Confidential Patient Information

Triangle CRC, PLLC
2011 Falls Valley Dr. Suite 102
Raleigh, NC 27615

(919) 792-8682 Phone
(919) 882-1774 Fax
www.TriangleCRC.com

PEDIATRIC (3-10)

Date:_____/_____/_____

Patient's Full Name _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____ Weight:_____ Height:_____

How did you find us?

☐ Existing Patient
Name:_____
☐ Physician
Name:_____
☐ Friend
Name:_____
☐ Other_____

☐ Office Website
☐ MPI Website
☐ Doula _____
☐ Midwife_____

☐ Google:_____
☐ Social Media (i.e. Facebook)

Social Security # _____ - _____ - _____

Emergency Contact:_____ Relationship:_____ Phone: _____-_____-_____

Family Physician: _____ City: _____ State:_____ Phone: _____-_____-_____

Previous Chiropractic Care: ☐ Yes ☐ No
If Yes, for what Problem: _____

Doctor's Name: _____ City: _____ State:_____

Authorization of Release

In consideration of your undertaking to care for me, I agree to the following: Triangle Chiropractic and Rehabilitation Center, PLLC, and its physicians and staff are authorized to release **any information** deemed appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me. I understand that I acknowledge that my health-related information may be shared with other providers for my benefit and fully authorize TriangleCRC and its physicians and staff to **release and/or be the recipient of** information as necessary; this includes, but is not limited to: diagnostic imaging, patient records, procedures, surgical reports, and/or any pertinent health-related information.

Patient/Guardian Signature:_____ Date:_____/_____/_____

Payment/Insurance Information:

Who is responsible for your bill? ☐ Self Pay ☐ Personal Health Insurance Carrier: _____

Insurance Card ID Number: _____ Group # _____

Policy Holder's Name:_____ Policy Holder's Birth Date: _____

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Dear Parent/Gaurdian: Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if chiropractic care can help your child. If we do not sincerely believe this child will respond satisfactorily, we will not accept your case. THANK YOU.

Present complaint(s)/concern(s):_____

When did symptoms begin? (Specific date if possible)_____

Family Doctor / Pediatrician:_____

Any known food allergies? ☐ Yes ☐ No If yes, list:_____

Typical daily/weekly diet consists of: (Circle all that apply)

Meat Vegetables Fruit Nuts Fish Eggs Sugar Dairy Grains (refined/unrefined)

Milk source: Cow 2% Cow Whole Goat Almond Coconut None

Frequency of eating: _____

Types of snacks: _____

Breastfed/Formula? How long? _____

Birth history (natural, C-section, forceps, epidural, pitocin, length of labor, etc.): _____

_____

_____

Sleep Patterns: _____

Temperament and Social Interactions: _____

Exercise Routine/Activity level: _____

History of accidents/falls/trauma: _____

_____

_____

Significant Illness/Hospitalization: _____

_____

Immunizations: (Circle one) Current Delayed None

☐ Yes ☐ No Does anyone in the household smoke?

Other health concerns? If yes, explain: ☐ Yes ☐ No

_____

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INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as get-ting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Signature of Patient:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____

Signature of Witness(if a minor):_____ Date:_____

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Financial/Privacy Policy and Disclaimer

Please note: your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Like all types of care, coverage for chiropractic services varies from insurer to insurer and plan to plan. Our office uses an online software program to **estimate** what you will owe, but *charges are not guaranteed or finalized until claims have been filed and your insurance company reviews your claim*. This process typically takes 30-90 days. Most insurance plans limit the number of times they will pay for you to see certain practitioners per year. It is the patient's responsibility to ensure they do not go over their insurer's annual visit limit. Once your visit limit has been reached, you will be responsible for the full cost of each additional visit.

We are not responsible for your insurer's final payment and benefit determinations.

In order to help you determine your responsibility toward payment for services, please read the following and initial your preference for the method of payment for your account. Please notify this office if the status of your insurance changes.

Private pay: (please initial)

A_____As I have no insurance coverage for the services provided, I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

B_____I have insurance coverage, but I wish to file my claims personally, and I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

C_____I have insurance coverage, but wish to opt out of using any benefits I may have. I will not file claims on my behalf and understand TCRC will not be filing my claims.

Health Insurance: (please initial)

D_____I would like this clinic to bill my insurance. I understand that my insurance company's payment is not guaranteed to align with this office's estimate, and that I am responsible for payment in full according to my insurance company's final decision.

Missed appointments:

It is the policy of Triangle Chiropractic & Rehabilitation Center, PLLC to assess a $37.50 missed visit fee to patients who cancel appointments with less than a 24 hour notice. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care to others.

_____My initials here indicate that I understand the above missed visit policy.

I understand that all health services rendered to me and charged to me are my personal financial responsibility. I understand that if payment is not rendered at the time of service, I am expected to remit payment within 30 days of service*. All balances after 30 days will be charged to my credit care on file. If payment is unsuccessful, charges may be turned over to a collection agency. I understand and agree to conditions of this policy.

*If you are having trouble paying your bill, arrangements may be made for payment plans upon request. You will still be responsible for payment in full.

HIPAA Privacy Policy

Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you. By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

Designation of Authorized Representative

I do hereby designate TriangleCRC to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from TriangleCRC. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney

I do hereby authorize Triangle Chiropractic and Rehabilitation Center to act on my behalf to pursue claims and exercise all rights in order to collect payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from TriangleCRC.

Patient's Printed Name:_____

Patient/Guardian Signature:_____Date:_____/_____/_____