Chiropractic Associates of Rochester

Take Charge of Your Health

190 Perrin Drive
Rochester, NY 14622

www.chiroROC.com

CHILD HISTORY FORM:

PRESENT DATE:_____

PLEASE COMPLETE THIS DETAILED HISTORY FORM AND RETURN IT TO THE RECEPTIONIST. SHOULD YOU REQUIRE ANY ASSISTANCE, PLEASE LET US KNOW, AS WE WOULD BE HAPPY TO ASSIST.

NAME _____ TELEPHONE # _____
ADDRESS _____ POSTAL CODE _____
DATE OF BIRTH _____ REFERRED BY _____
INS CARD # _____
Present MD _____
Date of last MD visit & reason: _____
Previous DC name and last visit: _____
E-mail address: _____

AUTHORIZATION FOR CARE OF A MINOR

PARENT (S) NAMES _____ Work Telephone _____
I hereby authorize and consent to the chiropractic evaluation and care of my child
Parent/Guardian signature _____ Witness _____

CHIEF HEALTH CONCERNS:

REASON FOR CONTACTING US:_____

LIST OTHER CARE UNDERGONE FOR THIS COMPLAINT
(including medications) _____
Date of Onset ____/____/_____Onset was: Sudden / Gradual / Associated with an event
Duration of problem (episode) _____minutes / hours / days / months / years
Pattern of problem: Constant / Intermittent / Occasional / Cyclical
Initiating factors: _____
Aggravating factors: _____
Relieving factors: _____
Effects of problems on body function and daily ctivities:_____
_____
Prior occurrence or episodes: _____

OTHER HEALTH CONCERNS *or* QUESTIONS:_____
_____
_____
_____
_____
_____

HISTORY OF BIRTH:

Hospital: birthing center: home: medical: midwife:

Duration of Gestation _____ weeks

Assisted birth? No / Yes If yes, forceps / vacuum extraction / c-section / induced labour

Medications delivered to mother at birth? No / Yes. If yes what? _____

Duration of birth: _____

Complications at birth: No / Yes. Explain _____

Was delivery normal? Yes / No _____

APGAR at BIRTH _____ AFTER 5 MINUTES _____

BIRTH WEIGHT _____ BIRTH LENGTH _____

GROWTH & DEVELOPMENT

Was the infant alert and responsive within twelve hours of delivery? Yes / No

(Explain) _____

At what age did the child: Respond to sound _____ Follow an object _____

Hold up head _____ Vocalize _____ Sit alone _____

Teethe _____ Crawl _____ Walk _____

Does sleeping pattern seem normal to you: Yes / No Explain _____

Any health problems (cancer, diabetes, heart disease, etc.) on the mothers' side of the family? _____

On the fathers? _____ With siblings? _____

Since problems that chiropractors concern themselves with can be related to many types of stressors, the following information is also very important to us:

CHEMICAL STRESSORS:

Was the baby breast-fed? No / Yes How long _____

Formula introduced at aged _____ Type of formula used _____ Introduction to milk at age_____

Began solid foods at age_____ Type _____ Age & type of commercial baby food introduction_____

Food / Juice intolerance? No / Yes Type: _____

During pregnancy did the mother smoke? Yes / No

Did the mother drink alcohol? Yes / No

Any illness of the mother during pregnancy: _____

Any supplements taken by mother during pregnancy: _____

Any drugs taken during pregnancy: _____

Any exposures to ultrasound: No/ Yes. If so, how many & what was the medical reason? _____

Any invasive procedures (amniocentesis, CVS): _____

Any pets at home: No / Yes _____

Any smokers in the home: No / Yes (How much) _____

Any vaccinations: Which ones and any reactions: _____

Any antibiotics: No / Yes Explain: _____

Total number of courses of antibiotics to date: _____

PSYCHOSOCIAL STRESSORS:

Any difficulties with lactation: No / Yes _____

Any problems with bonding: No / Yes_____

Any behavioral problems: No / Yes Onset: _____

Any night terrors, sleep walking, difficulty sleeping No / Yes Specify_____

Age of child when began daycare: _____

Average number of hours of television/week _____

Does your child seem normal for their age? Yes/ No Explain _____

TRAUMATIC STRESSORS:

Any traumas during pregnancy (falls, accidents) _____

Any evidence of birth trauma: bruises, odd shaped head, stuck in birth canal, fast or excessively long birth, respiratory depression, cord around neck, other…_____

Any falls from couches, beds, change tables_____

Any traumas with bruising, cuts, stitches, fractures_____

Any hospitalizations: No / Yes Explain_____

Any surgeries or organs removed_____

Sports played and age began_____

Number of hours per week played_____

Weight of school backpack_____Approximate hours spent at play per week_____

Thank you for completing this form. We look forward to treating you.

Patient's Name_____ Date _____

OVERALL HEALTH HISTORY

Do you have vertigo (dizziness)?	YES_____	NO_____
Do you pass out easily (faint, loss of consciousness)?	YES_____	NO_____
Do you have double vision or have you lost sight in one eye?	YES_____	NO_____
Do you have any slurred speech or difficulty in arranging words properly?	YES_____	NO_____
Have you had any difficulty walking, with coordination or falling to one side?	YES_____	NO_____
Do you have any nausea or vomiting?	YES_____	NO_____
Do you have numbness on one side of you face or body?	YES_____	NO_____
Do you have any visual disturbances or rapid eye movement?	YES_____	NO_____
Do you have a headache or head pain that is unlike any you have had before?	YES_____	NO_____
Do you have headaches for hours or days?	YES_____	NO_____
Do you have history of stroke in the family?	YES_____	NO_____
Do you have chest pain?	YES_____	NO_____
Do you have any change in bowel or bladder habits?	YES_____	NO_____
Do you have a sore that does not heal?	YES_____	NO_____
Do you have any unusual bleeding or discharge?	YES_____	NO_____
Do you have any thickening in your breasts or elsewhere?	YES_____	NO_____
Do you have indigestion or difficulty swallowing?	YES_____	NO_____
Do you have a change in any wart or mole?	YES_____	NO_____
Do you have a nagging cough or hoarseness?	YES_____	NO_____
Do you have night sweats?	YES_____	NO_____
Do you have pain in the neck, jaw or face?	YES_____	NO_____
Do you have a drooping eyelid or changes in your pupils?	YES_____	NO_____
Do you have any ringing in your ears?	YES_____	NO_____
Do you take birth control pills?	YES_____	NO_____

PROBLEM SPECIFIC

Head: headaches y / n location_____
Neck: difficulty with: turning L—R—forward—backward—tilt right—tilt left
Midback: pain with cough, sneeze of bowel movement
Low Back: pain down the buttock—legs pain with cough sneeze or bowel movement
Shoulder:_____
Elbow:_____
Wrist:_____
Hand/Fingers:_____
Hip:_____
Knee:_____
Ankle:_____
Foot/Toes:_____

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Tina Shores, D.C.
Colby Shores, D.C., CCSP
Kevin O'Hagan, D.C.

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years that have been demonstrated to be a highly effective treatment for spinal pain, headaches and other symptoms. Maintaining spinal alignment through chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatment, medications and procedures given for the same condition.

I acknowledge that I have received information regarding my condition and proposed chiropractic treatment as well as alternative courses of care, the benefits, the risks, the side effects of treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to: muscle strains & sprains, fractures, dislocations, disc injuries and strokes. I wish to rely on the doctor to exercise judgment during the course of the treatment that he feels at the time based upon the facts then known, is in my best interests.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to apply to all my present and future chiropractic care in this office.

Patient Signature_____Date_____

Witness_____Date_____

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PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgement/Consent Form, but was unable to do so as documented below:

Date	Initials	Reason

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OFFICE FINANCIAL AGREEMENT-2024

It is your responsibility to know what your insurance policy covers. Insurance covers acute, medically necessary care. If your insurance denies payment for our services at any time, you agree to take full financial responsibility. Some insurance companies will not allow multiple family members to be treated on the same day in the same office.

Please sign and initial designated insurance line.

_____**Excellus BC/BS, Aetna and United**
Deduct- Referral may be needed. Until your annual deductible is met the office fee will be procedure dependent. Fee is due at time of service. Once the deductible is met, you will be responsible for co-insurance policy dependent. Supplements, orthotics, supports, etc. are not covered.
Co-Pay- Your co-pay is due at the time of service and will range from $10-$70 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsibility. Blues cover **acute care** and not maintenance care.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United**
Authorization is required on some Ins. Your insurance sets number of visits allowed. There are some costs that are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care not maintenance care.

____**Medicare:** No referral needed. Until your annual estimated Deductible of $240.00 is met the office fee is $40.00 - $80.00. You will be responsible for any usual and customary fee (ABN)

_____**MVP/CIGNA/OTHER*: T***he doctors in this office are out of network providers. Initial consultation fee, history and examination is $80.00. Subsequent visits thereafter are $40.00. Depending on your contract you may have out of **network coverage**. We will supply you with a claim form so that you can submit to your insurance company.

____Usual & Customary Office Fees: First visit for consultation, history and examination is $80.00. Subsequent visits thereafter are $40.00. Initial Spinal scan fee included in $80.00 charge.

Rock Tape (Kinesio Tape):
__ **Option 1: Free application with purchase of roll (for life of roll)**
__ **Option 2: $5.00 charge per region application**

_____**Worker's Compensation:** If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered. **Mileage sheets will be available for $20.**

_____**Auto Accidents/No Fault Insurance**: If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered. **Mileage sheets will be available for $20.00**

_____ **Maintenance Care**: Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. Treatment intervals are at regular intervals (example: 1 time a week, every 2 weeks, every 4 weeks, etc.) Benefits of maintenance care include enhanced quality of life, improved health, prevention of future injury. This is a service not covered by the insurance company and you will be responsible for the office fee of $40. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre complaint status or plateaued in improvement.

There may be additional services/products needed to supplement your care.

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

- **Please note that our office does not allow a personal balance over $100 (unless other financial arrangements have been made in writing). Should your account become 60 days delinquent a $10 charge per month will be assessed to the outstanding balance.**
- **Payment is due at the time of service. Payment in the form of cash, check, HSA, Credit Card is accepted.**
- **Returned Checks will have a $25 service charge.**

_____

Responsible Party Signature **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION:

TO: _____

_____

_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____

_____ X-Rays and / or report of findings, CT Scans, MRI's

_____ Consult reports from specialists

_____ Test Results

_____ Billing Records

_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____

Date of Birth: _____

Signature of Patient _____Date: _____

If under age 18 Signature of Guardian: _____Date: _____

Relationship to Patient: _____