Child History Form

Date: ____________________

Name: ____________________ Tel.: (___)______-________

Parent (s) Names: ______________________________

Address: ____________________ Zip: ____________

Date of Birth: ____________Referred By:____________

Present MD: ______________________________

Present DC name & last visit :____________________

Present length: ________" Weight: __________lbs.

Chief Health Concerns: ______________________________

Reason for contacting us: ______________________________

Have you seen anyone else for this problem: Yes No

If yes, please list: ____________________

Date of Onset: ____________

Onset was: Sudden Gradual Associated with an event

Duration of Problem (episode): ____ min. Hrs. Days mos. Yrs.

Pattern of Problem: Constant Intermittent Occasional Cyclical

Initiating Factor: ______________________________

Aggravating Factor: ______________________________

Relieving Factor: ______________________________

Effects of Problem on body function and daily activities: ____________

____

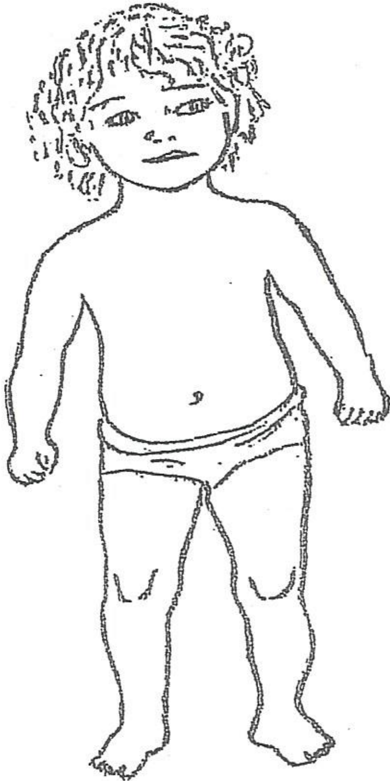
Prior occurrence: ______________________________

List any other health concerns: ______________________________

____

____

Patient Name: ______________________ Date: ____________________



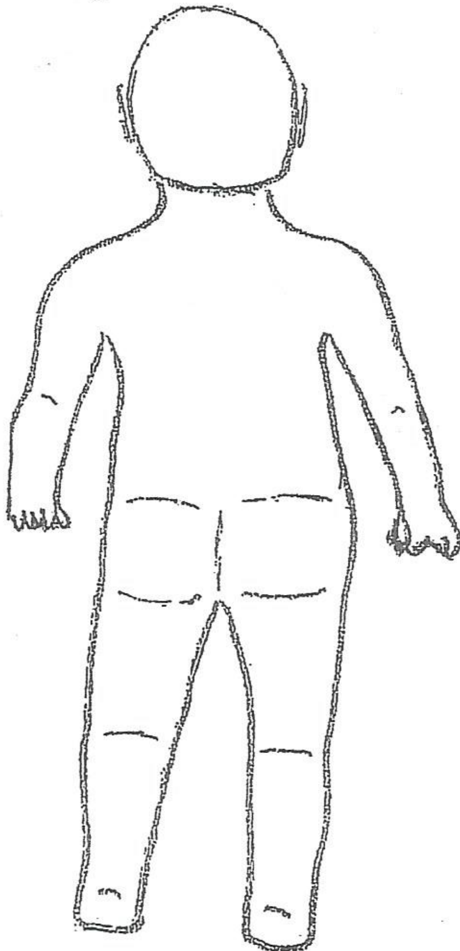
☐ Please check here for wellness visit.

How have you been since your last visit.

Much better   Better   Same   Worse   Much better

Please describe the reasons you have brought your child in today. Rate the severity of their symptoms from 0-10 (0 being no problem at all 10 being unbearable). ☐

Please note any changes in your child's condition here.



Parent's Signature: ________________________

Doctor's Notes:

Doctor's Signature: ________________________

COURTNEY MOORE D.C. MOORE FAMILY CHIROPRACTIC

6302 Broadway, Suite 230
Pearland, TX 77581
(281) 997-0157

Consent for Chiropractic Treatment of a Minor Child

I ________________________________, the ☐Mother ☐Father ☐Legal Guardian of

____ consent to the rendering of

care, including diagnostic procedures and treatment given by

____

(Name of Clinic/Doctor)

for the period ____________________________ to ___________________________

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

I have read this form and certify that I understand its contents.

Signature: ____ Date: ___________
Mother, Father or Legal Guardian

Witness: ____ Date: ___________

FINANCIAL POLICY

Thank you for selecting Moore Family Chiropractic for your medical needs. We look forward to working with you to provide the highest quality of care possible. As one of our patients we would like to keep you informed of our current office and financial policies. We require that you read and sign this document prior to any further treatment/services rendered. We recommend that you keep a copy of this document for your records.

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

We ask that you please bring your insurance card with you at the time of your appointment. If your insurance plan has changed from your last visit we ask that you please notify us so that the information can be updated in our system. With insurance plans where we have agreed to participate in the network as a provider, your carrier requires that all co-pays be collected for any services being rendered. The co-pay requirement cannot be waived by our practice as it is a requirement placed on you by your insurance carrier.

PATIENTS WITHOUT INSURANCE

We request that payment be made at time services are rendered unless previous arrangements have been made.

GROUP OR INDIVIDUAL INSURANCE

Plans that are HMO or POS where we participate, and require a referral, obtaining the referral will be the **patient's responsibility.** We ask that you please keep track of the referrals on file allowed by your primary care provider. If for any reason there is no current referral on file for the particular date of service and the insurance carrier denies payment for no referral a bill will be generated to you for full payment of services. We suggest that the patient always be aware of their insurance benefits and requirements to reduce any further out of pocket expenses not necessary if taken care of prior to your visits. When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays. Please be aware that you, the patient, are ultimately responsible for any services rendered that the insurance did not cover.

ON THE JOB INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, you will be responsible for the payment of services rendered. We will not treat a work injury until all questions are answered concerning payment of services.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

You are considered a cash patient. Therefore you must make payment arrangements and you must facilitate our business office in communications with any responsible insurance companies. Please notify your auto insurance carrier of your visit to our office immediately. Notify us immediately if an attorney is representing you.

MEDICARE

Medicare only covers manual manipulation of the spine for chiropractors. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

I have read and understand the payment policy of Moore Family Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Moore Family Chiropractic and my insurance company. I request that Moore Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days that fees will be due and payable immediately.

______________________________________ ________________
Patient's signature (or guardian if patient is a minor) Date

____________ (Employee Initials)

Office Policy Regarding insurance Assignment & Payment

Our office will accept your insurance assignment and submit to your insurance on a weekly basis. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. We will not enter into a dispute with your insurance company over policy limitations or issues. As such you will be responsible to clear these issues up with your insurance company; this is your responsibility and obligation. All charges incurred are your responsibility. Our office will file your claims for you and assist in every way possible to ensure benefit recovery as a courtesy to you the patient.

Please read the following and sign:

1. Prior to your treatment we will make every attempt to verify your policy benefits, however this DOES NOT guarantee your insurance policy or payments. If something on your policy should change it is YOUR responsibility to let us know.
2. You are required to sign an "Assignment of Benefits" form and any other forms required by your insurance company on your first visit.
3. If your insurance requires their own claim form, you are required to bring in the completed forms by your second visit and then as needed.
4. You will be responsible for your deductible and co-payment. If your insurance does not pay something that *was anticipated*, you will be responsible for the amount as soon as we/you are aware of the denial.
5. Your insurance should pay within 60 days from the date in which it was filed. By taking your insurance assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance does not pay on a timely basis YOU will be asked to pay after 60 days.
6. If your insurance mails a check directly to you for our services, you must bring in the misdirected check to our office within 48 hours.
7. Any overpayments made by your insurance company which credits your account will be refunded to them. However, any errors which do not credit your account will be your responsibility. Anything that is not paid within 90 days will be sent immediately to our collection agency and you will be responsible for the amount owed PLUS a 30% fee from our collection agency.
8. If you discontinue care without the doctor's authorization, the balance on your account is due and payable immediately, even if your insurance has been filed. (If your insurance does pay, after your account has been paid, refunds will be sent to you.)

I have read and understand the policy regarding insurance assignment and payment; I realize that I am responsible for all charges incurred by me at this office regardless of the reason for non-payment.

____

Signature Printed Name Date

Assignment of Benefits

Moore Family Chiropractic Courtney L. Moore, DC

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered assigns to the physicians or facility named above the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owned by an insurance company, in accordance with Article 21.55 of the Texas Insurance Code or other applicable insurance or state statue. I as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 21/45 days (electronic/paper) following your receipt of such bill for services to the extent such bills are payable under the terms of demand specifically conforms with Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court costs, and interest from judgement upon violation.

THIRD PARTY LIABILITY: If my injuries are the results of negligence from a third party, then I instruct the liability carrier to cut a separate draft to pay in full all the services rendered, payable directly to the physician/facility named above.

STATUE OF LIMATATIONS; I waiver my right to claim any Statue of Limitations regarding claims for services rendered or to be rendered by the physicians/facility named above, in addition to reasonable costs of collection, including *attorney fees and court costs if incurred.*

LIMITED PWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts, or other negotiable insurance representing payment from any insurance company representing payment for treatment and health care rendered by the physician/facility named above. I agree that any insurance payment representing an amount excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in noting to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this chiropractic office, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of my care, my insurance company requires me to take examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.
A photo copy of this instrument shall serve as original.

Signature of Patients and/or responsible parties:

1. ______________________________ Date____________