# Pediatric Patient Questionnaire

## CONFIDENTIAL PATIENT INFORMATION

Child's Name: Parent/Guardian Name(s):

Street Address: City, State, Zip:

Cell Phone: Other Phone: Child's Sex: ○ M ○ F

Email: Child's SS #: Birthdate: Age:

How did you hear about us? Weight: Height:

Who is your primary care physician?

Is your child receiving care from any other health professionals? ○ Yes ○ No
- If yes, please name them and their specialty:

Please list any drugs/medications/vitamins/herbs/other that your child is taking:

## CURRENT HEALTH CONDITIONS

What health condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin? How did the problem start? ○ Suddenly ○ Gradually ○ Post-Injury

Has your child ever received care for this condition before? ○ Yes ○ No
- If yes, please explain:

Is this condition: ○ Getting worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What makes the problem better? What makes the problem worse?

## HEALTH GOALS FOR YOUR CHILD

What are your top three health goals for your child:

1. _____
2. _____
3. _____

What would you like to gain from chiropractic care?

○ Resolve existing condition
○ Overall wellness
○ Both

Have you ever visited a chiropractor? ○ Yes ○ No If yes, what is their name?

What is their specialty? ○ Pain Relief ○ Physical Therapy & Rehab ○ Nutritional ○ Subluxation-based ○ Other: _____

## PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy

Any fertility issues? ○ Yes ○ No If yes, please explain:

Did mother smoke? ○ Yes ○ No If yes, how many per week?

Did mother drink? ○ Yes ○ No If yes, how many per week?

Did mother exercise? ○ Yes ○ No If yes, please explain:

Was mother ill? ○ Yes ○ No If yes, please explain:

Any ultrasounds? ○ Yes ○ No If yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any other concerns or notable remarks about your child's conception or pregnacy:

## LABOR & DELIVERY HISTORY

Child's birth was: ◯ Natural vaginal birth ◯ Scheduled C-section ◯ Emergency C-section At how many week's was your child born?

Child's birth was: ◯ At home ◯ At a birthing center ◯ At a hospital ◯ Other: Doctor/Obstetrician's Name:

Please check any applicable interventions or complications:

◯ Breech ◯ Induction ◯ Pain meds ◯ Epidural ◯ Episiotomy ◯ Vacuum extraction ◯ Forceps ◯ Other _____

Please describe any other concerns or notable remarks about your child's labor and/or delivery.

Child's birth weight: Child's birth height: APGAR score at birth: APGAR score after 5 minutes:

## GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? ◯ Yes ◯ No If yes, how long? Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use formula? ◯ Yes ◯ No If yes, at what age? If yes, what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? ◯ Yes ◯ No
- If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? ◯ Yes ◯ No
- If yes, please explain:

At what age did the child: Respond to sound:_____ Follow an object:_____ Hold their head up:_____ Vocalize:_____ Teethe:_____
Sit alone:_____ Crawl:_____ Walk:_____ Begin cow's milk:_____ Begin solid foods:_____

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ◯ No ◯ Yes, on a delayed or selective schedule ◯ Yes, on schedule
- If yes, please list any vaccination reactions:

Has your child received any antibiotics? ◯ Yes ◯ No
- If yes, how many times and list reason:

Night terrors or difficulty sleeping? ◯ Yes ◯ No If yes, please explain:

Behavioral, social or emotional issues? ◯ Yes ◯ No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ◯ Mostly whole, organic foods ◯ Pretty average ◯ High amount of processed foods

## ACKNOWLEDGMENT & CONSENT

Patient Signature: _____ Date: _____

## MEDICAL HISTORY

Have you ever suffered from any of the following conditions:

1. Dizziness_____
2. Backaches_____
3. Heart Trouble_____
4. High Blood Pressure_____
5. Arthritis_____
6. Diabetes_____
7. Headaches_____
8. Asthma_____
9. Neuritis_____
10. Digestive Disorders_____
11. Nervousness_____
12. Sinus Trouble_____
13. Neck Pain_____
14. Cancer_____
15. Thyroid Issues_____
16. Depression_____
17. Abuse (Physical, Emotional, Sexual, Drug, Alcohol)

## FAMILY HEALTH INFORMATION

For example, we are particularly interested in Spinal Problems, Cancers, Diabetes, Thyroid, Hormonal Issues, and Cardiac Issues.

| Relation | Past and Present Health Problems |
|---|---|
| | |
| | |
| | |
| | |

## OFFICE POLICIES

I understand that the office charges a $30 fee for returned checks.
I also understand the fee-for-service is required at the time services are rendered, or the office reserves the right to charge a $5 fee.
If you are unable to keep your scheduled appointment time, kindly provide 24-hour cancellation notice. If an appointment is cancelled with less than 24 hours' notice, or if you miss your appointment, a $70.00 cancellation/no show fee will be assessed for each missed appointment. Out of respect for other patients, if you are more than 5 minutes late to your appointment, we will assist you in rescheduling to another day and you will be charged the missed appointment fee.

## APPOINTMENT REMINDERS

Chosen Spot Chiropractic & Wellness offers appointment reminders VIA TEXT MESSAGE OR EMAIL. If you would like to receive these reminders, please provide us with your phone number, and or email. These reminders are a **courtesy,** it is the responsibility of each patient to keep track of their own calendar and report to their scheduled appointments even if you do not receive a text/email. **Missed appointments continue to be subject to a missed appointment charge of $70.00**. Please do not respond to any text or emails received. Please call the office at 585-394-2030 to cancel or reschedule any appointments.

Patients Signature:_____ Date:_____

Guardian or Spouse's Signature:_____ Date:_____

Cell Phone Number: _____

**OR**

Email Address:_____

## STATEMENT OF POLICY REGARDING INSURANCE COVERAGE AND BILLING

Thank you for selecting Chosen Spot Chiropractic & Wellness as your health care provider. Our personnel will be happy to discuss our fees and this policy with you at any time. Please read and sign this financial policy prior to seeing the physician.

**Payment for services is due at the time services are rendered.**

This includes unmet deductibles, co-insurance and co-pays established by your insurance company. For any portion of your balance that is not covered by insurance we accept cash, check, Visa, MasterCard, and Discover.

**YOU MUST BE FAMILIAR WITH YOUR INSURANCE BENEFITS AND ANY CHANGES TO YOUR HEALTH CARE PLAN.**

## INSURANCE POLICIES

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a part of that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary charges".

   Please present your insurance card at the front desk so that we can file claims on our behalf. We will follow their guidelines for submission of claims, co-pay, deductibles, co-insurance and reimbursements. We ask that you contact your insurance company to verify your own benefits as well.

2. All charges are your responsibility whether your insurance company pays or does not pay. There are large variations from policy to policy with regard to what is covered and what is not. Please check your specific policy to find out your specific coverage.

3. You will be given an **estimated** payment amount based on the amount of your current deductible and the percentage of co-insurance responsibility set by our contracted rate with your insurance company.

***Our office makes every effort to obtain accurate benefit information for you prior to your visit. However, our quote of benefits to you **does not guarantee** payment to us by your insurance company.

You are ultimately responsible for knowing your own insurance benefits and **are responsible for any balance on your account should your insurance company's payment differ from our preliminary quote.**

## ASSIGNMENTS OF BENEFITS AUTHORIZATION

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered or goods purchased. I hereby assign and authorize my insurance carrier(s) to issue payment (checks) directly to Chosen Spot Chiropractic & Wellness, PLLC, for medical services rendered to myself or my dependents. I authorize release of any information concerning me or my child's health care, advice given and treatments provided for the purpose of evaluating claims for insurance benefits and agree to allow a photocopy of my signature to be used to process insurance claims.

**Patient/Legal Guardian's Signature**_____**Date**_____

chosen spot chiropractic
Healthy By Choice

142 Bemis Street
Canandaigua, NY 14424
Phone (585) 394-2030

## Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and recommended care and treatment to be provided to you so that you can make a decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

**Chiropractic** is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

**Adjustments** are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebrae in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

A chiropractic adjustment is the application of precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractor adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy, or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risk and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as well as allergic reaction and muscle and/or joint pain. In addition, there are reported cases of stroke associated with the sists to medical doctor's ad chiropractors. Research and scientific evidence does not establish a cause-and-effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

**I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.**

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THE INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORITZER CHOSEN SPOT CHIROPRACTIC & WELLNESS, TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED THIS _____ DAY OF _____, 20_____

Patient Signature or Legal Guardian : _____

**Maggie Benham, DC**

**Melissa O'Loughlin, DC, CACCP**

**Stephanie Meglino, DC**

**John Petro, DC**

**Kellie Dattilo, DC**

**Hannah Henderson, DC**

**Gracie Hullings, DC**

**Parental consent for Minor Patient:**
Patient Name: _____
Patient Age: _____ DOB: _____
Printed name of person legally authorized for patient:
_____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above-named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for
Patient: _____
Signature: _____
Relationship to Patient: _____

*Chosen Spot Chiropractic & Wellness*
*142 Bemis Street, Canandaigua, NY 14424*
*PHONE-585-394-2030*
*FAX-585-394-0454*

# HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Chosen Spot Chiropractic & Wellness to use and/or disclose Protected Health Information in accordance with the following:

**SPECIFIC AUTHORIZATIONS:**

- I give permission to Chosen Spot Chiropractic & Wellness to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If Chosen Spot Chiropractic & Wellness contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give permission to Chosen Spot Chiropractic & Wellness to use my name on a welcome board, referral board, and birthday board.

- I give permission to Chosen Spot Chiropractic & Wellness to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

- I give permission to Chosen Spot Chiropractic & Wellness to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- I give Chosen Spot Chiropractic & Wellness permission to treat me in an open room where other patients are also being treated. I am aware that other people in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.

- I consent to my data being used for research and/or teaching purposes.

- By signing this form, you are giving Chosen Spot Chiropractic & Wellness permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Chosen Spot Chiropractic & Wellness plus 7 years or until revoked by me.

(over)

**RIGHT TO REVOKE AUTHORIZATION:**
You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Chosen Spot Chiropractic & Wellness The written notice must contain the following information:

Your name, Social Security number and date of birth;
A clear statement of your intent to revoke this AUTHORIZATION;
The date of your request; and
Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by Chosen Spot Chiropractic & Wellness for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Chosen Spot Chiropractic & Wellness will not refuse to provide treatment however, it will not be possible for ____ to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since Chosen Spot Chiropractic & Wellness will be unable to contact me 3) all contact with Chosen Spot Chiropractic & Wellness regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

## HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN:_____ DOB:_____

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

**Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)**

Parent or Personal Representative name (please print):_____

Signature:_____

Description of Representative's Authority to Act on Patient's Behalf:_____

_____

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

# Authorization for Access to Patient Information Through a Health Information Exchange Organization

**PROVIDER:** CHOSEN SPOT CHIROPRACTIC & WELLNESS, PLLC

| Patient Name | Date of Birth | Patient Identification Number |
|---|---|---|
| Patient Address | | |

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at **www.RochesterRHIO.org**.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

**The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.**

**My Consent Choice**. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at **www.RochesterRHIO.org** or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

| Signature of Patient or Patient's Legal Representative | Date |
|---|---|
| Print Name of Legal Representative (if applicable) | Relationship of Legal Representative to Patient (if applicable) |

**Details about the information accessed through Rochester RHIO and the consent process:**

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at:_____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.