Palmer Chiropractic

Date _____ Case No._____

Name _____ Address _____

Phone _____ Date of Birth _____ Age _____ Male/Female

Parent or Guardian's Name _____

Parent or Guardian's Social Security # _____

Address (if different from child's) _____

Chief complaint or problem _____

What type of birth:

_____ Vaginal _____ C-Section _____ Forceps _____ Suction Cup

Presentation: _____ Normal _____ Breach _____ Frontal

With anesthesia (pain killer)? _____ Yes _____ No

Type used: _____ Oral _____ Hypo _____ Spinal Block _____ Subdural Injection _____ General Anesthesia

Child Presently Has _____X or Has Had _____ ✓

_____ Cholic _____ Chicken Pox _____ Measles _____ Mumps Right/Left _____ Colds

_____ Constipation _____ Diarrhea _____ Difficult Sleeping _____ Overactive _____ Asthma

_____ Difficult Breathing _____ Skin Eruptions _____ Vomiting _____ Frequent Crying

_____ Feet Turn Out Right Left Both _____ Feet Turn In Right Left Both

Falls: (details) _____

_____

___

Injuries: (details) _____

_____

___

Is she/he taking any medication? Prescription or patent? _____

If so, what drugs? _____

Operations: _____ Ear Tubes _____ Tonsillectomy _____ Heart Other _____

I hereby authorize Dr. Palmer and/or whomever he may designate as his assistant to administer Chiropractic care as he deems necessary to my child. It is understood and agreed the amount paid to Palmer Chiropractic Center for X-Ray is for examination only, and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand that if my insurance company covers services and the check(s) is sent to the patient, it is the patients responsibility to bring the check and explanation of benefits to this office. I understand and agree that if my insurance or medicare fails to provide payment for services rendered that it is my responsibility to pay for these services. Co-pays and/or deductibles that are left unpaid for more than 30 days will incur an 18% interest rate, per month of deliquency.

_____ _____

Parent/Guardian Name (Print) Parent/Guardian Signature

Palmer Chiropractic

Your health is our concern

I, (print your name) _____, as the parent or legal guardian of minor child

_____ give to Dr. Trace Palmer and his staff my permission to do the following listed and initialed procedures on the above named child.

- ☐ Perform a chiropractic examination. (Your initials please) _____
- ☐ Perform x-rays needed on this patient. (Your initials please) _____
- ☐ Initiate chiropractic care as deemed necessary. (Your initials please) _____

I understand that I am responsible for any portion of the bill not paid for by any health care coverage, including: private or group insurance, accident coverage, and any State or Federal health care program, etc.

Parent or Legal Guardian Signature _____

PALMER CHIROPRACTIC

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operation**
- **The practice reserves the right to change the privacy policy as allowed by law**
- **The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions**
- **The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease**
- **The practice may condition receipt of treatment upon execution of this consent**

May we phone you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell? **YES** **NO**

May we leave a message at your employment? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:_____

_____

This consent was signed by:_____
PRINT NAME PLEASE

Signature:_____

Date:_____

Witness:_____ **Date:**_____

AUTHORIZATION FORM

Patient Name_____

RELEASE OF INFORMATION
I hereby authorize ***Palmer Chiropractic*** to release medical and financial data to my insurance carriers and attorney.
INITIALS_____

RESPONSIBILITY OF BILL
The undersigned hereby accepts full financial responsibility for charges and services rendered to the patient. The undersigned understands that services are rendered and charged to the patient and not to the insurance company. ***Palmer Chiropractic*** cannot accept total responsibility for collecting an insurance claim or negotiating a disputed settlement. The undersigned also agrees that this obligation shall exist regardless of private contractual agreement between the patient and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges and services not covered by insurance for which payment is denied through any utilization review or precertification procedures. I also understand that if I suspend or terminate my care and treatment, the fees for services rendered me will be immediately due and payable. In the event that of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection.
INITIALS_____

AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO PROVIDER
I hereby authorize payment of the medical benefits otherwise payable to me to be made payable and mailed directly to ***Palmer Chiropractic*** professional services rendered. NO OTHER THIRD PARTY, including attorney, should receive payment of my bills except this office for the remainder of this claim. It will be assumed and relied upon that the insurance carrier has agreed to and acknowledges medical coverage and will send payments directly to this office. **INITIALS**_____

CONSENT FOR TREATMENT OF MINOR CHILD
Consent is hereby given by the undersigned for chiropractic treatment and diagnostic studies as ordered by the doctors and performed by the technical staff of ***Palmer Chiropractic***. The undersigned states that he/she is the patient's legal guardian. **INITIALS**_____

SUBROGATION AND RIGHTS OF REIMBURSEMENT AGREEMENT
If I, or one of my covered dependents receive benefits under my health insurance carrier, hereinafter referred to as Carrier, due to an injury or illness as a result of the acts of a third party. I agree to repay the Carrier any amount of money that I receive from third party or its insurer as compensation for such injuries up to the amount paid out by the Carrier. I understand that this includes the insurer or other agent or if I enter into any form of settlement regarding an accident which I or my covered dependents are injured as a result of the acts of a third party. I will do whatever is reasonably needed to secure the Carriers rights and shall do nothing to damage such rights. I will abide by this agreement only if my health insurance policy contains language that gives the health insurance carrier subrogation and rights of reimbursement. **INITIALS**_____

BOUNCED CHECK FEES
I understand that the fee for any bounced check or return check for insufficient funds, closed accounts or any other ancillary concerns will be an additional $35.00 charge and will be required to be paid by credit card, money order, or cash. **INITIALS**_____
Please check the following boxes to inform us that you are in compliance with our office standards of operation. Any questions or concerns please feel free to talk with us.
□ Permission to use you as a source of testimonial letters
□ Permission to use or take photos for marketing or website
□ Permission to call you for updates regarding your care or finances

Permission can always be revoked, but this must be done in writing

Sign _____ Date _____

PERMISSION SLIP FOR PHOTOGRAPHING YOUR CHILD

From time to time we take pictures of our well-adjusted children. We would like your permission to use these pictures in a collage photo frame. We will never reference your child by name or provide any specific information regarding your child. We also will never sell these pictures; we will use them exclusively for our photo wall. Please take a moment to let us know your preferences regarding our use of photos of your children:

_____YES. I grant you permission to use photos of my child on Palmer Chiropractic's photo wall.

-OR-

_____ NO. Please do NOT take or use any photos of my child.

Child(ren)'s Name(s) (PLEASE PRINT):

_____

_____

Parent/Guardian's Name (PLEASE PRINT):

_____

Parent/Guardian's Signature:

_____

Date: _____