FOSTER

Family & Sports CHIROPRACTIC

127 Union Ave
Phone (732) 537-0009
Dr. Renee T. Foster
Chiropractic Physician

Middlesex, NJ 08846
Fax (732) 537-9966
Dr. Alan K. Foster
Chiropractic Physician

PEDIATRIC PATIENT INTAKE FORM

First Name: _____ Last Name: _____ Middle Initial: ___ Gender: € Female € Male

Date of Birth: _____ Age: ____ Home Phone: _____Parents cell phone: _____

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

Social Security # _____ Parents E-mail: _____

May we contact your cell phone? € Yes € No

May we send you text messages? € Yes € No

May we contact you at home? € Yes € No

If yes, can we leave a message? € Yes € No

May we contact you via email? € Yes € No

May we contact you at work? € Yes € No

How did you hear about us? € Our website € Insurance Company: Which? _____

€ Patient referral who? _____ € € Physician Referral Who? _____

Parent and/or Guardian information

Name: _____ Relationship: € Parent € Guardian € Other _____

Cell Phone: _____ Work Phone: _____ Same address as above? € Y € N

If no, please provide address: _____

Primary Care Physician Information:

Doctor's Name: _____ Phone number: _____ City/State: _____

If no, please provide address: _____

Primary Insurance What Type? € Commercial € Self Pay € Auto Insurance

Insurance Name: _____Subscriber ID#: _____ Group#: _____

Who is the primary insured? _____ Date of Birth: _____

If auto or work-related injury; Date of Accident/Incident? _____ Was it REPORTED? € Yes € No

*Female section only

I hereby expressly acknowledge that I am not pregnant at the present time and that the Drs. Alan & Renee Foster and Foster family & Sports Chiropractic is hereby expressly authorized and directed to complete a radiographic examination (X-rays) in connection with my chiropractic treatment.

_____	_____	_____
Print Name	Signature	Date

*Minor section only

I hereby authorize Drs. Alan & Renee Foster at Foster Family & Sports Chiropractic, together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

_____	_____	_____
Print Name (Parent/Guardian)	Signature (Parent/Guardian)	Date

Scheduling: Cancellation of an existing appointment requires 24 hours' notice or the fee for cancellation (cost of the appointment) will be applied to your account.

Payment: Payment is expected in full each visit. We accept cash, debit, Visa, MasterCard, American Express, Discover, checks, and/or apple/google pay. Bounce check fee is $25. If you receive a statement, payment is due immediately.

By signing below I certify that the above information is true to the best of my knowledge. I clearly understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Finally, I authorize the release of my medical information relevant to my condition and treatment at this office to any insurance company or doctor as may be needed in the normal course of my care and treatment.

Signature: _____ Date: _____

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the

condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

Patient Authorization for open Adjusting Environmental and contact regarding Chiropractic care, related health services and/or related health products

It is our desire for our staff to use your name, address, and email and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products. In addition this information may be used to remind you about scheduled appointments, re-evaluation or other appointment related issues. The use of this information is intended to make your experience with our office more efficient, productive and to further enhance you access to quality health care.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting area. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, or providing examinations. These procedures are completed in a private, confidential setting. 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. If you have private issues to discuss we have several individual services available, see the front to schedule.

_____	_____	_____
Print Name	Signature	Date

FOSTER Family & Sports CHIROPRACTIC, L.L.C.

Alan K. Foster, D.C.
Chiropractic Physician
Renee T. Foster, B.S., D.C.
Chiropractic Physician

127 Union Avenue
Middlesex, New Jersey 08846
Telephone: (732)-537-0009
Facsimile: (732)-537-9966

ASSIGNMENT OF BENEFITS AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR

Patient name: _____ Insurance Company: _____

Subscriber ID#: _____ Claim/Group#:_____

I irrevocably assign to FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. all my rights and benefits under any insurance contracts for payment for services rendered to me by FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. I irrevocably direct that all payments go directly the above named insurance company to pay by check issued, and mailed, directly to:

FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C.

127 Union Avenue

Middlesex, NJ 08846

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to our office and mail it as follows:

FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C.

127 Union Avenue

Middlesex, NJ 08846

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. to be released to FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. I irrevocably authorize FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. to file insurance claims on behalf of services rendered to me. I irrevocably authorize FOSTER FAMILY & SPORTS CHIROPRACTIC, L.L.C. to act in my behalf and report any suspected violations of proper claim practices to the proper claim practices to the proper regulatory authorities.

This is direct and irrevocable assignment of my rights and benefits under this policy. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____ _____ _____

Print Name Signature Date

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

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Health Information Privacy Act Notice

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS: I consent to the usage or disclosure of my protected health information by FOSTER Family & Sports CHIROPRACTIC for the purpose of diagnosing or providing treatment to me, obtaining the payment for my health care bills or to conduct health care operations of FOSTER Family & Sports CHIROPRACTIC. I understand that diagnosis or treatment of me by FOSTER Family & Sports CHIROPRACTIC may be conditional upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to whom my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. FOSTER Family & Sports CHIROPRACTIC is not required to agree to the restrictions that I may request. However, if FOSTER Family & Sports CHIROPRACTIC agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that FOSTER Family & Sports CHIROPRACTIC has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* prior to signing this document FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practice*s has been provided to me. *The Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of FOSTER Family & Sports CHIROPRACTIC. The *Notice of Privacy Practices* so provided at the front office. *The Notice of Privacy Practices* also describes my rights and FOSTER Family & Sports CHIROPRACTIC's duties with respect to my protected health information.

FOSTER Family & Sports CHIROPRACTIC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____	_____
Print Name	Signature	Date

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

Patient Care Questions

Patient Name: _____

Present Complaint: _____

How long has your child been suffering with this condition? _____

Has your child had any past treatment for this complaint? € Yes € No Describe: _____

Has your child ever had chiropractic care in the past? € Yes € No

Have you sought treatment from any other health care professional? € Yes € No Which? _____

When did this begin? _____ Was there an accident or injury involved? € Yes € No

Current Medications/Supplements: _____

Has your child suffered any broken bones? € Yes € No If yes, where?

_____

Has your child suffered from the following in the past (Please circle all that apply)?

Ear Infections Headaches Growing Pains Colic Asthma Torticollis Autism Constipation Scoliosis

Chronic Colds Digestive Problems Bed Wetting Allergies Seizures Tonsillitis Frequent Fever Acid Reflux

Sensory Processing Sleep Problems Learning Difficulties Hip Dysplasia Postural Imbalances ADD/ADHD

Prenatal History

Any complications during pregnancy? € Yes € No Explain: _____

Medications during pregnancy: _____ Cigarettes or alcohol during pregnancy: € Yes € No

Birth intervention: Forceps Vacuum C-Section (emergency/planned) Induction Epidural

Complications during delivery? € Yes € No Explain: _____

Birth Weight: _____ Birth Height: _____ Birth location: _____ Birth plan? € Yes € No

Genetic disorders or disabilities: _____

How many times had your child been prescribed antibiotics in the past 6 months? ___ Total during lifetime: __

Has your child received vaccinations? € Yes € No If yes, is it the full or graduated schedule? € Full € Scheduled

Which Vaccines? _____

Age of 1st Vaccine? _____

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
Explain: _____

Feeding History

Breast Fed; How long:_____
Formula Fed; How long:_____
Introduced to:
Solids at ___Months
Cow's Milk at ___ Months
Food Allergies or Intolerances € Yes € No
List: _____

Whooping Cough, Age:____
Other: _____ Age: _____
Surgeries: _____

Developmental History:

At what age was your child able to:

_____ Respond to Sound	_____ Crawl
_____ Respond to Visual Stimuli	_____ Pulls up on Furniture
_____ Hold head up Alone	_____ Stand Alone
_____ Sit up Alone	_____ Walk Alone

Did you your child reach all their milestones so far? € Yes € No

Have they had any behavioral changes? _____

Is/Has your child been involved in any high impact or contact sports (i.e., soccer, football, gymnastics, baseball, cheerleading, marital arts, etc.)? € Yes € No € Other: _____

How you rate your child's diet? Well Balanced Average High Sugar/processed foods

Has your child had any dietary changes? _____

Number of hours your child sleeps: _____night _____day/naps

Has your child ever been involved in a car accident? € Yes € No Explain: _____

Other traumas not described above? € Yes € No Explain: _____