CENTRAL OREGON CHIROPRACTIC
1020 SW Indian Ave. Ste 102
Redmond, OR 97756
P 541.923.6024 F 541.699.4287
Info@CentralOregonChiropractic.com

Date ____-____-_____

## ABOUT THE CHILD

Name _____ Age _____ Date of Birth _____

Gender ❑ M ❑ F Height _____ Weight _____

Home Address _____City _____ State _____ Zip _____

Names and Ages of Siblings_____

| Parent A | Parent B |
|---|---|
| Name _____ | Name _____ |
| Home phone (_____) _____ | Home phone (_____) _____ |
| Cell phone (_____) _____ | Cell phone (_____) _____ |
| Cell provider (for txt reminders) _____ | |
| Employer _____ | Employer _____ |
| E-mail _____ | E-mail _____ |

**How did you hear about Central Oregon Chiropractic?** □ Magazine □Friend/Family □Healthcare Provider □Other

Who may we thank for referring you? _____

**Patient Health Information (PHI) Privacy Agreement**

1. The patient understands and agrees to allow Central Oregon Chiropractic to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
2. Central Oregon Chiropractic staff has been trained in the area of protecting PHI. Precautions have been taken to assure patient records are not available to those who do not need them.
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 has the right to examine and obtain a copy of his/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.
5. 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. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
6. Patients have the right to file a formal complaint with Central Oregon Chiropractic about any possible violations of these policies and procedures.

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

Patient Guardian Signature: _____ Date:_____

CENTRAL OREGON CHIROPRACTIC

# Consent to Treat a Minor

I, _____ (print name) am the parent and/or legal guardian of

_____ (print name of patient), currently a minor whose date of birth

is ____ / ____ / _____.

Dr. Kent Rookstool, DC has my permission to treat my son/daughter utilizing diagnostic exams, chiropractic adjusting techniques, physical therapy modalities, x-ray examination, and nutritional therapies as he deems necessary. By signing this, I acknowledge that I have read and understand this consent, and that any questions I had prior to signing this could be answered. I further understand that, once my child reaches age 18, my consent for treatment is no longer required.

Signature: _____ _____

Parent/Guardian Date

**Parent/Guardian Emergency Phone(s)**

Home_____ Cell _____ Work _____

**Next Emergency Contact**

Name _____ Relationship to Patient _____

Home_____ Cell _____ Work _____

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Central Oregon Chiropractic can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other _____

Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

## EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ OTHER_____

**The primary system in the body which coordinates health is the NERVE SYSTEM.**
**The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM.**
**Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION.**
**VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.**

**Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.**

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses your child has been subjected to, how they may relate to his/her present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

## PREGNANCY & BIRTH

During pregnancy, did the mother:
❑ Use any form of fertility treatment? Y N What treatment: _____
❑ Experience any significant illnesses, difficulties, or trauma? _____
❑ Take any drugs/medications? _____
❑ Smoke or consume alcohol? Y N

❑ Home birth ❑ Hospital birth ❑ Vaginal ❑ Water birth ❑ Caesarean

Was the delivery premature? ❑ No ❑ Yes Weeks _____Weight _____
Approximately how long did labor last? _____ hours
Was labor artificially induced? ❑ No ❑ Yes _____
Was it determined that the child was breech or otherwise malpositioned? ❑ No ❑ Yes _____

The birth process can be traumatic to a baby's spine and cause interference to the nervous system. Please check which, if any, of the following were administered during labor and birth.

❑ Epidural ❑ Forceps ❑ Vacuum ❑ Medications _____
❑ Pitocin ❑ Episiotomy ❑ Manual traction of the neck _____

Please check all that apply to the baby's status immediately after birth:

❑ Jaundice ❑ Respiratory problems ❑ Broken bones _____
❑ Feeding problem ❑ Displaced joints ❑ Other conditions _____

APGAR Score _____

Was the baby breastfed? ❑ No ❑ Yes For how long? _____

## EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if your child has ever or is currently experiencing any of the emotional stresses below:

❑ Academic pressure ❑ Loss of a loved one ❑ Bullying ❑ Relocation
❑ Lifestyle change ❑ Parents' divorce ❑ Loss of a pet ❑ New sibling

Does your child have difficulty interacting with schoolmates or friends? ❑ Yes ❑ No
Have you or anyone else noticed that your child is nervous, twitches, shakes, or exhibits rocking behavior? ❑ Yes ❑ No

## CHEMICAL STRESS

Chemical stresses can occur when a substance that is toxic to the body is breathed, injected, taken by mouth, or comes into contact with the skin. The following will reveal exposures your child may have experienced.

Have you chosen to vaccinate your child? ❑ No ❑ Yes.
If yes, please check all vaccinations the child has received and at what age they were administered:

❑ DPT _____ ❑ MMR _____ ❑ Other _____
❑ Polio _____ ❑ Chicken Pox _____
❑ Hepatitis _____ ❑ Flu _____

Please describe any and all reactions to vaccine(s)_____

Please check all that apply and give any necessary details:
❑ Child exposed to second hand smoke.
❑ Has taken antibiotics. Explain _____
❑ Currently taking medication. Explain _____
❑ Currently taking supplements. Explain _____
❑ Has allergies. Explain _____
What treatments have you used? _____

## PHYSICAL STRESS: INFANCY & CHILDHOOD

Is the reason you are seeking care related to?: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Other

Please check all that apply to your child and give any necessary details:

❑ Uncoordinated/Accident prone
❑ Has been hospitalized. _____
❑ Had a severe trauma. _____
❑ Been in an automobile accident. _____
❑ Has fractured a bone or dislocated a joint. _____
❑ Has/had a chronic illness. _____
❑ Has had surgery. _____

What physical activities does your child participate in? _____

## HEALTH CARE PRACTITIONER HISTORY

Has your child ever received chiropractic care? ❑ Y ❑ N Name of D.C. _____

Reason _____ How long? _____ Date of last visit _____

Why was care stopped? _____

Have you consulted or do you regularly consult any of the following providers for your child?

Check all that apply
❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Other

Reason _____

_____

CENTRAL OREGON CHIROPRACTIC

# *Financial Policy*

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to your health and well-being. Payment is due at the time of treatment. We accept several methods of payment including cash, check, major credit/debit cards (Visa, MasterCard, Discover), and CareCredit (a medical financing option, ask for details and/or an application).

All account balances are to be paid promptly. If a balance has exceeded $200.00 or existed over 90 days, your privilege to schedule appointments will be suspended until the account is current. In the event of unforeseen circumstances, please communicate with our office to arrange and sign a payment plan.

Missed Appointment Policy: Your appointment time is reserved for you; please arrive on time to maximize your time with the doctor. Please give 24 hour notice if you are unable to keep your appointment, or a $25 fee may be applied to your account.

If you have questions on your suggested treatment plan or the available payment options, please do not hesitate to ask. We are here to help you!

**Please sign your initials in the box next to the category that applies to you.** This indicates that you have read and clearly understand your situation and obligations.

□ **General (Non-insurance):** Fees are to be paid at the time of service, unless special arrangements have been made in advance. After your initial new patient office visit, your typical charges will be based on the treatment plan you accept from the doctor's recommendations. This may include an adjustment, therapies, exam fees, and/or other supportive care.

□ **Treatment Packages:** Purchase a bundle of treatments and save! Some packages may be used as a family plan also. You must have a signed Treatment Package Agreement on file to use this option.

□ **Group/Private Insurance:** Central Oregon Chiropractic will verify your insurance coverage as a courtesy, but as your insurance company cannot guarantee payments based on quoting your benefits, neither can we. You are responsible for ALL deductibles, co-payments, coinsurances, and non-covered therapies at the time of service. When necessary the fee will be estimated and you will be billed/refunded the difference when your insurance issues payment. All payments must be made in accordance with your agreement with your insurance provider and our agreement with your insurance provider (if any exists); this includes you being personally responsible for payment should you reach your benefit maximum or should any lapse in coverage occur.

□ **Medicare:** This office has contracted with Medicare to accept assignment. This means we bill Medicare for your adjustment fee. Medicare pays for adjustment fees only, not therapies and exams. You are responsible for deductibles and co-payments according to Medicare guidelines, and any other service you accept as part of your necessary treatment. If you have a secondary insurance, Medicare will forward your claim under the Medigap policy.

□ **Worker's Compensation:** Under the Oregon Worker's Compensation Law, Chiropractic services are covered initially for 18 visits or 60 days of care. Beyond these limits, you will need a referral and treatment plan from a medical doctor (MD) to return to our office for additional treatment. The insurance company has 45 days to accept or deny a claim. If your claim is denied, you will become personally responsible for the payment of your care

□ **Auto Accident/Personal Injuries:** It is our policy to bill your auto/personal insurance directly regardless of who was at fault in the accident/injury. If there is a third party involved, they will reimburse your insurance company when the claim is settled. Through your insurance policy, you are entitled to coverage for up to one year, after which you may need an attorney to arbitrate. If we have not received payment within 90 days, your claim is denied, or you are being treated past your one year PIP benefit date, you will be expected to pay for your fees in full.

**I have read and understand the office policies and fees of this office. I understand that I am ultimately responsible for payment of my care and any fees incurred.**

Patient (or Guardian) Signature_____ Today's Date_____

Print Patient Name _____ Date of Birth _____