Fairbanks Chiropractic Clinic
1118 2nd Ave.
Fairbanks, AK 99701
(907)456-6213

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: (___)_____-_____

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: _____

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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?_____

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

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

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About your Child:

Have any of the following occurred with your child?

○ Fall from height	○ Involved in car accident	○ Sports accidents
○ Frequent fevers	○ Constipation	○ Frequent bouts of diarrhea
○ Sleeping problems	○ Play in Jolly Jumper	○ Frequent colds
○ Frequent ear infections	○ Colic	○ Tonsilitis
○ Reaction to vaccination	○ Allergies	○ Stomach pains
○ Bed wetting	○ Hyperactivity/Autism	○ Learning difficulties
○ Asthma	○ Scoliosis	○ Leg/knee pain
○ Headaches	○ Numbness in arms/hands	○ Dizziness
○ Ringing in ears	○ Shoulder pains	○ Growing pains
○ Fatigue	○ Weight gain/loss	○ Other:_____

Please explain other:

_____

_____

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? _____

Are your child's daily activities affected? Y N

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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 that 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: _____

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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)

Signature: _____ Date: _____

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. (i.e.: parents or legal guardians other than person signing this page)

Name: _____ Name:_____

O I would not like to authorize anyone at this time.

Signature:_____

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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: _____

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Fairbanks Chiropractic Clinic: Financial Policy
August 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 visit fees (co-insurance or co-pay 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 of the date billed** whether insurance payment is still pending or not. Any balances past 90 days, of the date billed, 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: _____

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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 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 Clinic 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: _____

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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 the 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: _____

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: _____

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 visits after re-establishing care must be paid for in full.

Initial: _____ Date: _____

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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:_____

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GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY / AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE –SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK = 5 _____