PEDIATRIC HEALTH QUESTIONNAIRE

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name: _____ Birthdate: _____Age:_____
Weight: _____ Height: _____ Male or Female: _____
Purpose for your Visit? _____
Other Doctors Seen for this condition?: No ☐ Yes ☐ *(If yes):* Doctors' Names and Prior Treatments*:* _____
_____

Check any of the following Conditions Your Child Has Suffered from During the Past Six Months:

☐ Ear infections	☐ Scoliosis	☐ Seizures	☐ Chronic colds	☐ Headaches
☐ Asthma / Allergies	☐ Digestive problems	☐ ADHD	☐ Recurring fevers	☐ Growing / Back Pains
☐ Weight loss	☐ Autism	☐ Learning disabilities	☐ Speech delays	☐ Toe walking
☐ Colic	☐ Bed wetting	☐ Car accident	☐ Temper tantrums	☐ Other _____

Family History of Chronic Health Issues:
Family Member: _____Health Issue: _____
Family Member: _____Health Issue: _____
Family Member: _____Health Issue: _____

Previous Chiropractor: _____
Date of Last Visit: _____/_____/_____ Reason: _____

Name of Pediatrician/Family Doctor: _____
Date of Last Visit: _____/_____/_____ Reason: _____
Are You Satisfied With the Care Your Child has Received There? No ☐ Yes ☐

Number of Doses of Antibiotics Your Child has Taken:
During the past Six Months: _____, Total During His / Her Lifetime: _____ List: _____

Number of Doses of Other Prescription Medications Your Child Has Taken:
During the past Six Months: _____, Total During His / Her Lifetime: _____ List: _____

Is your child vaccinated? No ☐ Yes ☐ Alternate Schedule ☐
Did your child have any of the following reactions to vaccinations?

☐ None	☐ Fever	☐ Rash	☐ Pain at injection site
☐ Fatigue	☐ Excessive Crying	☐ Vomiting	☐ Developmental Delay or Regression
☐ Seizures	☐ Diarrhea	☐ Other _____	

Has your child contracted any childhood diseases? (i.e chickenpox, mumps, measles, etc.)
If so, please list_____

Prenatal History:

Name of Obstetrician/Midwife/Doula?: _ _____
Complications During Pregnancy? No ☐ Yes ☐ *(If Yes)* List: _____
Ultrasounds During Pregnancy? No ☐ Yes ☐ *(If Yes)* Number: _____
Medications During Pregnancy? No ☐ Yes ☐ *(If Yes)* List: _____
Cigarette / Alcohol Use During Pregnancy? No ☐ Yes ☐

Location of Birth: ☐ Hospital ☐ Birthing Center ☐ Home

How long were you in labor? _____

Birth Intervention: ☐ Forceps ☐ Vacuum Extraction ☐ Ceasarian Section ,Emergency or Planned? _____

☐ Epidural ☐ Ptocin ☐ Pain medication

Reasons for interventions: _____

Complications During Delivery? No ☐ Yes ☐ *(If Yes)* List: _____

Genetic Disorders or Disabilities? No ☐ Yes ☐ *(If Yes)* List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____, _____

Nutritional and Activity History:

Breast Fed: No ☐ Yes ☐ *(If yes):* How Long? _____Any Difficulty? _____

Formula Fed: No ☐ Yes ☐ *(If Yes)* How Long? _____ Type: _____

Introduced to Solids at: _____months old, cows milk at _____ months/years

Food / Juice Allergies or intolerances: No ☐ Yes ☐ *(If Yes)* List: _____

_____

Does your child eat any of the following:

☐ Dairy ☐ Sugar ☐ Gluten/wheat

☐ Eggs ☐ Soy ☐ Caffeine

List your child's 3 favorite foods _____

Does your child drink water? _____How many glasses a day? _____

Does your child play outside?_____ List child's favorite activities_____

Does your child play sports?_____Which ones?_____

Does your child watch tv?

☐ No ☐ Rarely ☐ Weekly ☐ Daily

How many hours of sleep does your child get each night?_____ Quality of sleep: Good Fair Poor

Does your child take naps? _____Length of naps _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spine nerve interference). At what age was your child able to:

_____ Respond to Sound
_____ Respond to Visual Stimuli
_____ Hold Head Up
_____ Sit Up
_____ Cross Crawl
_____ Stand Alone
_____ Walk Alone

According to the National Safety Council, approximately 50% of children fell head first from a high place during their first year of life (i.e., a bed, changing table, down stairs, etc.). Was this the case with your child? No ☐ Yes ☐

Is / Has your Child been involved in any high impact or contact type sports (i.e., Soccer, Football, Gymnastics, Baseball, Cheerleading, Martial Arts, etc.)

No ☐ Yes ☐ *(If Yes)* List: _____

_____

Has Your Child Ever Been Involved in a Car Accident? No ☐ Yes ☐ *(If Yes)* List: _____

Has Your Child Ever Been Seen on an Emergency Basis? No ☐ Yes ☐ *(If Yes)* List: _____

Other Traumas Not Described Above? No ☐ Yes ☐ *(If Yes)* List: _____

Prior Surgery? No ☐ Yes ☐ *(If Yes)* List: _____

Menarche: No ☐ Yes ☐ Age: _____

Is there anything else you would like to discuss with us at this point? _____

WE ARE HERE TO SERVE YOU, AND ENCOURAGE YOU TO ASK QUESTIONS.
YOUR PARTICIPATION IS VITAL AND WILL HELP DETERMINE YOUR RESULTS.

Patient Name: _____ Birthdate: _____ Age: _____

Address: _____
 # Street *City* *State* *Zip Code*

Mother's Name _____ Father's Name: _____

Email: _____

Home Phone: _____ Work Phone: _____

Insurance Company: _____ ID#: _____
Name *Address*

Name of Insured: _____ Policy #: _____ Ins. Co. Phone #: _____

Who may we thank for referring you to our office? _____

AUTHORIZATION FOR CARE OF A MINOR

I hereby authorize Total Wellness of NJ and its Doctors to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all services rendered by this office.

_____ _____
(Parent/Guardian Printed Name) *(Parent/Guardian Signature)*

_____
(Date)

I authorize the release of any and all medical records or other information necessary to process claims. I also request payment of benefits be made directly to Total Wellness of NJ. I am consenting to signing an open sign-in sheet every visit on behalf of my son/daughter and I understand that anyone who enters the office will be able to view his/her name on this sheet. The statements made on this form are accurate to the best of my recollection.

_____ _____
(Parent/Guardian Signature) *(Date)*

Total Wellness
of New Jersey
Your Health, Our Passion

28 Bowling Green Parkway, Suite 1A ♦ Lake Hopatcong, NJ 07849 ♦ (973) 663-5633

OFFICE POLICIES

Welcome to our office! We are here to enhance your life, help correct the cause of your problems and restore your health. It is our policy to accept only those patients whom we believe we can help, and those who are willing to help themselves by actively participating in their care and following our recommendations. To help you receive the greatest benefits from your care here at our office, please comply with the following…

A) YOUR CARE PLAN: At your report of findings, the doctor will determine a care plan that best suits your spinal needs. Your office visits are scheduled according to this care plan. The frequency of your visitation schedule is of paramount importance to your results. As such, you must assume the responsibility of strict adherence to your care plan as it is designed for optimum results. Your commitment to keeping your appointments is your part in the correction of your problem and the restoration of your health.

B) MISSED/CANCELLED APPOINTMENTS: If for any reason, you are unable to keep an appointment, please call as soon as possible to reschedule that visit. It is best to make that appointment up within 24 hours to maintain optimal correction. If you have chosen not to schedule appointments, care will be delivered on a first come first serve basis after those with scheduled appointments. Please remember that it is the frequency of visits that counts, not the days on which you receive them.

C) HEALTHY LIVING WORKSHOP: The purpose of this workshop is to inform, inspire and empower you to take control of your life and health with 5 key wellness strategies. We have found that patients who attend respond better because they understand the cause of their problem and what we are attempting to do to correct it. Attendance is strongly recommended in order to get the most out of your care and our office.

D) INSURANCE: The privilege of insurance assignment begins when our office receives your insurance forms.
1. Deductible payments MUST be made prior to insurance submittal.
2. You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.
3. All co-payments are payable when services are rendered or at the end of each week.
4. Should you discontinue care for any reason other than discharge by the doctor, any and all balance due will become immediately payable in full, regardless of any claims submitted.
5. Our office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office.
6. Since we do not own your policy, and, occasionally, we experience difficulty in collecting from the carrier, we may ask for your active assistance in rectifying this situation.
7. Ultimately, it is your responsibility to see that your account is paid.

Lastly, it is our goal to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know.

WELCOME TO OUR PRACTICE!!!

I, _____ have read and understand the above policies and agree to abide by them.

_____ _____

Signature Date Effective 2/28/2017

Authorization to Use or Disclose Protected Health Information

Patient's Name_____ E-Mail address:_____

Patient's SS#:_____ Date of Birth:_____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES TOTAL WELLNESS OF NJ TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITHTHE FOLLOWING:

Your authorization is requested for purposes of delivering your care in an open-door adjusting environment. In the course of your care in this environment, routine details of your condition may be inadvertently disclosed to other patients or staff in the approximate vicinity of where your care is being delivered. We cannot assure that any of the details of your care will be addresses and considered as confidential by other patients.

We are requesting your authorization in this regard to assure that you are fully informed and in agreement with the method and circumstances in which we deliver chiropractic care. Your care will not be conditioned on your agreement to this authorization.

I give permission to Total Wellness of NJ to use my address, phone number and clinical records to contact me with the appointment reminders, missed appointment notification, birthday cards, holiday related cards, holiday promotions, information about treatment alternatives or other related information.

I give Total Wellness of NJ permission to contact me at my work number.

If Total Wellness of NJ contacts me by phone, I give them permission to leave a message on my answering machine or voice mail.

I give Total Wellness of NJ permission to display my name, photograph, or testimonial for internal office use.

I give Total Wellness of NJ authorization to use my name in the office's newsletter; i.e. congratulations or birthday wishes.

I give Total Wellness of NJ authorization to send me an e-mail newsletter on a monthly basis. I am aware that other patients may gain access to my e-mail address.

By signing this form you are giving Total Wellness of NJ permission to use and disclose your protected health information in accordance with the directives listed above.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this authorization, Total Wellness of NJ will not refuse to provide treatment. However, if you refuse to sign this AUTHORIZATION, any services rendered on this day will be paid in full at the time of service.

A copy of the signed authorization will be provided to you, the original will be maintained by this office.

Signature:_____ Date:_____

If you are a minor or if you are being represented by another party, please provide the appropriate person's :

Name:_____ Date:_____

Relation to Patient:_____ Signature:_____

EXPIRATION

The authorization shall expire on the following date:_____, 2020.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke the AUTHORIZION is not effective to the extent that we have provided services or taken action in the reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Total Wellness of NJ. The written notice must contain the following information: Your name, Social Security number, and Date of Birth; A clear statement of your intent to revoke this AUTHORIZATION; the date of your request and your signature. The revocation is not effective until it is received by the Privacy Official.

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Adjustment: As adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of the chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment of those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjustment to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis

_____ _____

Signature Date

ATTENTION! MUST BE FILLED OUT BY:
ALL Blue Cross Insured Patients
Acknowledgement of Responsibility

To our valued BC/BS patients:

We are glad to accept BC/BS insurance, but as of January 1, 2009 we are a ***non-participating*** BC/BS provider. This simply means that BC/BS will usually send all correspondence and payments to you instead of us.

BC/BS instructs providers request patients to pay the bill in full at the time services are rendered, however, we do not want to put that financial burden on our patients. As a professional courtesy, we will submit to your insurance for you. When you receive their correspondence and/or payment, you will then turn over all that you received to our office.

Please note that we provide such services to our patients as long as the following is agreed upon by initialing below:

- ***I understand that I may be receiving the correspondence / checks from BC/BS. I agree to give the payment AND copies of ALL correspondence to the office within 7 days of receiving the information myself _____ (initial please).***

- ***I understand that I need to turn over copies of ALL correspondence I receive, even if there is no check attached. I have been advised that BC/BS explanation of benefits may show other valuable information such as deductibles applied and other denials which my provider may need for appeal / resubmission _____ (initial please).***

- ***I understand that as an out of network provider, BC/BS may only provide limited information about claims payment. If there is a claim that BC/BS is stating was processed to me which I insist was not received, I understand that I may need to have a conference call with my carrier, your billing office and myself _____(initial please).***

- ***I have been advised of the credit card debit program _____(initial please).***

Again, thank you for being our patient and we are glad to provide this service for you, we just ask that you work with us while we assist in having your claims processed.

I hereby authorize Total Wellness of New Jersey to act as my authorized representative, as defined by the Patient Protection and Affordable Care Act (federally mandated on September 23, 2010), in dealings with my third party payer. I hereby authorize the attending Doctor to release any information concerning my examination or treatment and receive any information appropriate to the payment for those services.

Patient Name _____

Patient Signature _____

Today's Date _____

This office is out of network with Blue Cross / Blue Shield (BC/BS) effective January 1, 2009.

As a courtesy to our BC/BS patients, we will continue to forward claims to BC/BS on your behalf for processing. However instead of checks, Explanation of Benefits (EOB's) and other correspondence being sent to us from BC/BS, all correspondence including checks will be forwarded directly to plan holder, which in most cases would be you, the patient.

In our "Acknowledgement of Responsibility" form, we stated that in the event checks are not turned over to this office within 2 weeks of being issued from BC/BS, with your authorization we will charge your credit card for the entire office visit.

Please keep in mind that because we are an out of network provider, we are limited to the information that we can obtain from BC/BS about any payments that have been forwarded to the plan holder, which in most cases would be you, the patient.

Therefore the only charge we have to go on is what was billed to BC/BS for your visit.

Please read and sign the information noted below.

Credit Card Debit Authorization

I, _____, authorize **Total Wellness of New Jersey** to debit my credit card (information provided below) under the following circumstance - **in the event the providers office is advised that BC/BS has processed a claim(s) to the plan holder, of which I am insured, over 2 weeks ago.**

My credit card information is as follows:

Name of cardholder: _____

Type of card: _____

Account Number: _____

Security Code (found on the back of card):_____

Expiration Date: _____

I understand that my credit card information will be kept in a secure location. I also understand that if my credit card is debited, the office is responsible for sending me a receipt for the transaction. Should I close the above account, while still a patient, I agree to contact the office immediately to set up my account with the new information.