



### History of Birth

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Hospital/Birthing Center: ☐ Home ☐ Medical ☐ Midwife

Duration of Gestation: \_\_\_\_\_ Weeks

Was the birth assisted? ☐ Yes ☐ No

If Yes, How? ☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Induced Labor

Duration of Birth: \_\_\_\_\_ Was the delivery normal? ☐ No ☐ Yes

If no, what complications were there at birth? \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Birth Length: \_\_\_\_\_

#### *Growth and Development*

Was the infant alert & responsive within 12 hours of the delivery? ☐ Yes ☐ No

If no, explain: \_\_\_\_\_

At what age did the child: Sit alone? \_\_\_\_\_ Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_

Do his/her sleeping patterns seem normal? ☐ Yes ☐ No

Describe any health problems that exist on the mother's side of the family? (e.g. Cancer, Diabetes etc.)

\_\_\_\_\_

The father's side? \_\_\_\_\_

Do the child's siblings have any health problems? ☐ Yes ☐ No

If yes, describe: \_\_\_\_\_

Any evidence of trauma during birth? ☐ Bruises ☐ Odd shaped head ☐ Stuck in birth canal

☐ Fast and/or excessively long birth ☐ Respiratory Depression ☐ Cord around neck

☐ Other: \_\_\_\_\_

Was your child breastfed? ☐ Yes ☐ No If Yes, How Long? \_\_\_\_\_

Any Difficulties? \_\_\_\_\_

Has your child had any antibiotics? ☐ Yes ☐ No

If yes, how many courses has the child had so far & why? \_\_\_\_\_

Any falls/accidents during pregnancy? ☐ Yes ☐ No

Has the child had any major falls since birth? ☐ Yes ☐ No

If Yes, did the child need stitches or cause a fracture? Please describe: \_\_\_\_\_

Any hospitalizations? ☐ Yes ☐ No Please explain: \_\_\_\_\_

Does your child play sports? ☐ Yes ☐ No Number of hours per week? \_\_\_\_\_ Age child began \_\_\_\_\_ Years

Weight of school backpack? \_\_\_\_\_ lbs

# 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

## **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): \_\_\_\_\_



## 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](mailto: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)

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Signature

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Date