Varney Chiropractic — Pediatric Intake Form

PERSONAL INFORMATION

PLEASE PRINT

First Name:_____**M.I**._____**Last Name**:_____ **Birthdate**:_____/_____/_____

Child's SSN#:_____/_____/_____ **Gender**: □ Male □ Female □ Unspecified **Siblings?** (# and ages)_____

Name of Parents/Guardians:_____

Address:_____**City**:_____**State:**_____**Zip:**_____

Primary Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Home Email:_____ **Work Email**:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which email would you like us to use to communicate with you? (check one) □ Home □ Work

Contact Method: (check one) □ Primary Phone □ Cell Phone □ Work Phone □ Home Email □ Work Email

Family Physician Name:_____City:_____

How were you referred to Varney Chiropractic?□ Patient_____ □ Physician_____

□ Yellow Pages □ Internet □ Radio □ Newspaper □ Sign □ Other_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Auto Insurance □ Other_____

Primary Insurance Carrier:_____ Phone:_____

Policy#_____ Group #_____ Claim#_____

Name of Policy Holder:_____ Relationship to Patient:_____

Policy Holder's Birthdate :_____/_____/_____ Policy Holder's SSN: _____/____/_____ Employer:_____

Is patient covered by another insurance? □ Yes □ No **Sec. Insurance Carrier**:_____Policy #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Varney Chiropractic, all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? _____

_____

When did this complaint begin? _____/_____/_____ **Other doctors seen for this condition**:_____

Treatments:_____

Medications past/present:_____

Vitamins /Supplements:_____

Other health concerns:_____

_____

FOR CHILDREN 0-6 YEARS OLD

1. **PRENATAL / BIRTH HISTORY**

Birth Weight_____ Birth Length_____

Type of birth: ___ Normal Vaginal ___ Forceps ___ Breech ___Cesarean

Location: ___ Home ___ Hospital ____ Birthing Center

Describe any problems during pregnancy:_____

_____

_____

Describe any problems during delivery: _____

_____

_____

Jaundice? ___Yes ___No Cyanosis? ___Yes ___No

Obstetrician / Physician / Midwife:_____

2. **INFANT QUESTIONNAIRE:**

Birth defects:_____

Infant Feeding: ___Breast ___ Formula/Brand:_____Number of bowel movements per day/type:_____

Child's average number of hours slept per night:_____ Quality of sleep: ___ Good ___ Poor

Is your child able to do the following (check all that apply): ___Respond to sound ____Follow object with eyes

____Hold head up ____Sit alone ____ Crawl ____ Stand ____ Walk alone

Childhood diseases (check all that apply): ___ Chickenpox ___ Mumps ___ Rubella ___ Rubeola ___Measles

___Whooping cough ___ Other:_____

3. **HEALTH HISTORY:**

Pediatrician (clinic) / Family MD (clinic)_____

Has your child been treated on an emergency basis?_____

Please check **ALL** any of the following which your child has suffered from in the last 6 months.						**Family History** Mark **ALL** conditions that run in your family		**Relationship:** (Father,Mother,Sister, Brother)
□	Ear Infections	□	Growing Pains	□	Anemia	□	Cancer *Type:*	
□	Asthma / Allergies	□	Back Pain	□	Poor Appetite	□	Anemia	
□	Diabetes □ Type I or □ Type II	□	Bed Wetting	□	Fainting	□	Diabetes (check one) □Type I □ Type II	
□	Fevers	□	Acid Reflux	□	Neck Pain	□	Heart Problems / Stroke	
□	Cancer/Tumor	□	Seizures	□	Convulsions	□	High Blood Pressure	
□	Colic	□	Temper tantrums	□	Hyperactivity	□	Genetic Disorders	
□	Headaches	□	Colds/Flu	□	Dizziness	□	Rheumatoid Arthritis	
□	Scoliosis	□	Accident/Injuries	□	Digestive	□	Other (List):	
□	Problems/Excessive Gas	□	Ruptures/Hernias	□	Other(List):			

NAME:_____ DATE:_____

VARNEY CHIROPRACTIC

Financial Policy

Patient Name:
Date of Birth:

Thank you for choosing Varney Chiropractic for your wholistic healthcare provider. We are committed to your care and treatment. This financial policy is an important part of your care. We ask you to read and agree to the following policy so there are no misunderstandings.

Commercial Insurance
We are out-of-network with all commercial insurances. Upon request we will provide you with a statement so you can self-bill and collect payment directly from your insurance company at out-of-network rates. Payment is expected at the time of service.

Medicare:
We do accept National Government Services Medicare, Humana, Martin's Point & Wellcare. Medicare will only cover acute chiropractic spinal manipulation treatment. Any exams, deductibles, co-insurances, co-pays, extremity adjustments, therapies and maintenance/wellcare will be the patient's responsibility as they are considered non-covered services.

Fees:
Below is an estimate by visit type:
New Patient (Total cost for 1st visit): $100 - $135
Re-Examination (Total cost for 1st visit): $85 - $120
Treatment Visits: $40 - $60

We accept cash, checks, Visa, Mastercard and Discover.

A $25.00 fee will be applied to your account for all returned checks.

Patients with a balance of $100.00 will be required to make a payment on their account and make a payment arrangement before another appointment can be scheduled.

Missed Appointments
*Varney Chiropractic **requires a 24 hour notice to cancel appointments**. A $40.00 fee will be charged for appointments that are not rescheduled within **24 hours** of the appointment time. If you miss three (3) appointments without prior notification to our office, you may be dismissed from our practice.*

Questions about this policy? Call Lori, the Billing Manager at 207-225-5949
I have read and agree to Varney Chiropractic's Financial Policy.

_____	_____	_____
Signature of Patient or Guardian	*Print Name*	*Date*

Varney Chiropractic
David W. Varney DC
Ruth L. Varney, DC
Warren D. Varney, DC

1071F Auburn Road
Turner, ME 04282
(207)225-5949

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

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- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____