Welcome to Vermillion Chiropractic, P.C.

Financial Agreement and Office Policies

Notice: Everything done in this office ether for diagnostic or treatment purposes is a valuable and billable service and it is the patient's responsibility to know what chiropractic services their insurance covers. If you do not understand why a procedure is being down or have a question of the cost of a service please ask. We are happy to explain the purpose and cost of any service. If you make an advance appointment and for some reason you must miss your appointment, it is **your responsibility** to notify this office at least 1 hour before your appointment time or Vermillion Chiropractic, P.C. reserves the right to charge your account for the missed office visit. If your account is 30 days past due, Vermillion Chiropractic, P.C. reserves the right to add a service charge up to 20% per annum or $5 per month to your total remaining balance.

_____I will pay any insurance indicated co-pay or deductible fees that are due after each office visit or after an explanation of benefits has been received from the insurance company. **I understand that it is my responsibility to know what my chiropractic benefits are.**

_____I have no health insurance or health insurance will not cover Chiropractic care and will pay full balance after each visit.

_____I will provide Vermillion Chiropractic, P.C. with auto insurance for billing, understanding that I am ultimately responsible for payment of all charges that may accrue to my account.

_____Worker's compensation claims will be billed accordingly under the patient's work comp. insurance with the understanding that if any service is denied the patient is personally responsible for their account balance unless other agreements have been made.

_____Medicare will cover the adjustment fee only. Medicare does not cover exam, x-ray or any other service provided by this office. All services will be billed to Medicare and patient's supplemental insurance.

_____Medicaid patient will pay $1.00 per visit for an adult. There is no co-pay for children under 18 years of age.

Patient Contact Information

Name: _____Date:_____
Address:_____City:_____State:_____Zip:_____
Sex: Male Female Date of Birth: _____Age: _____
Home Phone:_____ Cell Phone:_____
Parent's Name(s): _____
How did you find out about our office? _____
Emergency Contact: _____Number: _____

By signing, I have read and understand all information contained in this document that pertains to my account with Vermillion Chiropractic, P.C. and I authorize the release of necessary information for review by any third party responsible for payment where applicable.

Parent's Signature _____Date:_____

Patient Intake Questionnaire

Reason for contacting us?_____

Other doctor's seen for this condition? _____

Other health problems? _____

Has your child suffered from any of the following conditions during the past 6 months:

□ Ear infections □ Scoliosis □ Seizures □ Chronic Colds □ Headaches □ Digestive Problems □ ADHD □ Recurring Fevers □ Growing/Back Pains □ Bed Wetting □ Car Accident □ Colic □ Asthma/Allergies

List your **Family History:**

□ Arthritis □ Asthma □ Back Pain □ Cancer □ Depression □ Diabetes □ Epilepsy □ Genetic Spinal Condition □ High Blood Pressure □ Heart Problems □ Multiple Sclerosis □ Neurological Problems □ Parkinson's □ Polio □ Prostate Problems □ Stroke/Heart Attack □ Other: _____

Previous Chiropractic Care? _____

Name of Pediatrician: _____

Date of last visit: _____Reason:_____

Number of Doses of Antibiotics Your Child Has Take

In the past six months: _____ In their lifetime_____

Vaccination History: _____

Prenatal History:

Name of Obstetrician/Midwife: _____

Complications during pregnancy:_____

Number of ultrasounds during pregnancy:_____

Medication during pregnancy and delivery:_____

Cigarette or Alcohol use during pregnancy:_____

Location of Birth:_____

Birth Intervention:_____

Complications during delivery:_____

Genetic Disorders or Disabilities:_____

Birth Weight:_____ Birth Length:_____ APGAR:_____

Feeding History:

Breast Fed: _____ How long:_____

Formula Fed:_____ How long:_____

Introduced to solids at:_____ Cow milk at:_____

Food/Juice Allergies or Intolerances:_____

Developmental History

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

At what age was your child able to:

Respond to sound: _____ Respond to Visual Stimuli:_____

Hold Head up:_____ Sit up:_____

Cross Crawl:_____ Stand Alone:_____

Walk Alone:_____

According to the Nation Safety Council, approximately 50% of children fall head first from a high place during the first year of their life (i.e. changing table, down stairs, etc.)

Was this the case with your child?:_____

Is/Has your child been involved in any high impact or contact type sports (Soccer, Football, Gymnastics etc):

_____

Has your child ever been involved in a Car Accident: _____

Has your child ever been seen on an emergency basis:_____

Other trauma no described above:_____

Prior Surgery:_____Menarche:_____

Childhood Diseases:

□ Chicken Pox □ Rubella □ Rubella □ Mumps □ Whooping Cough □ Other

Informed Consent Form

Patient Name:_____ Date:_____

Provider Name: Paul J. Roob, D.C.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including examination, test, various modes of physical therapy and/or diagnostic X-rays, on me (or on the patient named above, for whom I am legally responsible) which are recommended by the doctor of chiropractic named above, and/or other licensed doctors of chiropractic who now or in the future render treatment to me, while employed by, work for, or at, the office, or at any other related office or clinic.

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

I understand and am informed that, as in practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disk injuries, strokes, dislocations, paralysis and strains/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 judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known by him, is in my best interest.

I have read, or have had read to me, the above explanation of chiropractic adjustment and related treatment. By signing below, I state that I have weighted the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks. I hereby give my consent to that treatment. I intend this consent for to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Parent Signature_____Date_____

Witness Signature_____Date_____

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I have received, or been offered a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact Paul J Roob D.C. at Vermillion Chiropractic Clinic (605-624-9101). I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

Parent Signature_____Date_____