NASHUA FAMILY CHIROPRACTIC

29 Riverside Street, Units A and B, Nashua, NH 03062 P: (603) 880-4150 F: (603) 880-6765

Mission: *"To raise the vibration of <u>everyone</u> who walks through our door."*
Vision: *"To revolutionize healthcare in our community."*

Welcome to Our Family! **Your child's health history is important to us. Please fill out this form COMPLETELY.**		
Today's Date:		
Patient First Name:	Patient Last Name:	
Parent/Guardian Name (s):		
Relationship to Patient:		
Street Address:		
City:	State:	Zip Code:
Home #:	Cell #:	Work #:
How would you like your future appointment reminders? ☐Call ☐ Text ☐No Reminder **Cell Phone Provider:**_____		
Email:		
Date of Birth: / /	Age:	Sex: ☐Female ☐Male
Emergency Contact Name:	Relationship:	
Emergency Contact Phone #: ( )	Secondary #: ( )	
Primary Care Provider:	Phone: ( )	
Primary Care Provider Address:		
Who may we thank for referring you?		

What school/daycare does the patient attend:

If you know your child's approximate height and weight please specify here	Height: _____'_____"	Weight: _____lbs

Why are you seeking chiropractic care? ☐Pain ☐Wellness ☐Nutrition/Lifestyle ☐Other	
What is the area of complaint?	
When did the symptoms start?	

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Has your child experienced this before?	
Has school been missed due to this condition?	☐ No ☐ Yes How Long?
Is this condition due to an automobile accident?	☐ No ☐ Yes
Has your child been seen by another provider or received treatment for this condition?	☐ No ☐ Yes Whom?
Has there been any previous tests, x-rays, CT scans or MRI's previously taken?	☐No ☐ Yes What was done?
Has your child been checked by a doctor of chiropractic before?	☐ No ☐Yes Whom?

Medications/Allergies		
Current Medications: Please list all prescriptions, over-the-counter medicines and dietary supplements. If possible, include the brand name for supplements. If NO current medications please check here ☐		
Medication/Supplement	Dose	Frequency
1.		
2.		
3.		

Please list any known allergies your child may have. If no known allergies, check here ☐	
1.	2.
3.	4.

Please check the following boxes if your child HAS or HAD any of the listed symptoms/conditions.

Cardiovascular	**Digestive**	**Endocrine**	**Integumentary**
☐No issues	☐No issues	☐No issues	☐No issues
☐Heart Defect	☐Reflux/GERD	☐Diabetic ☐Type I ☐Type II	☐Psoriasis
☐Excessive Bruising	☐Colic	☐Swollen glands	☐Eczema
☐Palpitations	☐Constipation	☐Other	☐Acne
☐Asthma	☐Diarrhea	**Developmental**	☐Rash
☐Persistent cough	☐Food Sensitivities	☐Delayed Speech	☐Birth marks
☐Mouth-breather	☐Poor Appetite	☐Delayed gross motor skills	☐Other
☐Congestion	☐Anorexia/ Bulimia	☐Delayed fine motor skills	

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☐Bronchitis/Pneumonia	☐Other	☐ Delayed social skills	
Immune	**Constitutional**	**Musculoskeletal**	**Neurological**
☐No issues	☐Lethargic	☐Joint/Bone pain	☐Dizziness
☐Chronic colds	☐Difficulty sleeping/ Irregular sleep patterns	☐Growing pains	☐Balance/Coordination Issues
☐Laryngitis/Tonsilitis			
☐Ear & Sinus Infections	☐Bed-wetting	☐Headaches	☐Epilepsy/Seizures
☐Low Energy	☐Pre-mature birth	☐Developmental Delays	☐ Visual/hearing issues
☐ UTI's			
☐Other	☐PTSD	☐ Torticollis	☐ADD/ADHD
	☐Other	☐ Scoliosis	☐Autism Spectrum
		☐ Abnormal Walk	☐Focus/Memory Issues
		☐TMJ/Jaw pain	☐Speech Issues
		☐Poor Posture	☐Anxiety/Depression
		☐Other	☐Other

Daily Habits	
How much exercise does your child get?	
How much time does your child spend watching TV or a screen?	About_____ hrs. per day
What sports or activities does your child participate in?	☐My child doesn't engage in sports/activities ☐Yes, my child plays…
What position does your child sleep in? **How much sleep are they getting a day?**	☐Back ☐Side ☐Stomach _____ hrs.
What is a typical breakfast for your child?	
How would you rate their diet?	☐Poor ☐Fair ☐Healthy ☐Very Healthy

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Please date/list reasons for any hospitalizations or surgical procedures.	
Date	**Reason**
Please describe any other injuries/accidents not mentioned previously.	
Date	**Injury**
Are there any past or current medical conditions you have not told us about?	
Is there anything additional we should know about your child?	

Family History Please include any pertinent, immediate family medical histories (Diabetes, hypertension, cardiac arrest, stroke, cancer, rheumatoid arthritis etc.)	

Parent/Guardian Signature:_____ 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 the 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 HIPPA 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 to the patient in this office.
4. 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 at any time during care 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.

Date: _____ Patient name (printed):_____

Patient signature: _____

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ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

Private, Group, Accident, HMO, PPO and Health Insurance

Patient Name: _____

Claim or Group Number: _____

Social Security or ID Number: _____

I hereby instruct and direct that _____ insurance company pay by check made out and mailed to:

Brandon Linatsas, DC, 29 Riverside Street, Unit B, Nashua, NH 03062

If current policy prohibits direct payment to the doctor, then I hereby direct you to make the check payable to myself and Brandon Linatsas, DC/Nashua Chiropractic and mail it to:

Brandon Linatsas, DC, 29 Riverside Street, Unit B, Nashua, NH 03062

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy is to be used as payment toward the total charges of the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a prompt manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this agreement shall be considered as valid as the original.

I authorize the release or reception of any information pertinent to my case to/from any insurance company, the insurance adjustor, health care establishment, or attorney involved. I also authorize the doctor to complain on my behalf to the insurance commissioner if the insurance company defaults on this agreement for any reason.

I understand that by authorizing this release of my medical records I also release Nashua Chiropractic from all legal responsibility or liability that may arise from the release of these medical records. This authorization is valid until further notification to the contrary.

Date: _____ _____

Signature of Policyholder/Patient

Date: _____ _____

Signature of Patient if other than Policyholder

Name of the Insured if not patient: _____

Insured's DOB: _____ Insured's Employer: _____

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POLICY FOR MAJOR MEDICAL INSURANCE

Our office is pleased to accept your insurance assignment as soon as your coverage has been verified. If you do not have a referral or your insurance is not assignable to this clinic, then you must pay in full at the time of service. The insurance company may reimburse you directly in these cases.

You must fully understand that your insurance contact is between you and your insurance carrier and that every individual policy varies regarding rules of specific coverage. Therefore, you are fully responsible for any amount not paid by your insurance company. This excludes specific HMO and PPO contracts in which we are participants. Nashua Chiropractic will make every effort to see that your claims are paid. However, we will not enter into a dispute with your company over your claim. If we do not receive payment from your insurance company within 90 days it becomes your responsibility. There is no guarantee that your insurance company will pay for the services provided. We make every attempt, at the beginning of your health care, to verify your policy and what it covers. However, if for some reason your claim is denied or we have received inaccurate information, you are responsible for the balance. (**Initials here please): _____**

If your company has limited coverage or a visit limitation that does not cover your total care it is your responsibility to pay the balance due. You are also responsible for tracking your visits and the limitations imposed by the insurance company. We will do our best to assist you with tracking but it is ultimately your responsibility. We provide direct billing as a courtesy to you, therefore we ask for your cooperation. This office bills on a weekly basis.

Should your insurance require a referral/preauthorization this must be received in this office by your second visit. Initial insurance information must also be received in this office by the second visit. Otherwise your account may revert to a cash account until the information is received.

Should your insurance coverage change it is your responsibility to inform us immediately. We are not obligated to back bill insurance and you are directly responsible for any balance due.

Should you terminate care of your own volition your account is due and payable immediately.

We ask that you pay your portion of your charges at the time of service. This may include deductibles, co-pays, and patient portions/percentages. If we must enter into any type of litigation to collect fees due to this office, you may be responsible for any and all collection and/or legal fees as well as a one and a half percent interest charge on unpaid balances.

I authorize the release or reception of any information pertinent to my case to/from any insurance company, the insurance adjustor, health care establishment, or attorney involved. I understand that by authorizing this release of my medical records I also release Nashua Chiropractic from all legal responsibility or liability that may arise from the release of these medical records. This authorization is valid until further notification to the contrary.

I have read, understand and agree with the above policy.

Date: _____ _____

Signature of Patient