Goulet Family Chiropractic

Adolescent

Confidential Patient History

Child's Name: ______________________ Parent / Guardian: ____________________________________

Address: ______________________________ City/State/Zip: ____________________________________

Phone: (______)__________________ Email: ____

Child's Birthdate: ___/___/______ Age: _________ Height: __________ Weight: _____________

Current Health Conditions

Is your child receiving care from any other health professionals? Yes ________ No ________

If yes, please name them and their specialty: ____

____

Please list any medications, vitamins, herbs or supplements that your child is taking: ____________________

____

What health condition(s) bring your child to be evaluated by a chiropractor?_____________________________

____

____

Is this visit due to or in any way to: school________ sports__________ Injury________ fall__________

When did the condition first begin? ____

How did the problem start? Suddenly _________ Gradually __________ Post Injury __________

Has your child received care for this condition before? Yes _______ No _______

If yes, please explain: ____

____

Is this condition Getting Worse ______ Improving ______ Intermittent ______ Constant ______ Unsure _______

What makes it worse? ___________________ What makes it better? __________________________

How heavy is your child's backpack? Very____ Heavy____ Moderately heavy____ Not heavy_____

Please list any food intolerance or allergies and when they began: ___________________________________

____

____

Please Complete Back of Form Also

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Please list any hospitalizations or surgeries and the dates performed: ____________________

____

____

Please list any major injuries, accidents, falls and / or fractures your child has sustained in his / her lifetime including the year: ____________________

____

____

Has your child received any antibiotics? Yes______ No______

If yes, how many times and for what reason: ____________________

____

____

How many hours a day does your child spend watching TV, computer, tablet, phone? ____________________

Is your child involved in sports? ____________________

____

Does your child exercise on a regular basis? __________. What type of activities? ____________________

____

____

Any difficulty sleeping? ____________________

How would you describe your child's diet? ____________________

____

Parent or Guardian Signature: ____________________ Date: ______________

Goulet Family Chiropractic
Terms of Acceptance

When a patient seeks chiropractic care, and we accept a patient for such care, it is essential for both doctor and patient to be working towards the same objective. Chiropractic has only one goal – to eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom. It is important that each patient understands both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is specific adjustments of the spine.
Health: A state of ***Optimal*** physical, mental and social well-being; not merely the absence of disease or infirmity.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae 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.

We do not offer to diagnosis or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a healthcare provider who specializes in that area. 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

Consent to Evaluate and Adjust a Minor Child

I, ______________________________, being a parent or legal guardian of __________________, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

____   ________________________
Signature   Date

Goulet Family Chiropractic

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 these records. Before we began any healthcare 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 **PHI**, 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 **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 with 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 have 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 know 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 healthcare operations, the chiropractic physician has the right to refuse to give care.

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

____

Print Patient Name

____

Patient / Guardian Signature

____

Date

GOULET FAMILY CHIROPRACTIC

Pediatric Fee Schedule -

Service	Fee
Initial Exam/Consultation	$40.00 - $100.00
Cervical X-Rays (3 views)	$50.00
Thoracic X-Rays (2 views)	$50.00
Lumbar X-Rays (2 views)	$50.00
Regular Adjustment	$45.00
Active Military Adjustment	$25.00

Patients Without Insurance - It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered. We accept cash, your personal check, MasterCard and Visa cards.

Group Or Individual Insurance - Benefits quoted to us by your insurance company are not a guarantee of payment. At time of service, you are responsible for any non-covered services, deductibles or co-pays. We will file your claim and wait payment for 90 days. You will be responsible for any charges not paid by your insurance company. Please inform us of any secondary insurance you might have.

Insurance does not always cover chiropractic coverage for infants and children; should this occur payment will be your responsibility.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process my claim(s). I also request payment of government benefits either to myself or to the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I understand and accept the fee schedule listed above. I authorize payment of medical benefits to Dr. Jeremy M. Goulet for services provided.

Patient's Name: ______________________________

______________________________ ______________

Parent or Guardian Signature **Date**