



Pediatric New Patient Form

In order to provide you with the best wellness care, please complete this form in its entirety. All information is strictly **CONFIDENTIAL**.

Patient Information

Today's Date: _____ / _____ / _____ Name: _____

Gender: ☐ Male ☐ Female Age: _____ Birth Date: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

Your email will NOT be shared with any third parties, and is used for general office announcements and promotions. We won't spam you, promise!

How did you find out about us? ☐ Facebook ☐ Instagram ☐ Twitter ☐ Website ☐ Google/Web Search

☐ Referral (Name): _____ ☐ Other _____

Has your child previously had chiropractic care? ☐ Yes ☐ No How long ago? _____

Family Information

Parent or Guardian's Name: _____ Phone: _____

Parent or Guardian's Name: _____ Phone: _____

Parents' Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Custody: ☐ One Parent ☐ Both Parents ☐ Other _____

Ages of other children in the family: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Reason for Visit

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause, and others to prevent future ailments. Your doctor will weigh your needs and desires when recommending your health program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Pain Relief ☐ Correction of Problem ☐ Prevention ☐ Let the doctor decide

Account Information PERSON RESPONSIBLE FOR THIS ACCOUNT.

Name: _____ Relationship to Patient: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Driver's License #: _____ Social Security #: _____

Insurance Company: _____ ID #: _____ Group #: _____

Name of Insured on Policy: _____ DOB of Insured: _____ / _____ / _____

I understand that outstanding balances of more than 30 days will be charged to this account. _____
Initials

Consent to Evaluate and Treat a Minor

I, being the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request Lighthouse medical Center, PLLC and/or the Staff Doctor(s) of this clinic to administer such treatment deemed advisable, including but not limited to examinations, radiological exams, and/or treatment. I agree that I will be responsible for any bill incurred on behalf of the above named individual. A photocopy of this form and associated signature(s) shall be considered as effective and valid as the original.

Parent/Guardian Signature: _____ Date: _____ / _____ / _____

Please check reasons for pursuing chiropractic care for your child:

- ☐ She/He is continuing ongoing care from another chiropractor.
- ☐ I recently had my spine checked and I see the value in getting my child checked.
- ☐ I'm concerned about his/her health and I'm looking for answers.
- ☐ She/he has a specific condition that concerns me.
- ☐ Explain condition or symptom: _____
- ☐ I want to improve my child's immune function.
- ☐ I have no idea why we're here. Please take the time to explain to me what you do for children.

In order for us to better understand your child's current level of health, please check any of the following body signals which your child has or has had previously:

- | | | | | | |
|---|---|-------------------------------------|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Postural Imbalance | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> POD/Autism | <input type="checkbox"/> Seizures | <input type="checkbox"/> Growing/Back Pains | <input type="checkbox"/> Car Accident | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Colic | <input type="checkbox"/> Other: _____ | |

List prescription or over-the-counter medications now taken: _____**Known allergies (including foods):** _____**Number of doses of antibiotics your child has taken:** Past 6 months: _____ Total during his/her lifetime: _____**Reasons:** _____**Number of doses of other prescription medications taken:** Past 6 months: _____ Total during his/her lifetime: _____**Medications:** _____**PRENATAL HISTORY****Adopted?** ☐ No ☐ Yes **Ultrasounds during pregnancy?** ☐ No ☐ Yes # _____**Complications during pregnancy?** ☐ No ☐ Yes List: _____**Medications/drugs/caffeine during pregnancy?** ☐ No ☐ Yes List: _____**Cigarette/alcohol use during pregnancy?** ☐ No ☐ Yes**BIRTH AND INFANCY****Location of birth:** ☐ Hospital ☐ Birthing Center ☐ Home**Birth Intervention:** ☐ Mother induced ☐ Mother medicated (Pitocin, etc.) ☐ Cesarian Section**Complications during delivery?** ☐ No ☐ Yes List: _____**Genetic disorders or disabilities?** ☐ No ☐ Yes List: _____**Breast fed?** ☐ No ☐ Yes How long? _____**Formula fed?** ☐ No ☐ Yes How long? _____**PAST INJURIES**

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

Is/has your child been involved in any high impact or contact type sports? ☐ No ☐ Yes**List:** _____**Has your child been seen on an emergency basis?** ☐ No ☐ Yes List: _____**Prior surgery?** ☐ No ☐ Yes List: _____**Has your child been involved in a motor vehicle accident?** ☐ No ☐ Yes How long ago? _____**Does your child have any other health problems that concern you?** ☐ No ☐ Yes**Explain:** _____

It is well known that families who maintain strong, healthy, well-maintained spines have much improved health. We appreciate your willingness to allow us to help your child start out life by living better, feeling healthier, and avoiding unnecessary and preventable spinal problems.

The information recorded above is true and accurate to the best of my knowledge.**Parent/Guardian Signature:** _____ **Date:** _____ / _____ / _____



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 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 HIPAA NOTICE that is available to you at the front desk before signing this consent.

The patient understands and agrees to allow this 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 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.

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.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

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.

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.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the provider(s) has/have 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.

Name of Patient: _____ Date: ____/____/____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____
Print Patient's Name

Date: ____/____/____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal law.

Dated this ____ day of _____, 20 ____

By _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By _____
Signature of Parent / Guardian (circle one)



Authorization for the Release of Protected Health Information (PHI)

Name of Patient: _____ Date of Birth: ____/____/____

I hereby request and authorize Lighthouse Medical Center:

- ☐ To disclose medical information to the following individual(s):
- ☐ To receive medical information from the following individual(s):

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

Name: _____ Relationship to Patient: _____ Phone: _____

- ☐ To disclose medical information to the following physician(s) or entity(ies):
- ☐ To receive medical information from the following physician(s) or entity(ies):

Physician Name: _____ Practice Name: _____

Type of Doctor: _____ Phone: _____

Physician Name: _____ Practice Name: _____

Type of Doctor: _____ Phone: _____

Physician Name: _____ Practice Name: _____

Type of Doctor: _____ Phone: _____

Information to be disclosed includes (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Entire Patient Record | <input type="checkbox"/> Initial Exam Notes | <input type="checkbox"/> Daily Treatment Notes |
| <input type="checkbox"/> Financial Information | <input type="checkbox"/> X-ray Reports/Film | <input type="checkbox"/> MRI Reports/Film |
| <input type="checkbox"/> Treatment Plan Information | | |
| <input type="checkbox"/> Email Imaging to: _____ | | |

By signing this form, I authorize Lighthouse Medical Center, PLLC to release confidential health information about me, by releasing a copy of my patient records, or a summary or narrative of my protected health information, to the person(s) or entity(ies) listed above. I understand that I have a right to revoke this authorization at any point in time by stating so in writing.

Signature of Patient: _____ Date: ____/____/____

If patient is a minor or under a guardianship order as defined by State law:

By _____ Date: ____/____/____
Signature of Parent / Guardian (circle one)

Staff Signature: _____ Date: ____/____/____



Informed Consent to Physical Medicine and Chiropractic Treatment

Name of Patient: _____

DEAR PATIENT:

Welcome to Lighthouse Medical Center PLLC. We are glad you chose our office to partner with you in relieving your pain and improving your quality of life. Our integrated, multi-specialty medical practice strives to provide exceptional care in every aspect of the patient experience, including communication. To that end, we want you to be aware that every type of healthcare is associated with some risk. We want you to be informed about important potential risk factors involving the various treatments/procedures performed in this office before consenting to treatment. This is called informed consent.

In this office, in addition to our licensed Family Nurse Practitioners (FNP-C), Doctors of Chiropractic (DC), and Massage Therapists (LMT), we use experienced, trained assistants who may assist the provider(s) with portions of your care. This includes but is not limited to: consultations, examinations, PT/rehab/exercise instruction, spinal decompression, injections, blood draws, medical procedures, etc. On the occasion when your attending provider is unavailable, your care may be handled by another provider or trained assistant.

GENERAL RISKS:

Soft Tissue Injury.

Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment/treatment or rehabilitation exercise/therapy may tear some muscle or ligament fibers. The result is a temporary increase in pain and soreness, but there are no long term effects for the patient. This process can be necessary with some patients to help achieve a resolution to your problem(s). These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns.

Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness.

It is common for chiropractic adjustments, spinal decompression, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your provider.

CHIROPRACTIC ADJUSTMENT RISKS:

The primary treatment used by doctors of chiropractic is the spinal manipulation, sometimes called spinal adjustment.

The nature of the chiropractic adjustment.

Our doctors will use their hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains/separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement within and



without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Ancillary treatment.

In addition to chiropractic adjustments, the following additional treatments may be used: physical therapy and/or rehabilitation, massage therapy, medical weight loss, regenerative joint and trigger point injections, peripheral neuropathy treatment, allergy testing/treatments, bio-identical hormone therapy.

These treatments involve the following additional risks: infection, allergic reaction, scars, bleeding, pain at the site of injection, vasovagal reaction.

The availability and nature of other treatment options.

Other treatment options for your condition include:

- Self-administered, over-the-counter analgesics and rest
- Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers.
- Hospitalization with traction
- Surgery

The material risks inherent in such options and the probability of such risks occurring include.

Overuse of over-the-counter medications produces undesirable side effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.

Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks – some with rather high probabilities.

Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is uncertain, and exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.

The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors.

The risks and dangers attendant to remaining untreated.

Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with a licensed healthcare provider and/or a staff member at Lighthouse Medical Center, PLLC and have had all questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _____ / _____ / _____

Patient Printed Name

Patient Signature

Signature of Parent or Guardian (if a minor)

Witness:

Printed Name

Signature

Thank you for choosing Lighthouse Medical Center, PLLC healthcare provider. This office is committed to providing exceptional patient care and service. We politely request that you read and understand our policy regarding your responsibility for payment of professional services rendered to you by licensed providers of this office.

Patients Without Insurance

Payment for all services is due at the time the services are rendered, unless arrangements are made with our billing staff as part of a payment plan. We accept cash, Visa, Discover, MasterCard, American Express and Care Credit. We also accept HRA and/or FSA payments.

Patients With Health Insurance

We are an in-network provider for most major insurance plans. While not all insurance plans provide coverage for all medical, chiropractic and/or rehabilitation treatment, most do. We do accept assignment on MOST insurance plans. We do accept assignment on MVA (automobile accident) claims. We do accept Letters of Protection from attorneys. We must have your insurance information verified prior to your first visit to do any insurance billing. In the event that your insurance company does not pay within 45 days, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us has been satisfied. Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan. All copays and deductibles are due at the time of treatment unless a payment plan is authorized.

Credit Card Guarantee / Electronic Debit Authorization

Our office utilizes a credit card guarantee to provide simplicity for both the patient and our billing staff in securing payment of outstanding balances. **ALL patients with ALL types of cases accepted by this office are required to have a valid credit card on file.** This card will only be billed for the following reasons:

1. Patient gives specific authorization to use this card in accordance with pre-arranged payment for professional services as part of ongoing treatment plan.
2. Upon notification of an outstanding balance, including missed appointment fees, if a patient refuses to make other arrangements with our billing staff, the card on file will be charged for all balances owed.

***If a patient does not wish to provide a credit card guarantee, this office will require payment up front for all services prescribed as part of the treatment plan, and it will be your responsibility to recoup payment from any third party payer (insurance). Patient Initials: _____**

Treatment Financing Options

Our office works hard to make sure the care you need is affordable for you. We do provide the following financing options: Care Credit and weekly payments. This will be explained in detail to you after your treatment plan has been prescribed and explained by the doctor.

Missed Appointment Policy

Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. While emergencies happen periodically, we ask that you contact us by phone at 928-424-1600 in the event you won't be able to make your appointment. This will enable us to offer your appointment time to other patients that desire to get their treatment performed that day/time. Our policy is to charge \$50.00 for missed (no-show) chiropractic appointments and \$65.00 for massage appointments. **Patient Initials: _____**

Practice Fee Schedule

Our practice is committed to providing the highest quality treatment available to our patients. We charge a fee for all services provided that is "usual and customary" for our geographic area. While we are a participating provider for various insurance networks, and we do take contractual write-offs where appropriate, please remember that you remain responsible for payment regardless of any insurance company's arbitrary determination for usual and customary rates.

Minor Patients

Parents or legal guardians are required to accompany minor patients to the initial exam and explanation of treatment appointments. They are also required to give informed consent prior to any treatment being performed. Once treatment commences, parents/legal guardians retain full financial responsibility for all services performed.

Assignment of Benefits

I do hereby assign all medical and/or chiropractic benefits to Lighthouse Medical Center, PLLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I authorize Lighthouse Medical Center, PLLC to release all information necessary to secure payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. By my signature below, I acknowledge that I have read and agree to the aforementioned financial policy for Lighthouse Medical Center, PLLC.

Signature of Patient / Parent / Legal Guardian: _____ Date: _____ / _____ / _____

Staff Signature / Witness: _____ Date: _____ / _____ / _____