Cooper Chiropractic Center for Health and Wellness
4001 Main St. Suite 200 Vancouver, WA 98663
360-693-3030

Pediatric Intake Form

It's all about the uniqueness of your child

Patient Information

Patient Name: _____Date: _____

DOB: _____ Age: _____ Sex: ☐Male ☐Female

Address: _____City:_____ State: _____Zip: _____

Who may we contact on behalf of the patient? _____ Relationship _____

Home #_____ Office #_____ Cell #_____

Where do you prefer to receive calls? ☐Home ☐Cell ☐No Preference

Who can we thank for this referral to our office? _____

Responsible Party

Name of person responsible for account: _____

Relationship to patient_____ Phone #_____

Name of Employer: _____Work # _____

Insurance Information

Name of insured: _____DOB: _____

Insurance Carrier: _____ Phone # _____

Policy ID: _____ Group # _____

MEDICAL/FAMILY HISTORY: S= Self M=Mother F=Father

(please indicate which conditions have been experienced by the above by marking appropriate boxes)

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	dislocated joints	☐	☐	☐	neck pain
☐	☐	☐	anemia	☐	☐	☐	epilepsy	☐	☐	☐	nervousness
☐	☐	☐	arthritis	☐	☐	☐	German measles	☐	☐	☐	numbness
☐	☐	☐	asthma	☐	☐	☐	headaches	☐	☐	☐	polio
☐	☐	☐	back pain	☐	☐	☐	heart trouble	☐	☐	☐	poor circulation
☐	☐	☐	bladder trouble	☐	☐	☐	reproductive disorders	☐	☐	☐	hepatitis
☐	☐	☐	bone fracture	☐	☐	☐	high blood pressure	☐	☐	☐	rheumatic fever
☐	☐	☐	cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatism
☐	☐	☐	chest pain	☐	☐	☐	kidney disorder	☐	☐	☐	scarlet fever
☐	☐	☐	concussion	☐	☐	☐	bowel control loss	☐	☐	☐	serious injury
☐	☐	☐	convulsions	☐	☐	☐	menstrual cramps	☐	☐	☐	sinus trouble
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	indigestion	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Did you know that the persistent use of antibiotics can lead to an early onset of gastrointestinal tract distress leading to over growth of intestinal yeast? Did you also know that chronic use of antibiotics can lead to antibiotic resistant bacterial infections?
*Please list any and all prescription medications that your child is presently using and has used on more than one occasion. Please reflect carefully as your child's present health state may be related directly or indirectly to the treatment of a past problem

_____
_____
_____
_____

Each year a growing number of children are hospitalized due to acetaminophen and ibuprofen poising. Has your child taken any products that contain these chemicals?
□Yes □No -- If yes, for what reason and how long? _____

Has your child ever been hospitalized? □Yes □No
If yes, why and when? (Please list in chronological order)

_____
_____
_____

Accidental trauma is the number one cause of injury to children in the United States each year. Please list any and all injuries experienced by your child, how they occurred and what action was taken to correct them.

_____
_____
_____

Please check any of the following sports/activities that your child is engaged in

□ Football	□ Lacrosse	□ Soccer	□ Track & Field
□ Bowling	□ Tennis	□ Hockey	□ Volleyball
□ Baseball/Softball	□ Skateboarding	□ Snowboarding	□ Skiing
□Gymnastics/Trampoline	□ BMX/Motocross	□ Swimming	□ Golfing

□Other_____

Has your child ever been injured while playing sports? □Yes □No
If yes, what type of injury(s) occurred? _____
_____

Recent research reveals that 30% of American children are obese with more than 50% of all US children overweight. On a scale from 1-5, please rate the food groups that are most eaten by your child on a daily basis. Use the higher number for the most common foods eaten. (Please Circle)

1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Non-Complex Carbohydrates Bread Products, Cereals, pizza, cakes, cookies, chocolate, candy	**Complex Carbohydrates** Fruits and Vegetables	**Protein** Nuts, Seeds, Meats, Eggs	**Fats** Dairy Products

Please list the (3) most common foods eaten by your child each day: _____

_____

How many times per month does your child eat fast food? _____
What type? _____

What is the primary beverage consumed by your child? _____

How much water does your child drink each day? _____

Does your child drink soda? ☐Yes ☐No If yes, how much on a daily basis? _____

Does your child consume artificial sweeteners such as those found in sugarless, fat free products? ☐Yes ☐No – If yes, what kind? _____

Was your child breast fed? ☐Yes ☐No If yes, for how long? _____

Was your child formula fed? ☐Yes ☐No If yes, for how long? _____

At what age did you introduce solid foods? _____ What type(s) _____

Has your child exhibited any intolerance and/or allergy to any specific foods?
☐Yes ☐No -- If yes, please list all foods _____

_____

Has your child been tested for allergies?
☐Yes ☐No -- If yes, how were the tests performed? _____

_____

What were the results? _____

_____

If your child does have an allergy, how does it present itself? (Skin rash, hives, ENT/respiratory, digestive symptoms).

_____

_____

How your child received treatment for any type of allergy? ☐Yes ☐No
If yes, what type of treatment? _____

_____

_____

Present Health Challenge(s)

For what health challenge(s) is your child here for? _____

_____

What do you feel is the cause of your child's problem? _____

_____

When did you first notice this sign of body dysfunction? _____

_____

Is this dysfunction getting progressively worse?

☐Yes ☐No -- If yes, why do you think so? _____

_____

What are the most significant measures you have taken to date to improve your child's present health challenge(s)? Please list all the healthcare practitioners seen, treatments rendered, and any results experience. _____

_____

_____

Please list the (3) most significant stressful events in your child's life from the most recent to the most distant. Are any of these situations continuing to impact his/her life? If yes, please explain clearly.

_____

_____

_____

Please list any and all other concerns regarding your child's health and whether or not you feel they are related to your child's primary reason for being seen in our office today.

_____

_____

Please check any and all of the following health challenges your child has suffered

☐ Allergies	☐ Frequent Colds/ Congestion	☐ Upper Respiratory Infections	☐ Asthma
☐ Ear Infections	☐ Infected/ Sore Throat	☐ Tonsillitis	☐ Laryngitis
☐ Colic	☐ Reflux/Spitting Up	☐ U-Tract Infections	☐ Poor Appetite
☐ Poor Digestion (Constipation/Diarrhea)	☐ Thrush Mouth/ Chronic Diaper Rash	☐ Eczema / Psoriasis / Other Skin Rashes	☐ ADD / ADHD
☐ Irregular Sleep Patterns	☐ Night Terrors	☐ Bed Wetting	☐ Headache
☐ Anxiety	☐ Mood Swings	☐ Bruising	

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

_____

Signature of Patient, parent, guardian or responsible party Date

_____

Print Name of Patient, parent, guardian or responsible party Relationship to patient

Cooper Chiropractic

4001 Main St. Ste. 200 ♦Vancouver WA 98663 ♦ (360) 693-3030

Acknowledgement and Understanding

Please initial each item below:

1) _____I hereby authorize Dr. Matthew Cooper/Dr. Karis Cooper/Dr. Cassi Long/ Dr. Jacob Stockton to provide Chiropractic services to me.
2) _____I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by this chiropractic clinic.
3) _____ If this account is assigned to any attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost for collection.
4) _____ I hereby assign all chiropractic benefits, including major medical benefits in Medicare, private insurance, and all other health plans for services rendered by Dr. Matthew Cooper/Dr. Karis Cooper/Dr. Cassi Long /Dr. Jacob Stockton
5) _____ I authorize the release of my records to third parties whom require them for determination of financial liability.

By signing this application, I affirm under penalty of law that I have given true, complete information.

_____

Patient (print name) Date

_____

Patient/Guardian Signature Date

Consent to Treat

Chiropractic examination and therapeutic procedures (including spinal adjustment, heat/ cold application and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however complications may arise and any procedure intended to help may have complications. While the chance of experiencing complications is small, it is the practice of this clinic to inform patients about them. These complications include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side effects and complications are available upon request.

I have read and understand the above statements regarding treatment side effects. I also understand that there is no guarantee or warranty of a specific cure or result.

_____

Patient (print name) Date

_____

Patient/Guardian Signature Date

FINANCIAL POLICY

• It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

• All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $200 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.

• For your convenience, this office accepts payment by the following payment methods: cash, checks, Visa, and MasterCard.

Additional Fees and Discounts

• This office does not turn away patients due to their ability to pay. If you feel you might qualify for our financial hardship policy, contact the billing office immediately so we can begin your qualification process.

• This office offers a prompt payment discount of 15% if payment is made in full at the time of service and a third party is not being billed.

• *This office requires a minimum of 24 hour advance notice for appointment cancellations and rescheduling.* In the case that proper notice is not received for chiropractic and nutrition appointments, a **$40 fee will be incurred for "no-shows" and a $20 fee will be incurred for cancellations received in less than 24 hours** from the appointment time. For massage appointments, **a $35 fee will be incurred for a "no-show" or cancellation received in less than 24 hours** from the appointment time.

• Should payment be refused by your bank for any check written, this office will charge a fee of $30 to offset the charges we will incur as a result of the returned check.

Insurance Billing

• As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility. However, payment for services rendered is ultimately the responsibility of the patient**. Please present visible insurance information at the time of check-in on the first date of service.**

• The privilege of insurance assignment begins when our office receives your insurance information and a quote of applicable benefits. Until that time, you are considered a "Time of Service" patient and *payment is expected at the time of service.* As a courtesy to you, our office will request a quote of benefits from your insurance company, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

• Services such as muscle work (97140), exercise/stretching (97110 or 97530), deep tissue laser therapy (S8948), and cranio-sacral therapy/extra-spinal (98943) are **billed separately** from chiropractic adjustment and **may** apply to an exclusive benefit and/or **incur additional charges.** Patients are encouraged to discuss treatment recommendations with their provider and to discuss insurance benefits with their insurance carrier.

• **For New Patients with benefits quoted as applicable to deductible**, a $100 deposit is due at the time of check-in on the date of service. **For Established Patients with benefits quoted as applicable to deductible**, a $50 deposit is due at the time of check-in on the date of service. If the patient responsibility is more than this amount, a statement will be mailed indicating the additional cost. The patient will also have access to how the claim processed on the explanation of benefits that is sent to them by the insurance company.

• **For those with a per year visit limitation (dollar or number of visits),** we recommend that you track your benefit utilization since we may not have access to any visits rendered by another provider.

• The benefits applied to claims by the insurance company are not always predictable. If you see an in-network provider, you will not receive billing above the contracted rate. If you see an out-of-network provider, we will work with you to determine the amount of coverage and help estimate your responsibility.

• If your insurance has not paid on an assigned bill within 60 days, we ask that you contact your insurance company at that time. If it remains unpaid within 120 days the balance becomes due and payable immediately and your assignment is revoked.

• Patients who are being seen for maintenance or wellness are not eligible for insurance assignment and are required to pay the Time of Service rate.

Payment at Termination of Care

• Should you discontinue care for any reason, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Signed: _____ Date: _____

Witness: _____ Date: _____

Motor Vehicle Accident Patients ONLY

I, _____**,** authorize Cooper Chiropractic to release my records to _____ (carrier name) in regard to my personal injury case.

Signed: _____ Date: _____

Witness: _____ Date: _____

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patient Name or Legal Guardian (print) Date

_____

Signature Date

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt _____

Staff Name_____