

Blue Q Health & Wellness

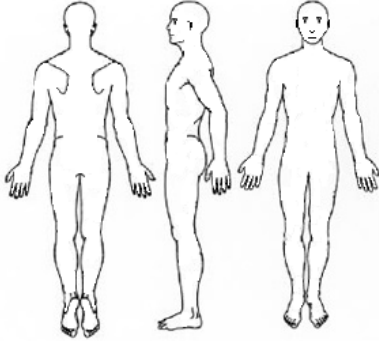
PEDIATRIC FORM

Name: _____ Date of Birth: _____ Today's Date: _____

Guardian/Person Completing Form: _____ Relationship: _____

Reason for Visit: _____

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:



Treatment Goals (What would you like to see short term and long term):

- 1) _____
- 2) _____
- 3) _____

Past Health History – Pregnancy & Delivery:

How was the pregnancy? Easy Average Challenging

Delivery: Natural Epidural C-section Extraction Breach Premature

1st Month/Early Challenges: Colic Elimination Digestion Sleep Latching & Feeding Infections

Current Concerns: _____

Pediatrician (name/location/date of last visit): _____

Specialist(s) (name/location/date of last visit): _____

I hereby request and consent to the performance of a chiropractic evaluation and treatment (for myself or for a minor) by Dr. Erika Meister (chiropractor) at Blue Q Health and Wellness. I will have the opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known to her, is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature Patient Name (or Guardian)

Date

Blue Q Health and Wellness Policies

Cancellations and Missed Appointment Policy

Appointments canceled same day or missed (no call/no show) will incur either a **\$30 charge, the full service amount, or count toward the service package.** All appointments must be canceled or rescheduled by the close of the day prior (7:00pm the day before) in order to avoid the charge or package deduction.

I acknowledge and understand the policy and have been given a copy for my records (if requested).

Signature

Date

Blue Q Health & Wellness

(Please complete if verifying insurance benefits)

ASSIGNMENT OF BENEFITS

I, _____, assign all of the rights and benefits of any applicable health insurance policies, personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Erika Meister DC at Blue Q Health and Wellness PLLC or other provider, for services and supplies provided to me. I agree to pay any co-payment or deductible not covered by the applicable health insurance policy, personal injury protection, medical payments, or other insurance coverage.

This assignment includes, but is not limited to:

- all rights to collect benefits directly from any insurance carrier obligated to provide
- benefits for services and supplies I have received;
- all rights to take legal or other action against any insurance carrier obligated to provide
- benefits if for any reason the insurance carrier fails to pay any benefits due; and
- all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees
- and costs, for any legal or other action taken by Blue Q Health and Wellness PLLC as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I agree that Blue Q Health and Wellness PLLC or health provider may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries. I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

Patient Name (or Guardian)

Date

The undersigned, as authorized representative of Blue Q Health and Wellness PLLC accepts the assignment of benefits as set forth above.

Representative of Blue Q Health and Wellness

Date