Dr. Kathy Pansegrau, DC
6402 Westwind Way, Suite 5
Crestwood, KY 40014
502-241-8939
www.360dc.net

Pediatric New Patient Information

2 months to 2 years old

Patient Information:

Child's Name____________________________________ Child's Nickname______________________

Reason for Visit____

Sex M/F Date of Birth_____________ Age________ Child's SSN______________________

Child's Home Address____

Who may we thank for referring you?____

Family Information:

Mother's Name___________________________ Father's Name___________________________

Home Phone____________________________ Home Phone_____________________________

Work Phone____________________________ Work Phone______________________________

Cell Phone______________________________ Cell Phone_______________________________

Parents Martial Status Married Separated Divorced Widowed

List Ages of Other Children in Family____

Predominant language used in the home___________________________

Payment Information

Please Read and Sign the attached Financial Policy. Does your health insurance cover chiropractic? Y/N

If you have insurance that may cover chiropractic services, please provide your current insurance card so that we may make a copy. Additionally, please enter the following information relating to the person who is responsible for child's health coverage.

Insured's Name_________________________ Date of Birth__-__-____ SS#______________________

Insurance Company__________________________ Phone Number_____________________________

Employer__________________________ Employer's Phone Number ____________________________

Group Number________________________ Insured's ID Number______________________________

Infant History

Date:____________________________ Patient Name:____

Sex: M / F Date of Birth:_______________________ Age:_______________________

The following questions are designed to help the doctor provide the best possible spinal care for your child.

Nutrition

Y / N Is your child still being breast fed? If No, for how long did baby breast feed?__________________

If still breast feeding, how much cow's milk does the mother consume each day?_____________________

Y / N Is your child formula fed? Which formula or other milk source?______________________________

Y / N Is your child eating solid food? What foods does his/her diet contain?_________________________

______________________________ What is your child's favorite food?_______________________________

Y / N Does your child have any feeding difficulties?____

Y / N Does your child have any digestive disturbances?____

Y / N Does your child food have any food allergies?____

Y / N Does your child have any persistent or intermittent skin rashes?_____________________________

Y / N Is your child receiving any vitamin supplements?____

Trauma

Y / N Has your child had any recent falls or trauma? If Yes, please describe the trauma and date it occured.____

____

Y / N Has your child ever fallen down stairs or fallen from any height ?______________________________

Y / N Has your child ever been in a motor vehicle collision or a near-miss?___________________________

Y / N Has your child ever had a bone fracture or a joint dislocation?_________________________________

Y / N Has your child had any other trauma or injuries?____

Y / N Does your child ever bang his/her head repeatedly against a wall, bed, or other object? __________

Growth and Development

Y / N Can your child sit unsupported? At what age did your child start to sit-up? ________months

Y / N Is your child crawling yet? At what age did your child start to sit-up? ________months

Y / N Is your child walking yet? At what age did your child start to sit-up? ________months

Y / N Does your child often trip and fall?____

Y / N Do you have any concerns about your child's growth and development?_______________________

Health History

Y / N Has your child had colic?____

Y / N Has your child had an upper respiratory infections? How often?_____________________________________

Y / N Has your child had asthma?____

Y / N Does your child ever complain of back of neck pain?____

Y / N Does your child ever complain of pain in the arms or legs?______________________________________

Y / N Does your child ever complain of headaches?____

Y / N Has your child had any earaches?__________ At what age did the first earache occur?______________

How frequently does your child suffer with earaches?____

Do the earaches usually tend to occur in the same ear?____________________ Is it Right, Left, or Both?________

Y / N Has your child had any other illnesses? If so please list each illness and its approximate date ___________

____

Y / N Is your child presently receiving any medications?____

____

Y / N Has your child ever been to a hospital or emergency room for evaluation or treatment?_______________

Y / N Has your child recently been vaccinated?____

Y / N Do you have any other concerns about your childs health?_______________________________________

____

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INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Health Care Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

____ __________________
Patient Name Date

____ ___________________
Parent/Guardian Signature Date

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CONSENT FOR TREATMENT

I, the undersigned, hereby authorize Dr. Kathy J. Pansegrau and whomever she may designate as her assistants to perform and administer therapy and treatment as is necessary. I also certify that no guarantee or assurance had been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon request. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment.

Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son / daughter named ______________________________ as the examining/treating doctor deems necessary.
I understand and agree I am personally responsible for payment of all fees charged by this office for such care.

____ ___________________________
Patient Name Date

____ ____________________________
Parent/Guardian Signature Date

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, DEMAND & CERTIFICATION

Insurer and Patient Please Read the Following in its Entirely

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (P.I.P.), Workman's Compensation and General Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this agreement is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payment, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider.

Release of Information: I hereby authorize this provider to: furnish the insurer, an insurer's intermediary and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer request from the insurer all EOB's from all providers and non-redacted PIP payout sheets; obtain copies of all medical records, including but not limited to, documents, records, scans, notes, bills, opinions, X-rays, IME's, and MRI's, from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-reacted PIP payout sheet and the insurance coverage declaration sheet to the above provider with 15 days.

Certification: I certify: that I have not been solicited or promised anything in exchange for receiving health care; that I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment; and that I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name_________________________________ Patient's Signature____________________________________
(Please Print) (If patient is a minor, signature of parent/guardian)

Date _________________________________

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_______________________________________ ____________________________________

Name of Patient Date

_______________________________________ ____________________________________

Parent/Guardian Signature Date

360° CHIROPRACTIC
We've Got Your Back

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OFFICE FINANCIAL POLICY FOR PATIENT CARE

To help provide the most efficient and reasonable health care service, it is necessary for us to have a Financial Policy stating our requirements for payment of services provided to our patients. Patients are responsible for payment of all services provided by our office. It is our policy to file for insurance as a courtesy to you if we have accurate and complete information. The balance due is still your responsibility if we have not received payment from the insurance company within 60 days. If you have insurance and we file with your carrier, we require payment of balances which are deemed your responsibility (co-payments, deductibles, co-insurance) at the time the service is received. We ask that you please contact your insurance company if your claim has not been paid within 30 days.

If you fail to keep your appointments without notifying us in advance or No Show your scheduled appointment:

1. **The *first* missed appointment is forgiven.**
2. **The *second* missed appointment and any missed appointments thereafter without prior notification you will be charged a $25.00 “no show” fee.**

To help in this policy, we ask that you assist us by:

1. Providing us with current and updated information on yourself and your insurance company and to keep all changes up to date.
2. Make payment at the time of service for the entire balance if you are a “Self Pay” patient, or for the amount of any deductible, co-payments or co-insurance. If you are unable to meet your financial obligation, you may be asked to reschedule. If you are a “Self Pay” patient, please see the receptionist for an additional “self pay” policy.
3. Please be prepared to present your insurance card to the receptionist upon signing in. If you cannot provide a copy of your insurance card, you will be considered “Self Pay” and will be required to pay for services in full on the date they are received. Upon receipt of insurance information, and in the event your insurance pays your claim, you will be refunded the amount of the credit due to you at that time.
4. Understand that we, from time to time, may verify insurance benefits on your behalf. Please be aware that we cannot be responsible for misinformation received from your insurance company. Insurance companies have a disclaimer for all callers stating that the benefits given over the phone are only an estimate and that the benefits are not determined until the actual claim is paid. Therefore, it is not possible for us to guarantee any type of coverage or benefit on your behalf.

______________________________________ ______________
Patient Name Date

______________________________________ ______________
Parent/Guardian Signature Date

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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:___________________________ **Last Name**:___________________________

Email address: __________________@__________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Text

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ___________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Name: ____ Date:_________________

Parent/Guardian Signature:_____________________________________ Date:_________________

For office use only

Height: _________ Weight:____________ Blood Pressure:______ /______

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Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name___________________________________ Date________________

Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _______ day of ________________________, 20___

By______________________________________

Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_______________________________________

Signature of Parent/Guardian (circle one)