DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC
403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Child Questionnaire (Under 10 years old)

Date: _____

Child's Name: _____ ***Called Name:*** _____

Birthdate: _____ **Age:** _____ **Sex:** ☐ M ☐ F

Social Security #: _____

Child's Primary M.D.:_____ Phone:_____

May we contact your child's Primary M.D. regarding their care in this office? ☐ Yes ☐ No

Parent Information

Parents' Name: _____ ***Called Name:*** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____

Email Address: _____

How did you hear about our office? ☐ **Referral**, by whom?_____
☐ Office Sign ☐ Internet ☐ Yellow Pages
☐ Other (please specify)_____

Occupation: _____
(Describe activities involved – sitting, standing, lifting)

Employer Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

May we contact you at work, if necessary? ☐ Yes ☐ No

Person to contact in case of emergency: _____ **Phone:** _____

I authorize the release of any information concerning my child's health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance, Medicare, and No-Fault (auto accidents). I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

I certify that I have read and understand the following information. To the best of my knowledge the following questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health.

X_____ _____
Signature of Parent Date

DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC
403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Child's Name: _____ ***Date:*** _____

If you are using Medical Insurance to help pay for care, please complete the following:

Insurance Questionnaire (Confidential)

Primary Insurance Company Name:_____

Subscriber ID Number:_____ Group Number: _____

Primary Insured Name: _____

Address (If different): _____

City: _____ State: _____ Zip: _____

Primary Insured's Employer Name: _____

Primary Insured Birthdate: _____ **Sex: ☐ M ☐ F**

Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other / Domestic Partner

For Secondary Insurance:

Secondary Insurance Company Name:_____

Subscriber ID Number:_____ Group Number: _____

Secondary Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Insured's Employer Name: _____

Secondary Insured Birthdate: _____ **Sex: ☐ M ☐ F**

Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other / Domestic Partner

For Tertiary (3rd) Insurance:

Tertiary Insurance Company Name:_____

Subscriber ID Number:_____ Group Number: _____

Tertiary Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tertiary Insured's Employer Name: _____

Tertiary Insured Birthdate: _____ **Sex: ☐ M ☐ F**

Relation: ☐ Self ☐ Spouse ☐ Child ☐ Other / Domestic Partner

Child's Name: _____ ***Date:*** _____

What type of regular exercise does your child performs?

☐ None ☐ Light ☐ Moderate ☐ Strenuous

What is your child's height and weight?

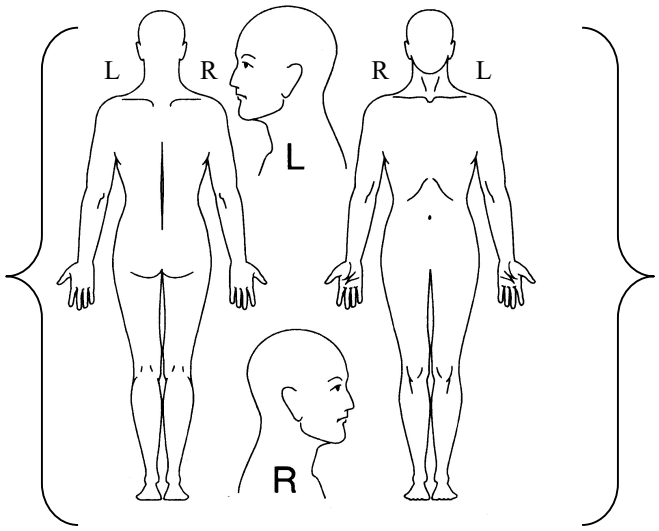
Height_____

Weight_____ Shoe Size_____

☐ **My child is here for Wellness Care**
(Please skip the next few questions)

Please use the following descriptive symbols on the body to the right to describe the location of your child's problem.

Aching	Burning	Pins & Needles
^ ^ ^ ^	= = = =	- - - - - - - - - -
^ ^ ^ ^	= = = =	- - - - - - - - - -
Numbness	Stabbing	Other
0 0 0 0 0 0	/ / / / / / /	X X X X
0 0 0 0 0 0	/ / / / / / /	X X X X



When/How did your child's symptoms start?

_____

Has your child had similar symptoms in the past?

_____

What are your child's symptoms?_____

_____

_____

How often do your child experience these symptoms?

☐ Constantly (76%-100%) ☐ Frequently (51%-75%) ☐ Occasionally (26-50%) ☐ Intermittently (<25%)

How would your child describe their symptoms?

☐ Sharp ☐ Dull ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

Please circle the level of pain on this scale at its worst: None 1 2 3 4 5 6 7 8 9 10 Worst Possible

Please circle the level of pain on this scale at its best: None 1 2 3 4 5 6 7 8 9 10 Worst Possible

What activities **aggravate** these symptoms (make worse)?

☐ Sitting ☐ Standing ☐ Walking ☐ Laying Down

What activities **alleviate** these symptoms (make better)?

☐ Sitting ☐ Standing ☐ Walking ☐ Laying Down

What is the age of your child's bed?_____

How are your child's symptoms changing? ☐ Getting Worse ☐ Not Changing ☐ Getting Better

When did your child last see a chiropractor? _____ Dr:_____

Why did your child see this chiropractor? _____

What spinal maintenance programs were your child given to follow to maximize the future stability of their spine?

_____

Did your child follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

Why did you come into our clinic and what are your expectations of us? _____

_____

What is your health philosophy? (What should you do to be healthy?) _____

_____

Child's Name: _____ *Date:* _____

Health Questionnaire

For each of the conditions listed below, place a check in the Past Column if your child has had the condition in the past. If your child presently have a condition listed below, place a check in the Present column.

Past	Present	
○	○	Anemia/Bruise easily
○	○	Accident prone
○	○	Bed Wetting
○	○	Bleeding Disorders
○	○	Bloating/Gas
○	○	Breathing Problems/Asthma
○	○	Chronic sinusitis
○	○	Colic
○	○	Constipation/Diarrhea
○	○	Dental problems
○	○	Digestive problems
○	○	Ear Problems
○	○	Falls
○	○	Fatigue
○	○	Fever
○	○	Flu
○	○	Fractures
○	○	Frequent Colds
○	○	Hearing loss or Ringing
○	○	Hyperactivity
○	○	Irritability
○	○	Learning disorders

Past	Present	
○	○	Migraines/Headaches
○	○	Mononucleosis
○	○	Anemia/Bruise easily
○	○	Nervousness
○	○	Osteoporosis
○	○	Persistent cough
○	○	Polio
○	○	Poor Posture
○	○	Problems socializing
○	○	Psychiatric care
○	○	Scoliosis
○	○	Sleep Disorders
○	○	Sweats
○	○	Rashes

Did you have a difficulty delivery? Y/ N

Were forceps/vacuum extraction used? Y/ N

Was your child premature? Y/ N

How long was your child breastfed?_____

Past	Present	
○	○	Back feels out of place
○	○	Back Stiffness
○	○	Back weakness
○	○	Grinding/popping sounds
○	○	Leg cramps
○	○	Muscle spasms
○	○	Pain from front to back
○	○	Pinched nerve
○	○	Tension in back
○	○	Pain between shoulder blades
○	○	Pain in shoulder joint
○	○	Pain across shoulders
○	○	Can't raise arm
		□ Above shoulder level
		□ Over head
○	○	Herniated disc
○	○	Numbness
○	○	Pins & needles
○	○	Weakness

Has your daughter started menstruation? Y/ N

Please indicate if YOUR Child or any of your immediate family has or had any of the following:

□ Cancer □ Thyroid Problems □ Rheumatoid Arthritis □ Heart Problems/Stroke □ Diabetes □ Lupus

List vitamins your child is currently taking:_____

_____

_____

List any medications:_____

_____

List any allergies: _____

List all broken bones, surgical procedures and hospitalizations:_____

_____

_____

On a scale of 1-10 (10 being the most, and 1 being the least),

_____ How committed are you and your child at being at your maximum health potential?

_____ How important is it for your family to be at their optimal health potential?

_____ How committed are you to preventing arthritis and maximizing your child's spinal stability?

Most clients that come to our office have one of two objectives in mind concerning their health care. Some clients come for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

□ **Relief Care** (Help the symptom but do not fix the cause of the problem)

□ **Corrective Care** (Correct the cause of the problem for maximum stability in the future)

DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC
403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Informed Consent for Chiropractic Care

When a client seeks chiropractic health care and we accept a client for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each client understands 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 and the recommended care to be provided so that you make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is the science, philosophy, and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmary.

One disturbance of the nervous system is called a vertebral subluxation. This is a misalignment of one of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments may be performed by hand or instrument where the doctor will put pressure on a specific segment(s) of the spine to adjust the vertebra into a better position.

We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. During the course of a chiropractic spinal examination, if we encounter non-chiropractic or unusual findings, we will advise you and recommend that you seek the services of another health care provider for further testing.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom.** Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

Chiropractic care has been proven to be very safe and effective. It is not unusual however to be sore after your first few corrective adjustments. Although rare, it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, headache, dizziness, rib fracture, and stroke.

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 accept chiropractic care on this basis.

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____	_____	_____
Print Name	**Signature of Client or Responsible Party**	**Date**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read, reviewed, understand and agree to the Notice of Privacy Practices, which describes the practice's policies and procedures regarding the use or disclosure of my protected health information created, received or maintained by the practice. _____ ***Initial***

DR. LAURA E. HARRINGTON
Liverpool Chiropractic & Wellness, PLLC
403 Tulip Street
Liverpool, New York 13088
Telephone: (315) 461-4510

Financial Policies

Thank you for choosing Liverpool Chiropractic as part of your healthcare team. We look forward to serving the needs of you and your family. We are committed to providing you with quality and affordable health care. We believe in informing our patients, from the beginning, about their financial responsibilities for services rendered to prevent any confusion. A copy will be provided to you upon request.

- Until insurance coverage and deductible is verified by our staff, all clients are on a private pay basis and payment in full is expected at each visit.
- This office may make payment plans on an individual basis. Any such plan or arrangement will be discussed after the final Report of Findings and treatment recommendations.

If you have insurance, we will gladly take assignment in most cases, provided we have prior authorization from your insurance company. **While we have taken efforts to verify your insurance, this is not a guarantee of benefits.** There are additional guidelines that apply to patients of Medicare or other federally reimbursed programs.

- We accept assignment as a courtesy to you. **You are responsible for your entire bill should your insurance company not pay any anticipated charges for any reason**. We are not a mediator between you and your insurance company and will not enter into any dispute, as your contract is between you and your insurance company. Knowing your insurance benefits is your responsibility. If a referral is required, it is your responsibility to make sure that it is in place prior to visiting our office.
- Services performed do not constitute a guarantee of payment by your insurance company. **Any services not covered or coverage reductions by your insurance company will be your responsibility.** Every insurance company is different and payments as well as denials are subject to your individual policy.
- **If an insurance carrier denies a claim due to "medical necessity", you are responsible for payment of that claim.** We feel that every adjustment we provide is medically necessary and we realize that we have no control over what any insurance carrier defines as medically necessary.
- Payments made by your insurance company directly to you for services rendered in this office should be returned to this office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue an over-payment check.
- If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor or agent. We will not enter into any dispute with your insurance company. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges in a timely fashion.
- **Changes in your insurance are to be reported to this office as soon as possible to prevent delays in billing**. If this information is not received by our office and your claim is denied, you will be responsible for the entire bill.
- In the event that your insurance company deniers your claim, we will bill you directly for the balance. There is a 1.5% per month interest charge on all past due accounts. If your account is over 90 days past due, you will receive a letter stating that you need to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with the doctor. Please be aware that if a balance remains unpaid, we will refer your account to collections and service fees will be applied as well.

Our practice is committed to providing exceptional chiropractic care to our clients. Our prices are representative of the usual and customary charges for our area.

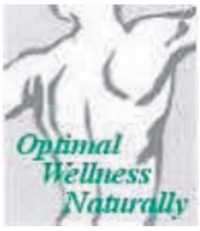
Thank you for reading and understanding our financial policy. Please let us know if you have any questions or concerns. We are here to help!

I have read and understand the Financial Policies above and agree to abide by these terms.

_____ _____

Signature of Client or Responsible Party **Date**

HealtheConnections®



Liverpool Chiropractic & Wellness, PLLC

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)