Dr. Daniel Murray, Dr. Brandon Meye,
& Associates

lakecountryhealthcare.com • 262.646.5800

Pediatric Chiropractic Intake Form

Patient (Child) Information:

Name: _____ Date: _____
Address:
_____

Sex: Male Female Date of Birth: _____ Height:_____ Weight: _____
Patient SSN: _____ Name of Parents/Guardian:_____
Home Phone:_____ Cell Phone: _____ Work Phone: _____
Email:_____ Would you like our appointment reminders: Y N

Whom may we thank for referring you? _____
Authorized Representative/Parent/Guardian:_____ Phone: _____
Present Complaint:_____
When did this begin?_____ Was there an accident or injury involved? Y N
Has your child had any past treatment for this complaint? Y N Describe: _____
Current medications: _____

General Questions/Prenatal History:

Any complications during pregnancy? Y N Explain:_____
Medications taken during pregnancy: _____ Cigarettes or alcohol during pregnancy: Y N
Birth Intervention: Forceps Vacuum C-Section
Complications during delivery? Y N Explain:_____
Genetic disorders or disabilities:_____
How many times has your child been prescribed antibiotics in the past 6 months? _____ Total during lifetime:_____
Has your child received vaccinations? Y N

Feeding History:

Breast Fed: Y N How long: _____
Formula Fed: Y N How long: _____
Introduced to: Solids at _____ Months
Cows milk at _____ Months
Food Allergies or Intolerances: Y N
List:_____
_____

Childhood Diseases:

Chicken Pox: Y N Age:_____
Rubella: Y N Age:_____
Rubeola: Y N Age:_____
Mumps: Y N Age:_____
Whooping Cough: Y N Age:_____
Other: _____ Age:_____

Developmental History:

During the following times your child's spine is the most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference).
At approximately what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up Alone
_____ Sit Up Alone
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie: a bed, changing table, down stairs, etc). Was this the case with your child? Y N
Explain: _____

Is/has your child been involved in any high impact or contact type of sports (ie: soccer, football, gymnastics, baseball, cheerleading, martial arts, etc)? Y N

Has your child ever been involved in a car accident? Y N Explain:_____
Other traumas not described above? Y N Explain:_____
Prior surgeries? Y N Explain:_____

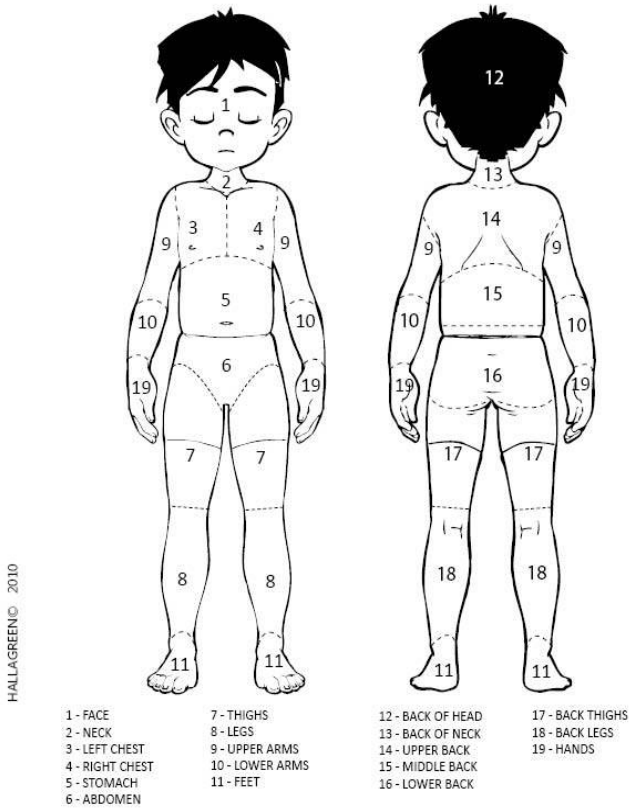
Review of Systems

Please check if your child has had any of the following:

____ Headaches	____ Postural Imbalances	____ Growing Pains	____ Scoliosis	____ Tonsillits
____ Asthma	____ Torticollis	____ Ear Infections	____ Seizures	____ Sleep Problems
____ Digestive Problems	____ Bedwetting	____ PDD/Autism	____ ADD/ADHD	____ Frequent Fever
____ Colic	____Learning Difficulties	____ Acid Reflux	____ Hip Dysplasia	____ Allergies

How would you rate your child's diet? ____ Well Balanced ____ Average ____High sugar/processed foods
Does your child consume artificial sweeteners? Y N
Number of hours your child sleeps:_____ hours per night _____hours per day/naps
Sleep Quality: ____Good ____Fair ____Poor

Imagine this picture is your body. Can you color the area that is hurting you right now?



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Authorization to Treat a Minor

I, _____, the undersigning parent/guardian having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Dr. Daniel Murray, and/or Dr. Brandon Meye and whomever they might designate as assistant to perform in judgment, any examination, x-ray, and chiropractic diagnosis or treatment which is deemed necessary. 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.
Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the front of this form.

Patient: _____ Signature: _____
Print Name
Parent/Legal Guardian Printed:_____

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Financial Policy

It is vital for you and your family to have access to quality health and wellness care. Every attempt will be made to make this care affordable to you and your family. We would advise an insurance policy that allows you and your family to choose your own physician, not allowing managed care to undermine the quality and standards you deserve. **Our office will file claims and facilitate payment from your insurance company (or third party payer), but please understand that your insurance policy is a contract between you, your employer, and the insurance company. If you have specific questions regarding your insurance coverage, please contact the member services number for the plan. We will submit claims for services rendered to your insurance company unless other payment arrangements are made within 24 hours of your initial visit.**

Our financial policy will require that everyone make a payment at the time of treatment. We accept cash, check pr credit card. This may only be your deductible and/or estimated coinsurance, or office visit co-payment, but it is necessary for us to collect payments toward your portion at the time of service. If your insurance company should pay more than anticipated, then we will be happy to refund you any overpayment. If your insurance company should pay less than anticipated, then you may be billed for an additional amount.

Our policy for a patient whose insurance company pays them directly, we will bill you for any outstanding balance after receiving your pre-set payment amounts.

Our policy for a patient, who is being treated under a motor vehicle accident/personal injury case, there is a separate financial policy form. – See Financial Policy for Personal Injury and Accident Patients Form

Our policy for a patient who is being treated under a worker's compensation case will be required to provide us with your workers compensation claim/case number and carrier information within 1 week of the initial visit for this condition. If your workers compensation claim is denied, you agree to work with our billing department to make payment arrangements until the balance is paid in full. Our policy for a patient who does not have insurance or does not have a current card will be required to pay at the time of the visit.

We offer reasonable rates and payment plans for anyone uninsured. We offer a "pay as you go" plan or "Pay-At-Time-Of-Service" plan which incorporates discounted rates when you pay the same day as the service is rendered. *We can offer our 'Pay At the Time of Service' rates to visits because they involve minimal paperwork, which means that a bill or statement cannot be submitted to insurance companies or to you by our office without additional fees.* If payment is not made at the time of service, our normal billed rate will apply to any statement sent to you requesting payment.

We reserve the right to charge for appointments cancelled without 24 hours advance notice. This includes appointments made for chiropractic services, massage, acupuncture or personal training. The fee charged will be $40.00.

If any special or unusual financial considerations are necessary, please communicate these special needs to anyone on our staff who will be happy to direct to the director of patient accounts.

We look forward to providing you with the finest in personalized care. Thank you.

I authorize the release of medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party Listed above accepts assignment. I also authorize payment of medical benefits to the physician or supplier for services listed above.

Signature _____ Date _____

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Treatment and Care Informed Consent for Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures; including various modes of physiological therapy, diagnostic X-rays, exercises, massage therapy, acupuncture and nutritional supplements/dietary recommendations which may be used for me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other authorized licensed doctors of chiropractic or persons who might now or in the future treat me while working or associated with, or serving as back-up for Dr. Daniel T. Murray at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. This includes but is not limited to: soreness, dizziness, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that I am responsible for monitoring my own condition throughout the treatments and will inform the doctor of any unusual symptoms that might occur.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____

Witness

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Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:
- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of you health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the “NOTICE OF PRIVACY PRACTICES” binder in reception or ask for a copy at the Front desk.

_____ _____ _____

Name (Printed please) Signature Date

If you are a minor or if you are being represented by another party:

_____ _____ _____

Personal Representative (Printed) Signature Date