

Van Wyk Family Chiropractic Terms of Acceptance

When a patient seeks health care in our office and we accept a patient for such care, it is essential the patient understands the type of services we legally provide.

Chiropractic care is a separate service from the practice of medicine. We do not prescribe drugs or diagnose medical conditions. If we ever feel you have a health situation that may require medical attention, we will advise you to consult with your medical doctor.

I have read and fully understand the above statements. I understand the terms of acceptance and accept care at Van Wyk Family Chiropractic Center on this basis.

(your signature)

(date)

Fees and Financial Policies

Payment will be due at the time services are rendered. If this is a problem, talk with the staff or doctor.

How will you be paying for your chiropractic care?

I will be using health insurance.

Deductibles and/or co-payments will be paid at the time of service or in advance. Your agreement with your health insurance company is between you and them. By signing this financial form, you understand you are responsible for any and all services rendered that your health insurance company denies payment for.

I will be paying without health insurance

Services

Fee

Complete Examination with X-rays and Diagnostic Testing	\$150.00
Chiropractic Adjustment	\$40.00
Medicare Adjustment	\$34.00
Progress Re-Examination	\$40.00
Physical Therapy: Ultrasound & Interferential	\$20.00
Ion Cleanse Detoxification	\$30.00

Products

Fee

Pillows	\$35-\$65
Custom Orthotics	\$75-\$225
Nutritional Supplements	Ask the doctor

I have read and understand the above options and policies. I have checked the method of payment that applies to my child (or myself.)

(Patient Signature)

(Date)

PEDIATRIC AND CHILD HISTORY FORM

Child Name: _____ S.S.# _____

Address: _____ City _____

State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ / _____ / _____ Sex _____ Weight _____ Height _____

Names of Parents / Guardians: _____

Work Phone: _____ Email: _____

Name who referred you to our office: _____

Purpose For Contacting Us? (If for wellness care, skip this section)

Onset of problem: _____

Has your child had this problem before? ____ N ____ Y, How many times? _____

Describe Child's Current Behavior: _____

Is the problem: ____ Constant ____ Intermittent Do you feel It Is Getting Worse? _____

Have other doctors been seen for this condition? ____ N ____ Y Doctor's Names and Prior Treatments:

Additional Health Problems? _____

Check any of the following your child has suffered from during the past six months:

- | | | | | |
|---|---|---------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Recurring Fevers | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Temper Tantrums | |
| <input type="checkbox"/> Other: _____ | | | | |

Family History: _____

Previous Chiropractor: _____

Date of Last Visit: _____ / _____ / _____ Reason: _____

Name of Pediatrician: _____ Date of Last Visit: _____

Reason: _____

Number of Doses of Antibiotics Your Child Has Taken:

Past 6 months _____ Total During Lifetime _____

Number of Doses of Other Prescription Medications Your Child Has Taken:

Past 6 months: _____, Total During Lifetime: _____ List Medications: _____

Vaccination History: _____

PRENATAL HISTORY:

Name of Obstetrician / Midwife: _____

Complications During Pregnancy? _____ N _____ Y, List: _____

Medications During Pregnancy? _____ N _____ Y, List: _____

Cigarette / Alcohol Use During Pregnancy: _____ N _____ Y

Location of Birth: _____

Birth Intervention: _____ Forceps _____ Vacuum Extraction
_____ Caesarian Section _____ Emergency

Complications During Delivery? _____ N _____ Y, List: _____

Genetic Disorders or Disabilities: _____ N _____ Y, List: _____

Birth Weight: _____ Birth Length: _____ APGAR Score: _____

FEEDING HISTORY:

Breast Fed: _____ N _____ Y, How Long: _____

Formula Fed: _____ N _____ Y, How Long: _____ Type: _____

Introduced To Solids At: _____ Months, Cow's Milk at _____ Months

Food / Juice Allergies or Intolerances: _____ N _____ Y, List: _____

DEVELOPMENTAL HISTORY:

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

Is/ Has your child been involved in any high impact or contact type sports (i.e. soccer, football, gymnastics, baseball, basketball, martial arts, etc.) _____ N _____ Y, List _____

Has your child ever been involved in a car accident: _____ N _____ Y, List: _____

Has your child been seen on an emergency basis: _____ N _____ Y, List: _____

Other traumas not described above: _____

Prior Surgery: _____ N _____ Y, List: _____

Menarche: _____ N _____ Y, Age: _____

CHILDHOOD DISEASES

Chicken Pox N / Y, Age _____

Rubella N / Y, Age _____

Rubeola N / Y, Age _____

Mumps N / Y, Age _____

Whooping Cough N / Y, Age _____

Other N / Y, Age _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office. If I am using insurance, I understand I am personally responsible for payment of any services not covered or denied by my insurance plan.

Signed: _____ Date: _____