



# FOSTER

## Family & Sports

# CHIROPRACTIC

3461Rt 22 East, Unit A,  
 Phone (732) 537-0009  
**Dr. Renee T. Foster**  
*Chiropractic Physician*

Branchburg, NJ 08876  
 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 contact you at home?  Yes  No

May we contact you via email?  Yes  No



May we send you text messages?  Yes  No

If yes, can we leave a message?  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





## Informed Consent for Chiropractic care

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.

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Print Name

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Signature

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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.

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Print Name

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Signature

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Date

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

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

3461 Rt 22 East, Unit A  
Branchburg, NJ 08876  
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.**  
**3461 Rt 22 East, Unit A**  
**Branchburg, NJ 08876**

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.**  
**3461 Rt 22 East, Unit A**  
**Branchburg, NJ 08876**

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.***

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Print Name

Signature

Date

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

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

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

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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 Practices* 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.

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Print Name

Signature

Date

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



## Patient Care Questions

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 1<sup>st</sup> 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: \_\_\_\_\_

### Childhood Diseases:

Chicken Pox; Age: \_\_\_\_\_

Rubella; Age: \_\_\_\_\_

Mumps; Age: \_\_\_\_\_

Whooping Cough; Age: \_\_\_\_\_

Other: \_\_\_\_\_ Age: \_\_\_\_\_

Surgeries: \_\_\_\_\_

### Developmental History:

At what age was your child able to:

\_\_\_\_\_ Respond to Sound

\_\_\_\_\_ Respond to Visual Stimuli

\_\_\_\_\_ Hold head up Alone

\_\_\_\_\_ Sit up Alone

\_\_\_\_\_ Crawl

\_\_\_\_\_ Pulls up on Furniture

\_\_\_\_\_ Stand 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, martial 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: \_\_\_\_\_





# FOSTER WELLNESS CORP.

3461 Route 22 East, Unit A  
Phone (732) 537-0009

Branchburg, NJ 08876  
Fax (732) 537-9966

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*Chiropractic Physician*

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*Chiropractic Physician*

## 2026 New Jersey Disclosure

New Jersey laws and the New Jersey Department of Health require healthcare providers to inform patients of the healthcare plan in which they participate and the facilities with which they are affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

A. Health Plans with which Our Practice participates:  
**Medicare / Blue Cross Blue Shield**

B. Facility with which Our Practice affiliates:  
**FOSTER WELLNESS CORP.**  
**3461 Route 22 East, Unit A**  
**Branchburg, NJ 08876**

C. Licensed Associate Healthcare Providers:  
**Alan K. Foster, DC**  
**Renee T. Foster, DC**

I understand the healthcare professionals with whom I am seeking healthcare services is "out-of-network" and does not participate with my insurance plan.

I understand the amount or estimated amount of my healthcare services may be beyond my "in-network" deductible, copayment, or coinsurance and I am responsible for those charges.

I understand I may contact my health insurance plan or administrator for further consultation regarding the cost and reimbursement of my healthcare charges.

I, the undersigned patient, acknowledge receipt of this disclosure from my healthcare provider, read and understand its content. I wish to receive evaluation and treatment at FOSTER WELLNESS CORP. with full notice of these disclosures. I certify I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures. I am not being coerced to sign this disclosure, and I do so of my own free will.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_