It is our 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 and your family!

Patient Name ______________________________ SS# ____________________

Name of Parents / Guardians ____

Address______________________ City __________ State________ Zip ________

Best Contact # Cell OR Home __________________ Parent/Guardian Work # ______________

Email ____

Patient Date of Birth ____________ Sex M / F Height _____ Weight _____ # of Siblings _____

How did you hear about our office? ______________________________________

Reason for seeking chiropractic care ______________________________________

Other doctors seen for this condition (circle) Yes / No

If yes, doctor's names and prior treatment __________________________________

Other health problems ____

Has your child ever suffered from (check all that apply)

☐ Dizziness	☐ Backaches	☐ Heart trouble	☐ Chronic earache
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Frequent Colds / Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Problems	☐ Sinus Trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic Problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Paralysis	☐ Behavioral Problems
☐ Bed Wetting	☐ Convulsions	☐ Broken Bones	☐ Muscle Jerking
☐ Fainting	☐ Walking Problems	☐ Leg Problems	☐ Ruptures/ Hernias
☐ Neck Problems	☐ Arm Problems	☐ Colic	☐ "Growing Pains"
☐ Joint Problems	☐ Blood Disorders	☐ Stomach Aches	☐ Other ____________

Family Health History

Previous Chiropractor(s) ______________________________

Reason for Care ______________________________

Are you satisfied with the care your child received there? Yes / No

Name of Pediatrician ______________________________

Reason for Care ______________________________

Are you satisfied with the care your child received there? Yes / No

Number of antibiotics your child has taken:

During the past 6 months ________ Total during his/her lifetime ________

Has your child ever taken any prescription medications? Yes / No

Current prescription medications ________________ Previous prescription medications ________________

Vaccination History ______________________________

PRENATAL HISTORY

Type of Birth Attendant: OB/GYN / CNM / Lay Midwife Name ______________________________

Location of Birth: Home / Birthing Center / Hospital

Complications during pregnancy: Yes / No List ______________________________

Ultrasound during pregnancy: Yes / No Number ________

Medications during pregnancy / delivery: Yes / No List ______________________________

Cigarette/ Alcohol use during pregnancy: Yes / No

Birth Intervention: Forceps / Vacuum / Caesarian Planned or Emergency? ______________________________

Complications during delivery: Yes / No List ______________________________

Genetic disorders or disabilities: Yes / No List ______________________________

Birth weight ______________ Birth length ______________ APGAR scores ______________________________

FEEDING HISTORY

Breast Fed: Yes / No How long? ________________ Formula Fed: Yes / No How long? ______________

Type ______________________________ Introduced to solids at ________ months, Cow's milk at ________ months

Food/ juice allergies or intolerances: Yes / No List ______________________________

DEVELOPMENTAL HISTORY

Number of hours sleeping per night ______________ Quality of sleep: Good / Fair / Poor

At what age was your child able to:

________	Respond to sound	________	Cross crawl
________	Respond to visual stimuli	________	Stand alone
________	Hold head up	________	Cruise
________	Sit up	________	Walk alone

According to the National Safety Council, approximately 50% of children fall 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? Yes / No

Is/has your child been involved in any high impact or contact type sport? Yes / No

Has your child ever been involved in a car accident? Yes / No

Other traumas not described above: Yes / No Date & Describe ______________________

Prior surgery: Yes / No Type and Date: ______________________ Menarche: ______________

CHILDHOOD DISEASES

Chicken Pox	Y / N	Age ______	Mumps	Y / N	Age ______
Rubella	Y / N	Age ______	Whooping Cough	Y / N	Age ______
Rubeola	Y / N	Age ______	Other ______________		

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

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctor(s) 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 fees charged by this office.

Patient Name______________________ Parent/Guardian's Name______________________

Parent/Guardian's Signature______________________ Date ______________

Witnessed ______________________ Date ______________

Informed Consent

We encourage and support a **shared decision-making process** between us regarding your health needs. As a part of that process, you have a right to be informed about the condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. This information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily of the nervous system) and how this relationship can affect the restoration and preservation of health.

Adjustments are made by chiropractors in order to correct or reduce spinal and extremity joint subluxations. **Vertebral subluxation** is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and/or does not move properly causing interference and/or irritation to the nervous system. The primary goal in chiropractic care is the removal and/or reduction of nerve interference caused by vertebral subluxation.

A chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, radiological examination (x-rays), and laboratory testing.

The chiropractic adjustment is the application of a precise movement and/or force into the spine in order to reduce or correct vertebral subluxation(s). There are a number of different methods or techniques by which the chiropractic adjustment is delivered but are typically delivered by hand. Some may require the use of an instrument or other specialized equipment. In addition, physiotherapy or rehabilitative procedures may be included in the management protocol. Among other things, chiropractic care may reduce pain, increase mobility and improve quality of life.

In addition to the benefits of chiropractic care and treatment, one should also be aware of the existence of some risks and limitations of this care. The risks are seldom high enough to contraindicate care and all health care procedures have some risk associated with them.

Risks associated with some chiropractic treatment may include soreness, musculoskeletal sprain/strain, and fracture. Risks associated with physiotherapy may include the preceding as

well as allergic reaction and muscle and/or joint pain. In addition there are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment.

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the risks of care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including the risks, consequences, and probable effectiveness of each. I have been advised of the possible consequences if no care is received. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPH. I UNDERSTAND THE INFORMATION PROVIDED. ALL QUESTIONS I HAVE ABOUT THIS INFORMATION HAVE BEEN ANSWERED TO MY SATISFACTION. HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. STEPHANIE KELLY AT BERKLEY CHIROPRACTIC TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT. DATED THIS ____ DAY OF ____________, 20___.

_________________________ _________________________

Patient Signature **Doctor's Signature**

Parental Consent for Minor Patient:

Patient Name: ____________________________
Patient age: __________ **DOB:** ____________
Printed name of person legally authorized to sign for Patient: ______________________________
Signature: ______________________________
Relationship to Patient: ____________________

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for Patient: ______________________________
Signature: ______________________________
Relationship to Patient: ____________________

Remarks:

Berkley Chiropractic
3179 12 Mile Road Berkley, Mi 48072

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is available through our online Kiosk system under the Acknowledgement's section, and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to Berkley Chiropractic to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to Berkley Chiropractic to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.

- If Berkley Chiropractic contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.

- I give permission to Berkley Chiropractic to use my name on a welcome board, referral board, and birthday board.

- I give permission to Berkley Chiropractic to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.

- I give permission to Berkley Chiropractic to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.

- By signing this form you are giving Berkley Chiropractic permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at Berkley Chiropractic plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION:

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

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Dr. Stephanie Kelly of Berkley Chiropractic. 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 Dr. Stephanie Kelly.

This AUTHORIZATION is requested by Berkley Chiropractic for its own use/disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, Berkley Chiropractic will not refuse to provide treatment however, it will not be possible for Berkley Chiropractic to file third party billing on my behalf and I will be responsible for 1) payment in full at the time services are provided to me 2) scheduling my own appointments since Berkley Chiropractic will be unable to contact me 3) all contact with Berkley Chiropractic regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

Patient's name (please print): ______________________________

Patient's Signature: ______________________________

Date: ______________________________

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print): ______________________________

Signature: ______________________________

Description of Representative's Authority to Act on Patient's Behalf: ______________________________

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Berkley Chiropractic
Assignment of Benefits Agreement

Patient Name______________________________ Date of Birth________________

I hereby certify that the insurance information that I have provided Berkley Chiropractic is true and accurate as of the date of service. I certify that benefits, to pay any and all medical claims, are available as of the date of this agreement. If authorization is needed to provide me with medical care, I certify that I have obtained said authorization, or have instructed Berkley Chiropractic to obtain authorization from my insurance company, in order to seek medical care from Berkley Chiropractic.

I understand that intentionally providing false insurance information may be considered as fraud. I am fully aware that having health insurance does not release me of my responsibility to ensure that my medical bill is paid in full. I also understand that my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company.

I hereby authorize Berkley Chiropractic to submit claims, on my behalf, to my insurance company, in good faith. I fully agree and understand that the submission of a claim does not release me of my responsibility to ensure that the claim is paid in full.

I hereby instruct and direct my insurance company, to pay by check, made payable to and mailed to: Berkley Chiropractic, 3179 12 Mile Road, Berkley, Mi 48072.

If my current policy prohibits direct payment to the provider of service, I hereby also instruct and direct my insurance company to make the check payable to me and mail it to: Berkley Chiropractic, 3179 12 Mile Road, Berkley, Mi 48072, where I will endorse the check and surrender payment for the professional or medical expense benefits allowable.

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 current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Berkley Chiropractic to deposit checks received on my account when made out to me. I authorize Berkley Chiropractic to make deposit into the account of Dr. Stephanie J. Kelly on my behalf.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. A photocopy of this document shall be considered as effective and valid as the original.

______________________________ ______________________________
Signature of Patient Doctor signature

______________________________ ______________________________
Date Date

Berkley Chiropractic
Designation of Authorized Personal Representative

I authorize Berkley Chiropractic to be my personal representative, which allows Berkley Chiropractic to: (1) submit any and all requests for benefit information from my insurance company and to receive such information on my behalf, (2) submit any and all appeals when my insurance company denies me benefits to which I am entitled, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my policy/benefits. I fully understand and agree that I am responsible for full payment of my accrued medical debt if my insurance company has refused to pay 100% of my benefits, within ninety (90) days of any and all appeals or requests for information. I also agree that any fines levied against my insurance company will be paid to Berkley Chiropractic for acting as my personal representative.

A photocopy of this document shall be considered as effective and valid as the original.

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Signature of Patient

____

Date

____

Doctor signature

____

Date

____

Witness signature

____

Date

Financial Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan. Any questions or concerns regarding insurance coverage will be resolved based on agreements between yourself and your insurance carrier(s), not your insurance company and this office. While we verify your benefits as a courtesy to you, we **cannot** guarantee these benefits.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of ChiroHealthUSA. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask for more information.
- Patients who meet state and or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of February 1, 2021, our office will be unable to extend any type of discounts other than those listed above.

I understand that I am responsible for payment of all services received by Berkley Chiropractic.

Patient's name (please print): ______________________________

Patient's Signature: ______________________________

Date: ______________________________

Appointment Policy

Thank you for choosing Berkley Chiropractic as your chiropractic health provider. In order to provide you and our other patients with the best care, we request that you follow our Appointment Policy. The times scheduled for your appointments are assigned to you and you alone. If you need to cancel or reschedule an appointment, we ask that you provide 24 hours notice. If you miss an appointment without canceling, or cancel with less than 24 hours notice, our policy is to collect $40. If the patient is a minor, the parent and/or legal guardian is financially responsible to pay the $40 fee. It is important to note that insurance companies do not provide reimbursement for canceled appointments; thus, you will be responsible for the fee. In addition, you are responsible for coming to your appointments on time; if you are more than 7 minutes late and have not made an attempt to communicate with our office, we will not hold the appointment. You will be charged as a no show and will be responsible for the fee. If we are contacted and it is possible, we will try to find another time to reschedule your appointment. A patient will not incur the fee in the case of an emergency (i.e. car accident, major illness, or death in the family). All no show and late cancellation fees will automatically be charged to the card on file.

____

Patient Printed Name

____

Patient/Legal Representative Signature	Date Signed

Credit Card Authorization Policy

All no show and late cancellation fees will automatically be charged to the card on file. By your signature on this form, you authorize charges to your credit card for services rendered. You have the right to request a paper copy of this document.

I authorize Berkley Chiropractic to charge my credit card. I also agree that my credit card can be charged $40 for any appointment that is not cancelled at least 24 hours prior to the scheduled appointment.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Berkley Chiropractic in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization policy. I acknowledge that credit card transactions could be linked to Protected Health Information.

____

Patient Printed Name

____

Patient/Legal Representative Signature	Date Signed