Jensen Family Chiropractic
&
Wellness Center

"creating a healthier generation with a purpose"

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____

JENSEN FAMILY CHIROPRACTIC, DC PC

FINANCIAL AGREEMENT

Fees: **Initial Exams**: $35-65 (determined by case severity) **Adjustments**: $30 for 1-2 regions,
X-rays: $65-70 for one region (neck, low back, etc.) $40 for 3-4 regions,
Re-exams: $15-35 *$25 Endo-cranial Adjustment
*$20 HRA's

Re-exams will be required to chart progress throughout your routine care within this office. We also offer pre-pay package discounts for those who want care at a discount. Inquire at the front desk.

Dear Patient:

We will do our best to provide you with the necessary information to determine the type of care you require and also the financial information you may need to determine how you wish to handle your financial obligation to Jensen Family Chiropractic, DC PC.

We wish to make it very clear that your health is the sole responsibility of you, the patient, or your guardian.

These policies apply only to the services actually performed and in no way obligates the patient to continue the course of treatment recommended. If care is discontinued, the balance due for care received up to that date is due in full within 30 days of discontinuance of care.

I have elected to use the following payment plan to finance my care at Jensen Family Chiropractic, DC PC:

____1. **CASH** - Payment is due at the time of service.

____2. **MEDICARE** - Payment is due at the time of service. Jensen Family Chiropractic, DC PC will complete all necessary Medicare forms on my behalf. I also understand that I will only be reimbursed for the adjustments, not for any other services required or rendered.

____3. **PERSONAL INJURY** - Although my insurance or lawsuit may eventually pay Jensen Family Chiropractic, DC PC in full for services rendered, I agree to take full responsibility for my account balance, whether active or inactive as a patient.

____4. **INSURANCE POLICY COVERAGE** - Although I am totally responsible for charges I may incur in this office, I will initially pay for my yearly deductible and the percentage agreed upon or co-pay at the time of each visit unless my insurance fails to pay its share, at which time I will pay my balance in full. I also understand that my insurance may not cover all the care I may require, and as I am responsible for my own health and my agreement is with my insurance company, not between them and this office, I will take care of any other necessary care. NOTE: There is never a guarantee that these services will be covered by your insurance company and our office may be out of network, which then deductibles may be applicable. Also, we do not write reports but we will send a copy of your records if requested by your insurance company.

-I authorize release of any protected health information (pertaining to myself or any family member) necessary to process this claim and request payment of insurance benefits either to myself or to Jensen Family Chiropractic, DC PC, depending upon who accepts assignment.

Signature_____ Date: _____/_____/_____

Office Witness: _____

Jensen Family Chiropractic DC PC
Timothy J. Jensen D.C. – Wellness Chiropractor

TERMS OF ACCEPTANCE

When an individual or family seeks chiropractic care, and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that everyone understands both the objective and the method used to attain it. This will prevent any confusion or disappointment.

Definitions:

Health: A dynamic state of wholeness in which your body can accurately perceive its constantly changing needs and respond appropriately in a timely manner. In short, *Health is the ability to adapt* to both internal and external stresses, whether they are physical, chemical, or emotional.

Subluxation: A disruption (interference) of the normal flow of information in the nerves between the brain and the cells of the body. This causes an alteration of the normal physiology and leads to a state of "dis-ease" (the inability of the body to adapt).

Chiropractic Adjustment: The specific application of a gentle force to facilitate the body's correction of subluxation and restore its innate healing processes so as to normalize function of the nervous system thus increasing the ability of the body to constructively adapt to its environment.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of your Chiropractic assessment, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnose or treatment for those findings, we will recommend that you seek the service of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. The only method used to accomplish this is the use of specific chiropractic adjustment to correct subluxation.

I, _____, have read and fully understand the above statements.
(Print Name)
All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care for myself and on behalf of my family on this basis

Signed _____ Date ____/____/____

Consent to evaluate and adjust a minor child

I, _____*(print)* being the parent or legal guardian of _____*(print)* have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signed _____ Date ____/____/____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor has my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual period: _____

Signed _____ Date ____/____/____

Jensen Family Chiropractic & Wellness Center

101 SW Jackson Street
Greenfield, IA 50849

Notice of Privacy Practice Summary

This summary discloses how health information about you may be used. A full notice of your privacy has been made available for your review. A personal copy of the full notice is available upon request.

Jensen Family Chiropractic DC PC will not disclose your information to others unless you tell us to do so or unless the law authorizes us to do so.

Jensen Family Chiropractic DC PC may use your information to provide appointment reminders, information about treatment alternatives or other health related issues.

Jensen Family Chiropractic DC PC may disclose your information for public health activities, research, health and safety and governmental function in order to comply with worker's compensation laws and regulations. You have the right to request restriction, and retain a copy of your health record, request communication of your health records.

You may complain to the Privacy Office, Kristen Jensen, and the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Jensen Family Chiropractic DC PC must retain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with the respect to your health information, abide by the term of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with the health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact Kristen Jensen, or any staff member of Jensen Family Chiropractic DC PC at 101 SW Jackson St., Greenfield, IA 50849. Please 641-743-2477

By my signature below, I acknowledge review of the Notice of Privacy Practices.

Signature of Patient of Authorized Representative Date

Print NAME IS SIGNED ON BEHALF OF Patient/Relationship (patient, legal guardian, personal representatives, etc.)

This form will be in your records.