Canton Dale Chiropractic

Child History Form

Date: _____

Please complete this detailed history form and return it to the receptionist. Should you require any assistance, please let us know as we will be happy to assist.

Child's Name: _____ Date of Birth: _____

Address: _____

_____ Postal Code: _____

Doctor's Name: _____ Doctor's Address: _____

Name of Previous Doctor of Chiropractic: _____

Date of Last Visit (dd/mm/yyyy): _____

Child's Height: _____ Child's Weight: _____

Name(s) of Parent(s) or Guardian(s): _____

Business Telephone: _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: _____ _____

Witness: _____

What are your chief concerns, if any, with your child's health?

_____

_____

What is your main reason for contacting us?

_____

_____

List any other care your child has undergone with regards to this complaint including medication:

_____

_____

Date of onset (mm/yyyy): _____

Onset was: (circle one)
Sudden Gradual Associated with an event

Duration of problem or episode: (circle one)
Minutes Hours Days Months Years

Pattern of Problem: (circle one)
Constant Intermittent Occasional Cyclical

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does the problem affect your child's body function and daily activities?

_____

Prior occurrence or episodes? _____

Other health concerns? _____

Canton Dale
Chiropractic

Drs. Kristen and Joel Favreau
351 Turnpike St. Canton MA 02021
P. (781) 821-0072
F. (781) 821-0071
www.cantondalechiropractic.com
info@cantondalechiropractic.com

Appointment Reminders and Health Care Information Authorization:

The following office procedures allow Canton Dale Chiropractic to operate in an efficient manner and allow us to support our patients with their care. Your signature authorizes us to follow through with these procedures.

- We may need to contact you by telephone at home or at work regarding appointments and other matters related to care in this office.
- We may need to leave a message with another person (e.g. spouse, co-worker) or on an answering machine/ voice mail at home or at work regarding appointments and other matters related to care in this office.
- We routinely have mailings (including email) from our office sent to you at your home or email address.
- We acknowledge and thank everyone who refers friends or family members to our office for chiropractic care; we would like to directly thank the person who referred you and use your name.
- We utilize an "open adjusting" environment for ongoing patient care. "Open adjusting" involves several patients receiving treatment at the same time. Patients are within sight of one another and some ongoing routine details of care are addressed within earshot of other patients and staff. This environment is used for ongoing care only; private histories, examinations, and reports of findings are conducted in a private setting.

You have the right to refuse any part of this authorization without affecting your care or the relationship with anyone at Canton Dale Chiropractic.
This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.
Your signature indicates your authorization of these activities (unless crossed out and initialed). This notice is effective as of the date below and expires seven years from the date you last received services in this office.

Patient Name:_____Date:_____

Patient Signature (Parent/Guardian): _____

Personal Representative: _____

Personal Representative Signature: _____

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Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office; for those patients using insurance this would include co-pays, deductibles, and charges denied or not covered by your insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Drs. Kristen or Joel Favreau/Canton Dale Chiropractic, Inc. for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

Note: Our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Drs. Kristen or Joel Favreau/Canton Dale Chiropractic, Inc.

I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

Release of Medical Records:

I give my permission for Drs. Kristen or Joel Favreau to share my relevant medical records with other healthcare professionals and/or request medical information from other medical facilities for the purpose of accurate assessment and treatment of my current condition.

The above information is true and accurate to the best of my knowledge.

Patient Name:_____Date:_____

Patient Signature (Parent/Guardian): _____

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Informed Consent:
Chiropractic is system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, disease or condition as a result of treatment in this office. We will always give you our best care and if results are not acceptable, we will recommend another provider whom we feel will assist your condition.

The most common type of adverse reaction to spinal manipulation is some degree of stiffness or soreness that may occur following the first few days of the initial treatment. This is equivalent to the soreness you would experience after initiating a new exercise program. Such soreness typically subsides following the first two or three treatments. Should the soreness continue after this period, it is your duty to report it to us. We cannot properly treat you without clear communication of how you are responding to care.

Consent:
By my signature below, I request and consent to the performance of chiropractic care including, but not limited to examinations, adjustments and supportive procedures, including various types of therapeutic modalities and exercise. I consent that the licensed doctors of chiropractic associated with this office, who now or in the future treat me, will use their own well-educated judgment in caring for me.

I understand that in the practice of chiropractic as in the practice of medicine there are some risks. I do not expect the doctors to be able to anticipate and explain all risks and complications. I wish to rely on the doctors to exercise their judgment during the course of the procedures which the doctors feel at the time, based upon the known facts will perform accordingly in my best interest.

I intend this consent form to cover the entire course of treatment for my present reasons for care and for any future conditions for which I may seek treatment at this office. I have read or have had read to me this consent form. I have had an opportunity to ask questions about the information contained herein. By my signature below I understand and give permission for examinations and treatment at this office.

The above information is true and accurate to the best of my knowledge.

Patient Name:_____Date:_____

Patient Signature (Parent/Guardian): _____

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CANCELLATION/NO-SHOW POLICY

As part of our continued effort to provide you with the best care and accommodate all appointment requests, beginning immediately we will institute the following "No-Show/Cancellation" Policy.

We understand that emergencies and scheduling conflicts arise that are sometimes unavoidable. However, adequate notice helps us to fulfill other patient's needs and keeps our office operating efficiently.

Cancellation Policy:

Please let the office know at least 24 hours ahead of time if you need to cancel or reschedule an appointment. For Monday appointments, please contact the office by 5pm on Friday.

Any cancellations made the same day as the appointment will be subject to a **$30** fee.

Likewise, if you do not show up to your appointment and do not call ahead of time to cancel (No Show/No call), it will be noted in your file and subject to a **$30** fee as well.

**Please note that insurance/medicare does not pay for missed or late cancellations. Patients are fully responsible for bills incurred.*

Late Arrivals:

If you are going to be 15 or more minutes late for your appointment, you may need to be rescheduled. Please call the office to let the staff know that you are running late.

How to cancel/reschedule an appointment:

You can call our office at 781-821-0072. You may leave a voicemail 24/7. The office staff will pick it up when we are in the office and will return your call as soon as possible. Please note the date and time of your call in the voicemail.

You can write us an e-mail at info@cantondalechiropractic.com

You can text us at text code: 91998

By giving us adequate notice, we can effectively help you to reschedule any missed appointments, as well as help other patients who are in need to get in for treatment sooner.

I _____ have read and understand the above policy.
(Print Name)

_____ _____

Signature Date