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
toPatient:_____

Signature:

_____

Fairbanks Chiropractic Clinic: Financial Policy

January 2019

Fairbanks Chiropractic Clinic is happy to work with our patients to provide the best quality of services. This letter is to acquaint you with our financial policy. Please read the following carefully and initial after each section to acknowledge your understanding and agreement to the policy. Your health insurance may have a deductible as well as a percentage (co-insurance or co-pay fee) for which you, the patient, is responsible. Therefore, it is our responsibility to have all initial visit fees paid for by the patient at the time of his or her appointment.

Initial: _____ Date: _____

Claims are sent out to insurance policies by our billing representative to primary and secondary insurances **as a courtesy** to the patient. Any insurance policies beyond a secondary policy must be billed out by the patient. **Health insurance is an agreement between the patient and the insurance company, not the provider's office**. Since there are no guarantees of payment from the insurance company, you, the patient, are held liable for unpaid balances after **90 days** whether insurance payment is still pending or not. Any balances past 90 days must be paid in full prior to any additional appointments. In the event that insurance pays after the 90-day period, a check will be issued back to the patient for any account credits at that time.

Initial: _____ Date: _____

Additionally, from time to time, insurance companies may send letters to the patient regarding accident questionnaires. These letters only go to the patient and often the provider's office is unaware they have been sent. It is the patient's responsibility to complete and return these questionnaires to the insurance company in a timely manner, **otherwise claims will be denied.** Claims denied due to lack of communication from the patient are solely the patient's responsibility.

Initial: _____ Date: _____

In the event that the patient's insurance requires an authorization to pay for treatments, it is the responsibility of the patient, and the patient alone, to get this authorization. Once authorizations expire, **it is the responsibility of the patient to contact his or her insurance to extend or create a new authorization**. Fairbanks Chiropractic Clinic and its billing department will work its best to remind the patient when authorizations are close to expiration, but this is only a courtesy and is ultimately the patient's duty to keep track of authorized visits.

Initial: _____ Date: _____

(Flip to page 2)

We encourage you to ask any questions you may have regarding our financial policy so that you may have a clear understanding. Our goal is to concentrate on returning you to optimal health and establish overall well-being. We have prepared the following checklist in order to help out patients determine their responsibility toward payment for chiropractic and/or massage services. Please check the statement that applies to you.

_____ **PRIVATE INSURANCE**: I understand that as a service to me, Fairbanks Chiropractic Clinic will bill my primary and secondary insurance for services rendered. However, I fully understand that it is ultimately my financial responsibility to be liable for all healthcare expenses regardless of insurance coverage. I agree to assume all financial responsibility.

_____ **MEDICARE**: I am eligible for Medicare and I understand that it only pays for manipulation of the spine, not for extra-spinal work, muscle work, diagnostic exams, or massage. I also understand that there is a yearly deductible which must be paid by the patient. Medicare will only cover 80% of the allowed fee and I request that Fairbanks Chiropractic bill my Medicare supplement or secondary insurance, if applicable.

_____ **PRIVATE PAY (CASH or CHUSA)**: As I have no insurance, or insurance that does not cover chiropractic care, I agree to assume all payment responsibility and keep my account current.

My signature gives Fairbanks Chiropractic Clinic permission to give out pertinent information to my insurance company to facilitate payment for services rendered. **(A scanned copy of this form will be kept in patient's electronic chart)**

Patient Signature (guardian if patient is a minor): _____

Patient Name (printed): _____ Date: _____

Fairbanks Chiropractic Clinic: Clinic Policies 2019

HIPAA:

I understand that under the Health Insurance Portability and Accountability Act of 1996 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.

A copy of the clinic's Notice of Privacy Practices containing more complete descriptions of the uses and disclosures of health information is available. I understand that this organization has the right to change this notice from time to time and I may contact this organization at any time and be provided a copy.

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 operations. 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: _____ Signature: _____ Date: _____

No Show/Late Policy:

If a chiropractic appointment must be cancelled or changed, 24 hours' notice is required so the provider may see others in need. If a new patient or massage appointment must be cancelled or changed, 48 hours' notice is required, as these spaces are less frequently available. In the event that an appointment is on a Monday, we ask that cancellations be made by Friday at the close of business. In addition, should a patient arrive more than 5 minutes late for his or her scheduled appointment, it will be rescheduled and marked in the patient's chart as a missed appointment.

No shows/missed appointments will result in a charge of $60 for adjustments and $100 for massages and/or new patient appointments.

Initial: _____ Date: _____

Texts/phone call reminders

If remembering appointments is difficult for you, Fairbanks Chiropractic Clinic can add you to the reminder call or text list for the day prior to your appointment. This text or call is made by a third-party company and is a courtesy to patients. However, it is still the patient's responsibility to show up on time to his or her appointment, regardless of receipt of a reminder.

Initial: _____ Date: _____

Auto Accidents:

In the event that a patient is in an automobile accident, he or she must make an appointment for an initial examination prior to being treated for an injury related to the accident. At this visit, complete claim information must be given to the front desk staff including the company, policy number, claim,

and claim adjustor name and contact information. **Additionally, all visits that are to be billed to the auto insurance company must be paid up front** due to many auto insurances taking up to one year to pay out claims. Once the auto insurance company has paid claims, a refund check will be sent to the patient within two weeks.

Initial: _____ Date: _____

Notification with family:

At times, it may be convenient for you to have a family member or friend access your health information (chart notes, statements, etc.) Please fill out the spaces below should you wish to allow someone other than yourself to have access to your health information at this clinic.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Initial: _____ Date: _____

Collections:

In the event that an account is past due, reminders will be sent on statements to the last known address for a patient. After three reminders, the patient account will be sent to Cornerstone Collections Agency based out of Anchorage, Alaska. **Once an account has been sent to collections, the patient can no longer be seen at the clinic until the collections has been settled**. Additionally, if an account has been to collections in the past, the first three (3) visits after re-establishing care must be paid for in full.

Initial: _____ Date: _____

Responsibility as a Patient:

While we do our best to provide excellent care for our patients, we ask that our patient have the responsibility for:

- Providing accurate and complete information about medical complaints, past illnesses, hospitalizations, medications, pain, and other matters relating to their health.
- Following the treatment plan recommended by those responsible for their care.
- Seeing that their bills are paid as promptly as possible.
- Being considerate of the rights of other patients and clinic personnel.
- Seeking information, and in the event that they have questions, asking them.

Patient Signature (guardian if patient is a minor): _____

Patient Name (printed): _____ Date: _____