 Fairbanks Chiropractic Clinic

1118 2nd Ave.

Fairbanks, AK 99701

**Initial Child & Adolescent Questionnaire**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First MI Last**

**Parents:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Street City State Zip

Date of Birth: \_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_ **M F**

Contact Number: \_(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Would you like text message reminders? Y N**

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE**

**Do you have Insurance?** **Y N**

Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

**I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. *I understand that I am financially responsible for all charges whether or not paid by insurance.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date

**Mainly for Moms:**

**Tell us about your pregnancy;**

Did you carry to full term? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any complications and when they occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tell us about your delivery and birth of this child:**

Did you use : Midwife Obstetrician

Did you have a C-Section? \_ Were forceps used? \_\_\_ Vacuum Extraction? \_\_\_ Were you induced? \_\_\_ Did you have an Epidural?\_\_\_ Was it a difficult birth? \_\_\_

**Tell us more:**

Did you breastfeed? **Y N** How long? What formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you consume alcohol during your pregnancy? **Y N** How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you smoke? **Y N** How much? How long? \_\_\_\_\_\_\_\_\_\_\_

List any medications, and why you were taking them during pregnancy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any exposures to ultrasound? **Y N** How many?\_\_\_\_\_\_

**About your Child:**

**Have any of the following occurred with your child?**

\_\_\_Fall from a height \_\_\_Frequent fevers \_\_\_Frequent bouts of diarrhea \_\_\_Involved in car accident

\_\_\_Constipation \_\_\_ Sleeping problem \_\_\_Play in Jolly Jumper \_\_\_Frequent colds

\_\_\_Frequent ear infection \_\_\_Colic \_\_\_Tonsillitis \_\_\_Reaction to vaccination \_\_\_Allergies

\_\_\_Stomach pains \_\_\_Bed wetting \_\_\_Hyperactivity/Autism \_\_\_Learning difficulties

\_\_\_Sports accident \_\_\_Asthma \_\_\_Car accident \_\_\_Scoliosis \_\_\_Leg/knee pain\_\_\_ Headaches

\_\_\_ Numbness in arms/hands \_\_\_ Dizziness \_\_\_ Ringing in ears \_\_\_ Sleeping problems

\_\_\_ Allergies \_\_\_ Shoulder pains \_\_\_ Hyperactivity \_\_\_ Stomach problems \_\_\_ Growing Pains

\_\_\_ Fatigue \_\_\_ Weight gain/loss \_\_\_ Other

Please explain other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you told that you had a choice in vaccinating your child? Y N**

**Would you like information on the other side of this issue**? **Y N**

**Please tell us the main reason your child has an appointment with us today**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this problem: \_\_ Constant \_\_ Intermittent \_\_ Occasional \_\_ Cyclical**

**How long has it occurred?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When it is at its worst, how does it make your child feel?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your child’s daily activities effected? Y N**

**What makes it better/worse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your goals for treatment?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any medications your child is currently taking:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any hospital stays:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there anything else you feel we should know?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have answered these questions to the best of my knowledge. I am a legal adult or I am the guardian/parent of someone for whom I have answered these questions.

**Signature of Parent/Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:\_\_\_/\_\_\_\_/\_\_\_\_**

**Consent to Treatment of Minor Child**

I hereby authorize:

Dr. Gappert, and whomever she may designate as assistants to administer chiropractic care as deemed necessary to my child,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of child).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Signature

**Authorization of Access to Account**

I authorize the below named person/s to have access to my account and discuss my billing information with Fairbanks Chiropractic Clinic. (ie; parents or legal guardians other than person signing this page)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & 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 among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that you have a copy of your *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information on hand if I want to read it. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Initials:\_\_\_\_\_\_\_\_\_ Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fairbanks Chiropractic Clinic Financial Policy**

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at this time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about fees, the Financial Policy, or your responsibility.

**PAYMENT:**

Full payment is due at the time of service. We look to you, the patient, not the insurance company for any unpaid balances. You are responsible for the timely payment of your account.

In order to help determine your responsibility toward payment for services, please read the following, and initial your preference for the method of payment of your account. Please notify this office if the status of your insurance changes.

**Private Pay:** (please initial below which option you have chosen)

A. \_\_\_\_ As I have no insurance, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

**OR**

B.\_\_\_\_ I have insurance, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

**OR**

**Health Insurance Option:**

C.\_\_\_\_ I would like this clinic to bill my insurance. I understand I am responsible for the costs of treatment. Please be aware that if we have not received payment from your insurance company within 90 days of being billed, you will be expected to pay any outstanding charges before continuing treatment. It is your responsibility to complete and return any questionnaires sent to you.

**HEALTH INSURANCE**

IT IS YOUR RESPONSIBILITY TO KNOW WHAT YOUR INSURANCE BENEFITS ARE.

If you have insurance, we will help you receive maximum benefits and verify your benefits if needed. We will file your claim for you as a courtesy. We agree to file your insurance claim for you if you obtain approval from our office staff prior to the date of service. If we do agree to bill your insurance you must pay the co-pay amount required by your insurance company on the day you receive services.

You may or may not have a balance once we receive payment from your insurance**.** **If your insurance has not paid your claim within 90 days, you are responsible to have your account balance paid in full within 30 days from the date you receive notice of non-payment.** This notice may be from Fairbanks Chiropractic Clinic Inc. or your insurance company, whichever arrives first. If you have a credit after your insurance pays, a refund check will not be issued to you for at least 60 days. This allows time for our office to audit the account for possible overpayment from your insurance. In some cases it takes up to six months or longer for insurance to realize they overpaid. Your account may also show reversals of incorrect payments by your insurance company. When we do issue a refund, it will never be more than what you paid out-of-pocket. Insurance overpayment will not be refunded to you without a letter of authorization from your insurance company. This must be obtained by you and presented to us for verification.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee correct payment of your claim. It cannot be assumed by either you or Fairbanks Chiropractic Clinic, Inc., that your insurance company will accept our charge as a basis for their reimbursement on what they consider an acceptable fee. If your claim is not paid, the insurance company should explain to you why it was rejected. If your claim is rejected, Fairbanks Chiropractic Clinic will make every effort to try and get your services covered by your insurance company. Your insurance company identifies Fairbanks Chiropractic Clinic, Inc. as the provider, not the recipient of your insurance benefits.

\_\_\_\_\_ My initials here indicate that I understand the above Payment and Health Insurance policy.

**MISSED APPOINMENTS:**

It is the policy of Fairbanks Chiropractic Clinic to assess a **$60.00** missed visit fee to existing patients who cancel **chiropractic appointments** with less than 24 hour notice. A **$100** missed visit fee will be added to patients who cancel **massage appointments** with less than 48 hour notice. Fairbanks Chiropractic Clinic will assess a $100.00 missed visit to a new patient who cancelled with less than 48 hour notice. 7 or more minutes late to an appointment is considered a missed appointment. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others.

\_\_\_\_ My initials here indicate that I understand the above Missed Appointment policy.

**Nonsufficient Fund and Returned Check Fees:**

A $25.00 processing fee will be charged for any NSF/Returned checks.

\_\_\_\_ My initials here indicate that I understand the above NSF/Returned check fee policy.

**I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand and agree to the conditions of this policy.**

Patient/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Updated 11/15/2017

**NEW OR CHANGE OF INSURANCE**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INS ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GROUP NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EFFECTIVE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POLICY HOLDER BIRTH DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY INSURANCE COMPANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INS ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GROUP NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EFFECTIVE DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POLICY HOLDER BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I WOULD LIKE FAIRBANKS CHIROPRACTIC CLINIC TO BILL MY INSURANCE. I UNDERSTAND THAT I AM RESPONSIBLE FOR THE COST OF TREATMENT. IF FAIRBANKS CHIROPRACTIC CLINIC DOES NOT RECEIVE PAYMENT FROM INSURANCE WITHIN 90 DAYS, I UNDERSTAND THAT THE OUTSTANDING BALANCE WILL BE MY RESPONSIBILITY. IT IS MY RESPONSIBILITY TO COMPLETE AND RETURN ANY QUESTIONNAIRE THAT INSURANCE MAY SEND ME.

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_**

