CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your photo ID and insurance card(s). All information you supply is confidential.

PEDIATRIC INTAKE FORM

Today's Date (MM/DD/YYYY) _____ **Patient Number (office use only)** _____

PERSONAL INFORMATION

Child's First Name: _____ **MI:** _____ **Last Name:** _____

Preferred Name: _____ **Social Security Number:** _____

Address: _____

City/State/Zip: _____

Birth Date: _____ **Age:** _____ **Sex:** **M** **F**

# of Siblings: _____

Sibling(s) Names & Ages: _____

_____

Parents' Names: _____

Best Contact Phone: (_____ **)** _____ **Alternate Phone: (** _____ **)** _____

Cell Phone Carrier (for texting): _____ **Email:** _____

Who can we thank for referring you or how did you hear about Enos Chiropractic Center? _____

_____

REASON FOR SEEKING CARE

What is your reason for seeking care at Enos Chiropractic Center? _____

_____

When did it first begin? (If applicable) _____

Are there any major injuries and/or surgeries we should know about? _____

_____

What is this affecting that is MOST important in your child's life? (List all that apply) _____

_____

Has your child seen any other providers for this condition? (List all that apply) _____

_____

Has your child seen a chiropractor before? **Yes** **No**

How long ago? _____ **Clinic/Doctor Name:** _____

What is your reason for the change? (If applicable) _____

_____ _____

Parent/ Guardian's signature **Date (MM/DD/YYYY)**

Patient Name: _____

Patient Number: _____

HEALTH CONCERNS

- ◯ Anxiety/Depression
- ◯ Constipation/Diarrhea
- ◯ Nausea/Vomiting
- ◯ Diabetes
- ◯ Bed Wetting
- ◯ Overweight
- ◯ Frequent Sickness
- ◯ ADD/ADHD
- ◯ Detachment/Distant
- ◯ Irritability/Nervous
- ◯ Fatigue/Sleep Issues
- ◯ Asthma/Chronic Bronchitis
- ◯ Colic/Acid Redux
- ◯ Back/Neck Pain/Stiffness
- ◯ Difficulty Gaining Weight
- ◯ Ear or Other Infections
- ◯ Headaches
- ◯ Learning Disorders
- ◯ Sinus Troubles/Allergies
- ◯ Autism/Asperger's
- ◯ Other _____
- ◯ Other _____
- ◯ Other _____

Explain any boxes checked above: _____

Is there anything else regarding your child's current condition you feel the doctor should know? _____

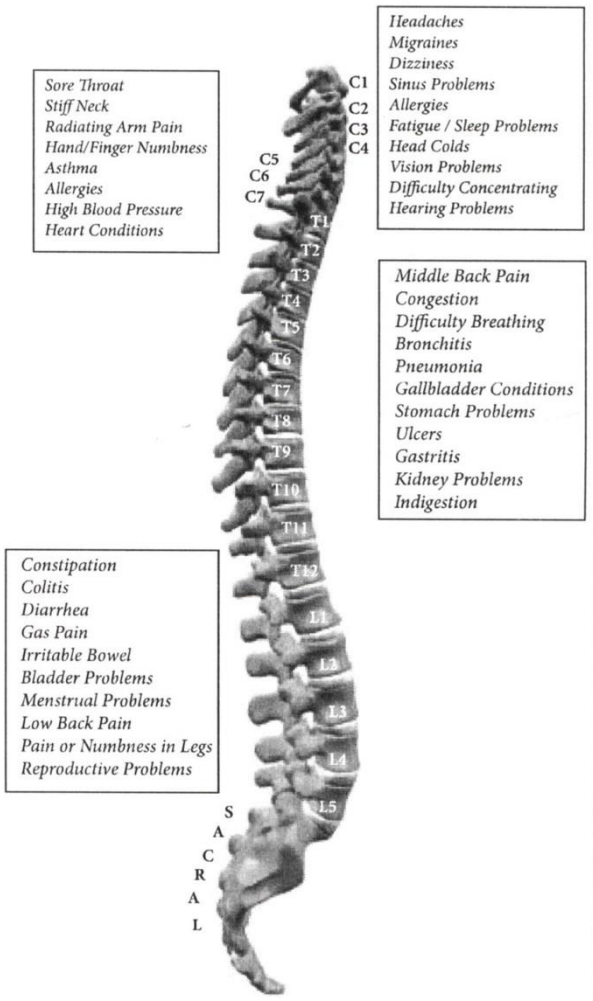
MEDICATIONS

- ◯ Anxiety/Depression
- ◯ Asthma
- ◯ Pain Narcotics
- ◯ Antibiotics
- ◯ Migraine/Headache
- ◯ Acid Reflux
- ◯ ADD/ADHD
- ◯ Digestive
- ◯ Other _____
- ◯ Other _____
- ◯ Other _____

Explain any boxes checked above: _____

Did You Know...

Each health concern relates to a specific area of the spine and nervous system? Please circle below or enter the information to the left.



VITAMINS

- ◯ Multi-Vitamin
- ◯ Vitamin D3
- ◯ Fish Oil/Omega 3
- ◯ Probiotics
- ◯ Other _____
- ◯ Other _____
- ◯ Other _____

Explain any boxes checked above: _____

Patient Name _____ **Patient Number** _____
(office use only)

PRENATAL HISTORY (ages 0-10 years)

Location of birth: HOME BIRTHING CENTER HOSPITAL Other: _____
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: _____

During pregnancy, did you use any drugs, tobacco, alcohol and/or medications? If yes, please list: _____

Did you experience any illness while pregnant? YES NO If yes, explain: _____
Do you have any physical disabilities? YES NO If yes, explain: _____
Birth weight: _____ Birth length: _____ APGAR scores (if remembered): _____
Was ultrasound used during pregnancy? YES NO Number of times: _____
Did you breastfeed the baby? YES NO If yes, how long? _____
Did you formula feed the baby? YES NO If yes, how long? _____
At what age did you introduce: Solids: _____ Cow's milk: _____

LIFESTYLE HABITS

Does your child exercise daily? YES NO How much? _____
Does your child drink soda? YES NO How much/often? _____
Does your child have a positive self-esteem or self-image? YES NO
Does your child watch more than an hour of TV per day? YES NO How much? _____
Does your child eat balanced meals? YES NO
Does your child experience prolonged sadness? YES NO Explain: _____
Does your child have difficulty sleeping? YES NO Explain: _____
Does your child play video games? YES NO How much? _____

CURRENT HEALTH STATUS

The National Safety Council reports approximately 50% of children fall head first from a high place during their first year of life (bed, changing table, stairs, etc.). Was this the case for your child? YES NO Explain: _____

Has your child ever been hospitalized or had surgery? YES NO Explain: _____
Does your child have difficulty interacting with others? YES NO Explain: _____
Have you noticed that your child is nervous, twitches, shakes or exhibits rocking behavior? YES NO Explain:

Has your child been involved in any high impact/contact sports (soccer, football, martial arts, cheerleading, etc.)?
YES NO Please list: _____
Are you aware of any food allergies or intolerance? YES NO Explain: _____
Has your child received all recommended vaccinations? YES NO Explain: _____
Please rate stress levels on a scale of 1-19 (10 being the highest)
School: 1 2 3 4 5 6 7 8 9 10 Personal: 1 2 3 4 5 6 7 8 9 10

PERMISSION TO TREAT A MINOR

I, (Parent/Guardian) _____, give Enos Chiropractic Center permission to examine, x-ray (if necessary), and treat _____. Minor's date of birth: _____

Parent/Guardian: _____ Date: _____

Witness Signature: _____

12 Calef Street
Warwick, RI
02886

BLANKET AUTHORIZATION/RELEASE FORM

Initials _____ I authorize payment of medical benefits from _____Insurance Company to be paid directly to: Jamie M. Enos, D.C. for services rendered to me. If my current policy prohibits the direct payment to Enos Chiropractic Center, and I as the subscriber receive a check from my insurance company that is intended for this practice for services rendered, I must immediately remit this to our office for credit to my account. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I agree to pay any balance that remains after my insurance company has made payment, and any unpaid balance that remains 60 days after services are rendered. I hereby direct all payers to release to ENOS CHIROPRACTIC CENTER any information regarding coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

Initials _____ I do not have insurance benefits available and agree to pay for all services rendered to me, at the time they incur, unless otherwise agreed to in the form of a financial payment contract.

Initials _____ I understand that I am ultimately responsible for payment in full and agree to pay a $10 per month billing charge and a 1.25% monthly interest charge for all unpaid balances, which become 30 days past due. If necessary, I also agree to take full responsibility for all third party costs, including collection agencies, reasonable attorney fees and/or court costs incurred in attempting to collect this debt

Initials _____ I hereby authorize the release of my x-rays and medical records from any medical provider, hospital, attorney or insurance company upon receipt of a copy of this form, to ENOS CHIROPRACTIC CENTER.

Initials _____ To the best of my knowledge I am not pregnant. I understand that x-ray radiation may pose risks to an unborn child. I consent having x-rays taken, and I release Dr. Jamie Enos, and the office from any responsibility that could in any way associate damage to an unborn child with the x-ray examination. If you have any concerns, please consult the doctor.

Initials _____ I instruct Dr. Enos to deliver the care that, in his professional judgment, can best help in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I hereby acknowledge and understand that if I do not keep appointments as recommended by my attending chiropractor, I cannot expect maximum chiropractic results and the doctor has full and complete right to terminate my case and discharge me from care.

Initials _____ I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending doctor and it is the responsibility of the staff to carry out the instructions of such doctor.

Initials _____ I grant permission to be called, texted and/or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office..

Initials _____ I hereby give my consent for Dr. Jamie Enos to examine and render treatment to my son/daughter _____ who is a minor.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

I have read the above blanket authorization/release form and agree to the initialed items.

_____ _____

Patient Name (print) Patient /Guardian Signature

Date:_____ ECC Witness: _____

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FINANCIAL AGREEMENT

The doctor and staff of Enos Chiropractic Center welcome you as a patient and are pleased that you chose us to provide your medical care. We are committed to your treatment being successful. Please understand that payment of our bill is considered a part of your treatment. The following is a statement of our financial/office policy, which we require that you read and sign prior to any treatment. All patients must complete our information and insurance form before seeing the doctor.

We have advised you that we do not participate in all insurance programs and that certain services in some cases are not covered by insurance. We reserve the right to perform services and utilize certain professional staff to assist us in your care regardless of your insurance coverage. Our office policy is to receive payment at the time services are rendered. We encourage you to ask questions and make sure you fully understand what your responsibilities are, because you are ultimately responsible for paying for all services you receive. We are available to explain some of the general parts of how your insurance will cover the services provided by our practice, but only your insurance company will have the specifics of how your plan works.

A finance charge of 1.25% per month (15% annually) with a $10 per month billing charge may be charged on all past due accounts along a $25 fee will be charged on any returned check. In the event of nonpayment of an account, I understand that I will be responsible for all collection costs, including reasonable attorney fees, incurred for the collection of said balance.

GENERAL CONSENT/AUTHORIZATIONS

I hereby give Enos Chiropractic Center consent for those services deemed medically necessary appropriate by the attending provider.

I request that payment of authorized Medicare or any other insurance benefits be made on my behalf to Enos Chiropractic Center for any services provided to me by that group. I understand that any holder of medical information about me may release any information to the Health Care Finance Administration (HCFA) and its agents in order to facilitate reimbursement for services rendered. I authorize Enos Chiropractic Center to release information to all parties and/or their representatives that may be required to provide or pay for services rendered.

I understand that the above consent/authorizations do not guarantee payment/reimbursement, nor does it release me from any obligation and responsibility for all outstanding charges not covered as a result of, but not exclusive to: copayments, co-insurance, deductibles, usual and customary schedules, maximum allowances/limits or non-covered services.

I understand that if may be necessary to use a photocopy or facsimile of this assignment and that it is to be considered as valid as the original.

PATIENT'S RESPONSIBILITY FOR MEDICAL CARE

During the course of your evaluation and treatment, your doctor may suggest that you have certain tests done, be evaluated by a physician of a different specialty, or return to this office on a future date for re-evaluation. In consideration of this, and your health, we ask that you keep all scheduled appointments and associated commitments. If you have any questions concerning the recommended treatment, please be sure to have them addressed during your visit or by phone should questions come up after your visit. The continuity of you care often depends on your full cooperation and open communication. If, for some reason, you cannot proceed with your doctor's recommendations, please let us know as soon as possible. Your doctor relies on your honest and complete feedback and will respect your decision. In regards to results from your visits or completed tests, we will call you when we have the results, but please feel free to call this office to request the information. It is important that you understand the consequences of not following through with recommended testing or scheduled appointments. Your signature below acknowledges your understanding of the importance of proceeding with the treatment plan as recommended and the subsequent consequences of not doing so.

Signature:_____ Date:_____
(PATIENT/PARENT/GUARDIAN)

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No-Show and Cancellation Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, a $25 charge will be billed and this is not covered by your insurance company.

If you have an extenuating circumstance that makes it impossible for you to either come to your appointment or to give us notice of your cancellation, please let the staff know of your situation and we will reconsider assessing the "no show" charge on a case by case basis.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctor on time.

If you are 15 minutes past your scheduled time we will have to reschedule your appointment.

_____	_____	___/____/____
Printed Name of Patient	**Signature of Patient/Guardian**	**Date**

Acknowledgment OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices when requested. I understand that 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 health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____	_____	___/____/____
Printed Name of Patient	**Signature of Patient/Guardian**	**Date**

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CONSENT TO TREAT A MINOR

I'm presenting my son/daughter for diagnosis and treatment

Name: _____for _____
Mother Father OR Legal Guardian *Son OR Daughter*

of _____ years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, medical treatment, by authorized members of the staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition. I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to Dr. Jamie Enos and Enos Chiropractic Center to treat my child for all medical care. We/I acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered during this period.

Name of Guardian: _____

Address: _____
_____

Telephone no.: _____

Name of health insurance carrier: _____
_____
_____

Group no.: _____

Member no.: _____

Family Physician:_____

Pediatrician: _____
Surgeon: _____

Orthopedist: _____

Child's allergies, if any: _____
_____
Date of last tetanus booster: _____

Medicines child is taking: _____
_____

Signature: _____ Date: _____
Mother, Father or Legal Guardian

Witness: _____ Date: _____

In case of emergency I can be reached at: _____
_____
_____
_____