother drink alcohol? Yes No

During pregnancy, did the mother use recreational drugs? Yes No

Did the mother suffer any illnesses during the pregnancy? Yes No

Did the mother take nutritional supplements during pregnancy? Yes No

Were ultrasound(s) performed during the pregnancy? Yes No

Were any instruments such as forceps or vacuum used during delivery? Yes No

Are there any pets in the child's home? Yes No

Are there any smoker's in the child's home or environment? Yes No

Has the child had any adverse reactions to vaccinations or medicines? Yes No

Has the child taken antibiotics in the past? Yes No



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PSYCHOSOCIAL STRESSORS

Have there been any difficulties with child-parent bonding? Yes No
Does the child have any behavioral problems? Yes No
What problems? Attention issues Bedwetting Sleeping Eye contact
Hearing Nervous tic Night terrors Sleepwalking
Stutter or stammering Other _____

On average, how many hours per week of television does the child watch? _____

Do you feel the child’s social and emotional development is normal for his/her age? Yes No

Was there any delay in terms of the child’s achievement of developmental goals? Choose all that apply.

- None, all developmental goals met on schedule
- Delayed response to sound
- Delayed ability to follow an object
- Delayed ability to hold an object
- Delayed ability to vocalize
- Delayed ability to sit unsupported
- Delayed normal appearance of teeth
- Delayed ability to crawl
- Delayed ability to walk

CURRENT PRIMARY HEALTH CONCERN

What is the primary concern regarding this patient? _____

What do you think caused this condition? _____

What positions seem to make this condition worse? _____

What positions seem to make this condition better? _____

Pediatrician: _____ Office Name/Location: _____

Date of Last Physical: _____

May we communicate our findings on your current health condition to the above provider(s)? Yes No

Please list any current medications: _____

Any prior hospitalizations, injuries or surgeries: _____

Any illnesses: _____

Any known allergies: _____

INSURANCE INFORMATION

Who is responsible for this account?: _____

Relationship to Patient: _____ Date of Birth: _____

Insurance Co: _____ Patient ID #: _____ Group #: _____

Is Patient covered by additional or secondary insurance? Yes No

Subscriber’s Name: _____

Relationship to Patient: _____ Date of Birth: _____

Insurance Co: _____ Patient ID #: _____ Group #: _____



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ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or this office to contact me via mail, email, phone, and text message in regards to treatment as well as promotional activities. This clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have also received a copy of this office’s Financial Policy and Appointment Policy and agree to its terms.

_____ Initial

AGREEMENTS and AUTHORIZATION

Consent to Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient’s behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professional and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient’s care as part of their education.

_____ Initial

Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to: 1) guarantee payment of all charges incurred by Patient in connection with such services (“Patient Charges”); 2) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ Initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual’s insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are “Medically Necessary” according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness chiropractic care, nutritional supplements, therapeutic modalities used for maintenance, massage and any services beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ Initial

Patient Right to Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on your behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ Initial

Responsibility for Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by this office for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____

Relationship to Patient: _____



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AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent to Release Information

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries. It is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient of Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ Initial

HIPAA Privacy Notice Patient Acknowledgement

Patient Acknowledgment and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent, I acknowledge and agree as follows:

- 1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
- 2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
- 3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
- 4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's website. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ Initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____