City Center Chiropractic

PEDIATRIC CONFIDENTIAL HEALTH INFORMATION (*For Ages 0-7*)

____
Today's Date (MM/DD/YYY)

Has your child been treated by a chiropractor before?
☐ No ☐ Yes **When?** ____________ ____________________
If so, Whom?

____
Whom may we thank for referring you?

Gender
☐ Male ☐ Female

____
Child's Last Name

____
Child's Social Security Number

______________________ ______________________ ______________________
Child's First Name | **Child's Middle Name (or initial)** | **Child's Birth Date (MM/DD/YYY)**

____
____
Address

Parent's Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

________________ ____________ ____________ ________________
City | **State/Province** | **Zip/Postal Code** | **Home Phone**

______________________ ______________ ________________
Child's School | **Grade** | **Cell Phone**

______________________ ______________________ ______________________
Mother's Name | **Mother's Occupation** | **Mother's Employer**

______________________ ______________________
Mother's Phone | **Mother's Work Phone**

May we contact her at work?
☐ Yes ☐ No

______________________ ______________________ ______________________
Father's Name | **Father's Occupation** | **Father's Employer**

______________________ ______________________
Father's Phone | **Father's Work Phone**

May we contact him at work?
☐ Yes ☐ No

______________________ ______________________ ______________________
Insurance Carrier | **Policy Number** | **Primary Care Provider**

____
Insured's Last Name

Who carries this policy?
☐ Self ☐ Mother ☐ Father

______________________ ______________________
First Name | **Middle Name (or initial)**

____
____
Address

________________ ____________ ____________
City | **State/Province** | **Zip/Postal Code**

City Center Chiropractic

PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

Patient Name ____

Date of Birth ____

I authorize information regarding the scheduling of appointments to be communicated via all the following modalities that I provided to the office, and that my/my child's name may be used in the communication:

- Telephone voicemail (on phone number(s) I have provided to the office)
- Via e-mail (if an e-mail address has been provided)

_____________________________________ __________________

Patient or Parent/Guardian Signature Date

I decline all the above forms of communications. I prefer that NO INFORMATION at all be communicated by e-mail or voicemail. (I understand that I am responsible for knowing the dates and times of all scheduled appointments, as this office is unable to send reminders of any scheduled appointments. Any missed appointments will be the responsibility of the person/parent/guardian and will be subjected to the office policy.)

_____________________________________ __________________

Patient or Parent/Guardian Signature Date

City Center Chiropractic

PEDIATRIC CONFIDENTIAL HEALTH HISTORY (*For Ages 0-7*)

Child's Name: ______________________________ **Date:** ________________

Your child's overall health as well as any medications your child takes could have an important interrelationship with the care your child receives. Please answer each of the following questions completely.

Personal Information

Please check any problems your child currently has or has ever had:

	Yes	No
Thumb Sucking	☐	☐
Toilet Training Problems	☐	☐
Diarrhea or Constipation	☐	☐
Does your child take vitamins, fluoride, iron, or other supplements?	☐	☐
Is your water fluoridated?	☐	☐
Does your child get along well with other children?	☐	☐
Is your child doing well in school?	☐	☐
Has your child ever eaten dirt, paint, or plaster?	☐	☐
Did the mother use any cigarettes, alcohol, drugs, or medications during pregnancy?	☐	☐
Was your child born more than two weeks early or late?	☐	☐

Meals per Day ________ # Snacks per Day ________

	Yes	No
Dental Problems	☐	☐
Bed Wetting	☐	☐
Feeding or Eating Problems	☐	☐
Irritable/Temper Problems	☐	☐
Nightmares/Sleep Problems	☐	☐
Eye Problems	☐	☐
Speech Problems	☐	☐
Hearing Problems	☐	☐
Emotional Problems	☐	☐
Discipline Problems	☐	☐
Developmental Problems	☐	☐
Was/is child breast-fed?	☐	☐

Age Discontinued ________________

Delivery: ☐ Vaginal ☐ C-Section

Child's weight at birth ______________

Health History

Has your child ever had:

	Yes	No
Mumps, Measles	☐	☐
Chicken Pox	☐	☐
Eczema/Skin Problems	☐	☐
Pneumonia	☐	☐
Asthma/Wheezing	☐	☐
Cancer	☐	☐
Hemophilia	☐	☐
Abnormal Bleeding	☐	☐
Allergies	☐	☐
Frequent Ear Infections	☐	☐

	Yes	No
Frequent Colds or sore throats	☐	☐
Croup	☐	☐
Kidney/Bladder Problems	☐	☐
Handicaps/Disabilities	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
Congenital Heart Defect	☐	☐
Heart Murmur	☐	☐
Convulsions/Epilepsy	☐	☐

Child's Name_______________________

Medical Problems
Please explain any medical problems that your child has:

____
____
____
____
____
____
____

Hospitalizations or Serious Illnesses
Please list any hospitalizations, serious and/or unusual illnesses which your child has experienced:

Date(s)	Hospitalization/Illness	Hospital/Physician's Name	City, State

Medications
Please list all medications your child currently takes:

Date	Medication/Strength	Frequency	Condition

Allergies
Please list allergies, sensitivities, and/or reactions to any drugs:

____
____
____

I certify that, to the best of my ability, the information I have supplied is complete and truthful. I understand that providing incorrect information can be dangerous to my child's health, and I acknowledge that I have not misrepresented the presence, severity, or cause of my child's health concern. I agree to notify the doctor's office immediately of any changes in my child's medical status.

________________________________ ________________
Parent/Guardian Signature Date

Doctor's Notes: ________________________________
____
____

Doctors' Initials _______

Patient Name_________________________ Date___________

INFORMED CONSENT

<u>To the patient:</u> Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures (***please initial each of the below procedures***):

___ spinal manipulative therapy
___ range of motion testing
___ muscle strength testing
___ ultrasound
___ acupuncture
___ moxibustion
___ palpation
___ orthopedic testing
___ postural analysis
___ hot/cold therapy
___ mechanical traction
___ vital signs
___ basic neurological testing
___ electrical stimulation
___ cupping

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during your history intake and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK BELOW AND SIGN.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Michele M. Orchard, D.C.* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _______________ Date: _______________

_________________________________ _________________________________
Patient Name Doctor Name

_________________________________ _________________________________
Signature Signature

____
Parent/Guardian Signature (if a minor)

Patient Name________________________ Date___________

OFFICE POLICY

OUR PURPOSE IS TO EDUCATE AND ADJUST AS MANY FAMILIES AS POSSIBLE TOWARD OPTIMAL HEALTH THROUGH CHIROPRACTIC CARE.

To help you receive the greatest benefit from your care, all patients are accepted on the following policies. Please read carefully and sign when completed.

The patient understands that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. The patient instructs the chiropractor to deliver the care that, in her professional judgement, can best help in the restoration of their health. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

OFFICE HOURS

Our office is open as many hours as possible to accommodate our patients. These office hours are subject to change.

Monday
8:15am – 11:00am and 2:30pm – 4:45pm

Tuesday
CLOSED

Wednesday
8:15am – 11:00am and 2:30pm – 6:00pm

Thursday
2:30pm – 6:00pm

Friday
8:15am – 10:45am

SCHEDULING APPOINTMENTS

Dr. Orchard will design a specific course of treatment to allow for your optimal care. If Dr. Orchard accepts your individual case, you will be given your choice of appointment times. Due to the large volume of patients that this clinic sees, we kindly ask that you give a 24-hour notice if you cannot keep your scheduled appointment. If you are more than 15 minutes late for an appointment, you will be asked to re-schedule.

MISSED APPOINTMENTS

If your appointment is missed, you will be asked to make up the appointment that week or the following week so that you stay in line with your treatment plan. If two consecutive appointments are missed without notice or excuse, patient treatment may be terminated.

PATIENT PAYMENT POLICY

CHARGES ARE DUE UPON SERVICES RENDERED unless otherwise discussed and agreed upon with the doctor or office manager. All accounts over 60 days past due are subject to a $5.00 monthly rebilling fee.

It is the patient's responsibility to provide City Center Chiropractic with their current insurance information. Until the necessary information is provided and verified, the patient is responsible for all charges. Patient is responsible for all co-pays and deductibles related to health insurance, as well as any and all non-covered services

In the event that your account is referred for collection and/or is subject to other lawful measure employed by Dr. Orchard in collecting what you owe, you will be held accountable for all costs associated with such actions, inclusive of but not limited to collection agency fees, court costs and attorney fees. In any event, irrespective of whatever action may be taken and whether collection costs are documented or not, a penalty surcharge of not less than 50% of your total outstanding balance as of the date upon which your account goes into default, will be assessed.

REFERRALS

The success of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like us to invite to our office, please let us know.

We at City Center Chiropractic appreciate your commitment to your health and welcome you to our clinic!

____ __________________

Patient or Parent/Guardian Signature Date

City Center Chiropractic

USUAL OFFICE FEES

(Effective January 1, 2016)

EXAMS	FEE
Brief Exam/New Patient	$ 82.00
Limited Exam/New Patient	$ 103.00
Intermediate Exam/New Patient	$ 135.00
Extended Exam/New Patient	$ 192.00
Minimal Service/Established Patient	$ 43.00
Brief Service/Established Patient	$ 62.00
Limited Service/Established Patient	$ 79.00
Intermediate Service/Established Patient	$ 114.00

TREATMENTS	
Manipulation (1 to 2 areas)	$ 45.00
Manipulation (3 to 4 areas)	$ 82.00
Manipulation (5 areas)	$ 108.00
Manipulation (Extremity)	$ 42.00

SUPPLIES	FEE
BioFreeze	$ 16 / $ 19.00
Cervical Pillow	$ 50.00

THERAPY	
IST	$ 36.00
EMS	$ 36.00
Ultrasound	$ 35.00
Manual Therapy	$ 44.00 / unit
Acupuncture	$ 80.00
Therapeutic Exercise	$ 55.00 / unit

TIME OF SERVICE DISCOUNT	
New Patient Exam	$ 45.00
Adjustment	$ 45.00
Kids adjustment 0-15yrs	$ 30.00
Kids new patient exam	$ 30.00

I hereby certify that I have been informed of the fees of City Center Chiropractic. Any treatment that my minor child or I received will have charges incurred. I understand that I am responsible for any deductible and/or co-payment. Pursuant to Colorado Criminal Code 18-13-119, it is illegal for City Center Chiropractic to waive my deductible or co-payment. At the end of my care if there are any unpaid visits, I will also be responsible for those visits. If I do not have insurance, I am responsible for the costs incurred unless other arrangements are made with City Center Chiropractic. I agree that I am fully responsible for all charges my minor child or I should incur.

PAYMENT IS DUE AS SERVICE IS RENDERED

____ ____________________

Patient or Parent/Guardian Signature Date

Michele M. Orchard, D.C. PHONE 303 752 1982 ADDRESS 578 S. Chambers Road | Aurora CO 80017 WEB chirocitycenter.com