Blue Q Health & Wellness

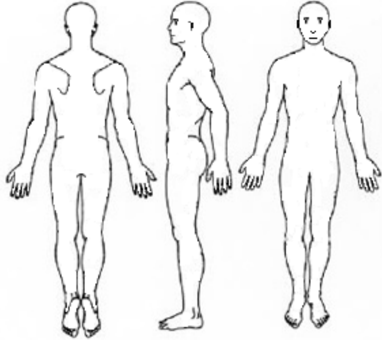
PEDIATRIC FORM

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

2480 E. Bay Dr. #13, Largo, FL 33771
727-530-7778

(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

Card on File Policy

In an effort to expedite the checkout process and to help with weekend and after hour appointments, we will require a credit or debit card on file (square card processing system). Other forms of payment will still be accepted at checkout. The card on file can/will be used for the following: balances due, payment for services completed, appointment cancellations same day ($30 fee), no call/no shows missed appointments (full fee), packages, insurance copayments, etc. An electronic notification will be sent by email or text when payment is processed. If notification preferences change, please notify us by phone or at the front desk.

I authorize Blue Q Health and Wellness to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

(Circle one of the following)

Amex **Visa** **MasterCard** **Discover**

Last 4 digits of your Card Number: ____________________

Cardholder Name: ______________________________

Zip Code: ____________________________

Email/Phone number you would like receipt sent to: _________________________________

I (we), the undersigned, authorize and request Blue Q Health and Wellness, LLC to charge my card on file, indicated above, for balances due for services rendered. This authorization relates to all payments not covered by my insurance company or any fees associated with missed and same day cancellations. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30 day notification to Blue Q Health and Wellness and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: _________________________________ Date:___________________