HEARTLAND
CHIROPRACTIC + WELLNESS CENTER

Pediatric Intake Form
(Birth to 12 years)

Child's Name: _____ DOB: ___/___/___ Sex: M / F Today's Date: ___/___/_____

Parent's/Guardian's Names: _____

Phone numbers: (H) _____ (C) _____ E-Mail: _____

Address:_____City_____State_____Zip_____

Has your child been checked by a Doctor of Chiropractic? ☐ **Yes** ☐ **No** Name: _____

Were x-rays taken? ☐ **Yes** ☐ **No** Who is your medical pediatrician?_____

How did you hear about us? Referral Name: _____

Local: Johnston Living, Dex or Yellow Book Internet Search: Google / Bing / Yahoo / Other:_____

Prenatal History:

Is your child adopted? ☐ **Yes** ☐ **No**

Did you have any prenatal complications and when? _____

Did you smoke/consume alcohol during pregnancy? ☐ **Yes** ☐ **No**

Did you take medication during pregnancy? ☐ **Yes** ☐ **No** Reason: _____

Did you have ultrasound during this pregnancy? ☐ **Yes** ☐ **No** Frequency_____

Birth History:

Place of birth: Home/ Birthing Center/ Hospital

Provider: ☐ Midwife ☐ OB-Gyn/ ☐ Other (Name): _____

Type of Birth: Vaginal / C-section. Were pain medications used? ☐ **Yes** ☐ **No** Type _____

Was labor induced? ☐ **Yes** ☐ **No** If yes, why? _____

What position did you deliver in: ☐ Squatting ☐ On Back ☐ Other _____

Birth Trauma: ☐ Doctor assisted ☐ Twisting and/or Pulling ☐ Vacuum Extraction ☐ Forceps

Newborn trauma (medical procedures and tests): _____

APGAR score: at birth _____ /10 at 5-minutes _____ /10 ☐ **U**nsure

Did your child have a misshaped skull/head? ☐ **Yes** ☐ **No** Purple markings on their face? ☐ **Yes** ☐ **No**

Do you/Did you breastfeed your child? ☐ **Yes** ☐ **No** If yes, for how long?_____

Does your child prefer one breast/side over the other? ☐ **Yes** ☐ **No** **Side:** ☐ Right ☐ Left

Does your child have any food or other allergies? (list) _____

Has your child been immunized according to the recommended schedule? ☐ **Yes** ☐ **No**

Reason for vaccination: informed decision, didn't know had a choice, recommended

Did your child have any negative reactions to vaccinations? ☐ **Yes** ☐ **No** _____Were they reported? ☐ **Yes** ☐ **No**

Has your child ever had any surgeries? ☐ **Yes** ☐ **No** Please explain: _____

Have they been on antibiotics? ☐ **Yes** ☐ **No** How many times? _____ Reason: _____

Is your child currently taking any meds? ☐ **Yes** ☐ **No** _____

Any vitamins? ☐ **Yes** ☐ **No** _____

Baby/Toddler (0-4): have/did any of the following occur?

☐ Fall from a changing table ☐ Frequent crying spells ☐ Frequent fevers ☐ Colic ☐ Tumble down stairs
☐ Fall out of crib ☐ Involvement in MVA ☐ Tonsillitis ☐ Constipation ☐ Repeated infections or colds
☐ Fall off of playground equip ☐ Sleeping problems ☐ Inadequate weight gain ☐ Reaction to vaccines
☐ Frequent ear infections ☐ Play in a Johnny jumper ☐ Frequent bouts of diarrhea
☐ Other: _____ Please explain: _____

Child (5-12): have/did any of the following occur?

☐ Fall from a tree ☐ Fall on playground ☐ Scoliosis ☐ Leg/knee pains ☐ Fall off of a bicycle
☐ Hyperactivity/autism ☐ Car accident ☐ Asthma ☐ Sports accident ☐ Learning difficulties
☐ Stomach pains ☐ Allergies ☐ Bed wetting ☐ Other: _____

Please explain: _____

Which of the above bothers your child the most? _____

When did it begin? _____ Is it getting worse? ☐ **Yes** ☐ **No** Is the pain: ☐ Constant ☐ Intermit ☐ Cyclic

How much has the complaint affect daily activities/routines? ☐ Not at all ☐ Somewhat ☐ Frequently ☐ Always

Which sports does your child play? ☐ Soccer ☐ Football ☐ Gymnastics ☐ Karate ☐ Hockey ☐ Lacrosse ☐ Basketball ☐ Dance ☐ Wrestling ☐ Baseball/ Softball ☐ Volleyball ☐ Tennis ☐ Swimming ☐ Rugby ☐ Other: _____

How would you rate your child's diet? ☐ *Well balanced* ☐ *Average* ☐ *High amounts sugar & processed food*

Does your child consume artificial sweeteners? ☐ **Yes** ☐ **No** Fluoridated water? ☐ **Yes** ☐ **No**

Number of hours your child sleeps? ____/day Quality: ☐ Good ☐ Fair ☐ Poor

Is there anything else we should know about your child? _____

Authorization to Treat a Minor

I, _____ the undersigning parent/person having legal custody/guardianship of _____, a minor, do hereby authorize, request and direct Drs. Skow and/or Davis and/or Lindsay Wilson and whomever he/she may designate as assistant to perform in judgment any examination and chiropractic diagnosis or treatment which is deemed necessary, including but not limited to HCWC massage therapist(s) and staff.

Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

Patient: _____ Date of Birth: _____ Social Security #: _____
Name (Print)

Signature: _____ Date: _____
Parent/Legal guardian

Insurance Information

*** If you would like to consider our Time of Service (Cash) Plan please request information at the front desk.**

Insured's Name: _____ Relationship to patient: _____

Date of Birth: _____/_____/_____ SS#: _____ Insured's Employer: _____

Insurance Company: ☐ BC/BS (PPO) ☐ Medicare ☐ Coventry ☐ United Health Care ☐ Other: _____

Insurance ID#: _____ Group #: _____ Plan/Program: _____

Assignment and Release: *I certify that I, and/or my dependent(s), have insurance coverage with above insurance company and assign directly to Valerie Skow/Tyler Davis/Lindsay Wilson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor/facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.*

Signature _____ Print _____

HEARTLAND
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5521 N.W. 86th Street · Johnston, IA · phone 515.252.8668
fax 515.270.2457 · www.HeartlandWellnessCenter.com

Dr. Valerie Skow | Dr. Lindsay Wilson | Dr. Tyler Davis

Insurance Benefits and Time of Service Plan Information

Heartland Chiropractic and Wellness Center ***is not responsible*** for confirming your health insurance benefits. Please contact your insurance company prior to your first visit.

We are **in-network** with most major insurance plans; including but not limited to:
Wellmark Blue Cross/Blue Shield-PPO (not HMO), Coventry, Aetna, First Administrators, and United Health Care.

We have included information below for you to ask your insurance representative to assist you in your call.
This information is only a guide - there may be further benefit considerations for your plan.

You may also choose not to go through your insurance and utilize our Time of Service Payment option. Please see below.

****** IMPORTANT NOTE: Be sure to ask specifically for your chiropractic benefits.**

In Network Y / N **Copay:** $_____ **Co-Insurance:** _____% **HSA/HRA:** yes no

Individual Deductible: $_____ met to date: $_____ **Family Deductible:** $_____ met to date: $ _____

Number of visits allowed:_____ met to date: $_____ **Insurance Coverage Max** $_____ met to date: $_____

Individual Out of Pocket Max: $_____ met to date: $_____ **Family Out of Pocket Max:** $_____ met to date: $_____

Time of Service Payment Option

Initial Visit *(adults and children)* **Includes:** Initial exam, chiropractic adjustment, and therapy $100
Adult Established Patient: Adjustment $50 **see Family Plan*
Established Patient Minors/Young Adult Students: $30
Re-exam *(6 months - 3 years since last visit)*: $20-$35
Recommended Therapy at Time of Chiropractic Visit: $10

Family Plan

First adult family member's chiropractic visit fee is customary pricing, above.
Your spouse/partner will receive discounted customary chiropractic fee if seen the same day.

Therapies/Modalities include: Electric Muscle Stimulation (EMS), UltraSound, and Kinesio Tape
Minors/Young Adults: dependent 18 years or younger and living at home/full-time student.

*Family Plan TOS benefits: 1) Status Married/Partnered. 2) Adult members of the family MUST be seen for chiropractic care the same day to receive full Family Plan TOS benefits. 3) Member's services at the lesser rate will be half the regular fee. 4) You must pay at the time services are rendered *or you will be subject to the insurance fee schedule rate*.
Insurance benefits and TOS cannot be combined with the Family Plan.

I recognize and acknowledge by virtue of my signature below that this Agreement, to reduce usual and customary charges is undertaken for my benefit, that it will result in a fee arrangement distinct from the one usually in place for the services in question, for my sole benefit.

In light of the foregoing, I hereby agree to the following: 1.I will not seek reimbursement for the services rendered to me under this arrangement from any insurance company, employer, welfare program, government entitlement program (Medicare or Medicaid), Workers' Compensation program or other third-party payor. 2. If any third-party payor responsible for all or part of the payment due as a result of services rendered under this Agreement contacts me, I will notify such payor of this arrangement and the reduced fees achieved as a result of the Agreement.

_____ _____
Signature Date

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Acknowledgment of Heartland Chiropractic and Wellness Center Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me.
I also understand that this Notice is available at HeartlandWellnessCenter.com\Forms or by request.

_____

Signature of Patient or Legal Representative *Date*

_____

Print Patient Name

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www.HeartlandWellnessCenter.com

HEARTLAND
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No Show and Cancellation Policy

Thank you for trusting your medical care to Heartland Chiropractic & Wellness Center. When you schedule an appointment with Heartland Chiropractic & Wellness Center we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule your appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Initial	Please read the following closely and initial when finished
x_____	**Cancellation & No Show Policy:** Heartland Chiropractic and Wellness Center has a 12-hour cancellation & rescheduling policy. If you miss your appointment, cancel, or change your appointment with less than 12 business hour notice, you will be charged $30.00. If you no-show or late cancel for two or more visits, you will receive a $50.00 fee. This policy is out of respect for our doctors and our patients in order to help as many individuals as possible. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
x_____	**Late Arrivals:** If you arrive late (10+ minutes) to your appointment, we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.
x_____	**Terms & Conditions:** I understand the terms of this form. I understand that these fees are not related to my insurance coverage, co-pay, or deductible and cannot be billed to my insurance company.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

You may contact Heartland Chiropractic & Wellness Center during our regular business hours with any questions or concerns regarding our policies.

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Informed Consent

We encourage and support a **shared decision making process** between us regarding your health needs. As a part of that process you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the

preceding as well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE

_____

TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.
DATED THIS ____ DAY OF _____, 20___

_____ **_____**

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: _____
Patient age: _____ DOB: _____
Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: _____
Signature: _____
Relationship to Patient: _____

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info@hcwellness.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 19th, 2013

This Notice of Privacy Practices applies to the following organizations.

Heartland Chiropractic and Wellness Center Privacy Official:
Stephanie Sandvig, Office Manager steph@hcwellness.com 515.252.8668