Mount Vernon Chiropractic

Pediatric Intake Form

Dr. Randi Grafft & Dr. Jason Salier
216 2nd St SW
Mount Vernon, IA 52314

Date: _____

Social Security #: _____/___/_____

Name: _____Preferred Name:_____
First Middle Last

Address:_____

City/State/Zip: _____

Cell Phone: _____ Alternate Phone: _____

Date of Birth: _____ Age: _____ Number of Siblings:_____

Sibling's Names:_____

Parents' Names: _____ Parent's Email: _____
(for updates on office hours, events,etc.)

Who may we thank for referring you or how did you hear about the office?_____

Insurance

Insurance Co._____ Member ID:_____ Group:_____

Policy holder name:_____ DOB:_____Relationship to patient:_____

Do you have any additional insurance? __Yes __No

Insurance Co._____ Member ID:_____ Group:_____

Policy holder name:_____ DOB:_____Relationship to patient:_____

Authorization For Care

I hereby authorize the doctors and staff at Mount Vernon Chiropractic to treat my condition as deemed appropriate. At Mount Vernon Chiropractic, we do not diagnose or treat any disease or condition other than vertebral subluxation and the doctors/clinic will not be held responsible for any pre-existing medical conditions. I certify that the below information is correct to the best of my knowledge. I will not hold the doctors or any staff member of Mount Vernon Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as all other types of health care is associated with potential risks in the delivery of treatment. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. Please inquire if you have further questions. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal, and if the results are not acceptable,we will refer you to another provider who we feel can further assist you.

Parent/Guardian Signature:_____ Date: _____

Health Questionnaire

What is the reason for seeking care today? _____

When did this begin? (If applicable) _____

What is this affecting the most in your child's life? _____

What is child's level of pain today? No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

How are your child's symptoms changing? Getting Better Not Changing Getting Worse

Has your child seen any other providers for this condition? _____

Has your child seen a chiropractor before? Yes No Doctor Name: _____

Please list any past surgeries:_____
_____

Please list any fractures/injuries:_____
_____

Please list any health concerns:_____
_____

Please list any medication/vitamin/supplements:_____
_____

Does your child have difficulty sleeping? Yes__ No__ Explain:_____

Did any of the following happen during delivery:

☐ C-section delivery ☐ Doctor pulled or twisted baby ☐ Anesthesia ☐ Labor was induced
☐ Forceps/vacuum extraction ☐ Premature delivery ☐ Special medical procedures/tests

Describe any of the above plus any additional complications experienced during delivery:
_____
_____

Permission To Treat A Minor

I, (Parent/Guardian) _____, give the doctors of Mount Vernon Chiropractic and whomever they may designate as their assistants permission to examine, x-ray (if necessary), and treat _____ Minor date of birth: _____ from this date forward.

Parent/Guardian Signature: _____ ***Date:*** _____

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to define situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view charges to your records. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and/or understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Mount Vernon Chiropractic. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I grant permission to be called, text, e-mailed to confirm or reschedule an appointment and to be sent occasional cards, letters, e-mails or health information to me as an extension of my care in this office.

Mount Vernon Chiropractic reserves the right to change the privacy practices that are descried in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read and understand your Notice of Privacy Practices. I also understand that I can request in writing that you restrict how my personal information is used and disclosed.

Parent/Guardian Signature:_____ Relationship to Patient:_____ Date: _____

Financial Policy

Our goal is to provide the highest quality of healthcare possible for our patients. In order to achieve this goal, we need your commitment as well.

Our policy is to charge $35.00 for missed appointments not canceled within 12 hours before scheduled appointment. These charges will be your responsibility and billed directly to you.

Appointments: We urge our patients to follow the doctors' recommendations for care. Please keep your appointments as scheduled or call our office to make any changes. In order to attain the level of achievement we both desire, care must be followed.

Patients Without Insurance: We require that 100% of the services performed be paid at the time of the visit. Failure to not pay for treatment at the time of service may result in loss of time of service discounts and incurring other finance charges.

Medical Insurance: When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Medicare: We do accept assignment from Medicare. Medicare covers ONLY manual manipulation of the spine for Chiropractic.

Advanced Beneficiary Notice of NON-Coverage (ABN): Your health insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your health insurance will not pay for items and services such as your initial visit and any chiropractic care deemed maintenance or wellness care by your carrier (as well as other items that may arise in the future). Signing below signifies that you want these items and services, but understand that they will not be billed to your insurance company. Therefore, you are responsible for payment and cannot appeal to your insurance carrier as they were not submitted and/or billed to them. This notice gives our opinion, not an official Medicare or other insurance carrier's decision.

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Nonpayment: Procedure charges not paid at the time of service will be assessed a processing fee of $5.00. If your account is over 30 days past due, you will receive a 10% monthly interest charge on your balance every month that your account is not paid in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and/or small claims court. We reserve the right to refuse treatment to those persons with outstanding account balances.

Insurance Authorization, Assignment of Benefits, Release of Information, Payment Agreement: I understand that my insurance is an arrangement between my insurance company and myself, NOT between Dr. Grafft or Dr. Salier and my insurance company. I request that Mount Vernon Chiropractic to send all of my health insurance claims. I authorize that any insurance benefits or reimbursement for services rendered which amounts would otherwise be payable to me under any insurance, pre-paid health care plan, or Medicare be made directly to: Mount Vernon Chiropractic, LLC.I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan, or Medicare. I understand that there is no guarantee that my insurance companies will cover or pay for all of my charges. I understand that I am responsible for all remaining charges.

If you have questions about our financial policies, please speak with our staff. If you need to make special payment arrangements, we will do everything possible to meet your financial needs.

Parent/Guardian Signature:_____ Date: _____