
Phone: 402-318-5797

8550 Andermatt Drive, Suite 2

Lincoln, NE 68526

www.expresslifechiropractic.com

## Patient Information

First Name: Last Name: Date of Birth: Age:

Gender:
○ Female ○ Male

Height (ft, in):

Weight (lbs):

Home Address: City: State: Zipcode:

Name(s) and Age(s) of your child's siblings:

Primary Care Physician:

Is your child receiving care from any other health professionals?
○ Yes ○ No

If yes, please name them and their specialty:

## Parent/Guardian Information

Parent/ Guardian A

Full Name:

Home Phone:

Cell Phone:

Employer:

Email:

Parent/ Guardian B

Full Name:

Home Phone:

Cell Phone:

Employer:

Email:

How did you hear about us?

## Current Health Conditions

What condition(s) bring your child to be evaluated by a chiropractor?

When did the condition first begin?

How did the problem start?

- ○ Suddenly
- ○ Gradually
- ○ Post-Injury

Has your child ever received care for this condition?

- ○ Yes
- ○ No

If yes, please explain:

Is this condition:

What makes the problem better?

What makes the problem worse?

Please list any drugs/medications/vitamins/herbs or other that your child is taking, the dosage, and why:

## Health Goals For Your Child

Please list your top three health goals for your child:

What would you like to gain from chiropractic care?

- ○ Resolve existing condition(s)
- ○ Overall wellness
- ○ Both

Has your child ever visited a chiropractor?

- ○ Yes
- ○ No

If yes, what is their name?

## Pregnancy, Labor, & Delivery History

Child's birth was:

- ○ Natural vaginal birth
- ○ Scheduled C-section
- ○ Emergency C-section

At how many weeks was your child born?

Where was your child born?

Who delivered your baby?

Birth weight (lbs, oz):

Birth height (in):

Please indicate any applicable interventions or complications:

- ☐ Breech
- ☐ Induction
- ☐ Pain meds
- ☐ Epidural
- ☐ Episiotomy
- ☐ Vacuum extraction
- ☐ Forceps
- ☐ Other
- ☐ None

Please describe any other concerns or notable remarks about your child's conception, pregnancy, labor, and/or delivery:

## Growth & Development History

Is/was your child breastfed?

- ○ Yes
- ○ No

If yes, how long? _____

Difficulty with breastfeeding?

- ○ Yes
- ○ No

Did they ever use formula?

- ○ Yes
- ○ No

If yes, at what age? _____

If yes, what type? _____

Did/does your child suffer from colic, reflux, or constipation as an infant?

- ○ Yes
- ○ No

If yes, please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head?

- ○ Yes
- ○ No

If yes, please explain:

Please list any food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history (including the year):

Please list any major injuries, accidents, falls, and/or fractures your child has sustained in their lifetime (including the year):

Have you chosen to vaccinate your child?

- ○ No
- ○ Yes, on a delayed/selective schedule
- ○ Yes, on schedule

If yes, please list any vaccine reactions:

Has your child received any antibiotics?

- ○ Yes
- ○ No

If yes, how many times and list reason:

Night terrors or difficulty sleeping?

○ Yes ○ No

If yes, please explain:

Behavior, social, or emotional issues?

○ Yes ○ No

If yes, please explain:

How would you describe your child's diet?

○ Mostly whole, organic foods ○ Pretty average ○ High amount of processed foods

## Practice Member Information

Child's Full Name:

Social Security Number:

Date of Birth:

Contact In Case of Emergency and Relation to Child:

Emergency Contact Phone Number:

### Primary Insurance

Name of Primary Insurance Carrier:

Name of Insured:

Insured Date of Birth:

Insured Social Security Number:

### Secondary Insurance

Name of Secondary Insurance Carrier:

Name of Insured:

Insured Date of Birth:

Insured Social Security Number:

## Acknowledgment and Consent

### INSURANCE POLICIES AND FEE SCHEDULE

**Consultation/Assessment (New or Established Practice Member):** Includes one or more of the following: practice member history, thermography, orthopedic/neurological evaluation, range of motion, motion and/or static palpation, leg check $50-$100.

**Chiropratic Adjustment:** The actual re-alignment of the vertebra done by hand. Often a sound will be heard, but if there is no auditory result, it does not mean that the adjustment has not taken place. $30-$60.

**X-rays:** Specific x-ray views taken of your spine to determine a misalignment/subluxation of your vertebrae. These can also be used to indicate progress after period of care. $30 per view. Reproductions of x-rays are $15 per copy.

*These prices are not reflective of physical injury or bodily injury cases in relation to car accidents or auto insurance cases.*

### RELEASE OF AUTHORIZATION/ ASSIGNMENT OF BENEFITS

I authorize and request payment of insurance benefits directly to Troy Hayes, D.C. I agree that this authorization will cover all services rendered until i revoke the authorization. I agree that a photocopy of this form may be used in place of the original. All professional services rendered are charged to the patient. It is customary to pay for services when rendered unless other arrangements have been in advance.

A quote of benefits and/or authorization does not guarantee payment or verify eligibilty. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the practice member's insurance at the time of service. Your health/auto insurance company will only pay for services that it deermines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health/auto insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. If my health/auto insurance company denies payment (in whole or in part), I understand that iam personally and fully responsible for payment. I also understand that if my health/auto insurance company does make payment for services, I will be responsible for any co-payment, deductible, out of pocket, or coinsurance that applies.

I understand that I am financially responsible for charges not covered by this assignment.

e-signature

Signature: Date:

## TERMS OF ACCEPTANCE

In order to provide the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patiet relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following point regarding chiropractic care and the services that are offered through this clinic:

A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a seperate and distant science, art, and practice. It is not the practice of medicine.

B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of spinal subluxation(s). Subluxations are deviations from normal spinal structures and configurations that interfere with normal nerve processes.

C. The chiropractic adjsutment process, as defined in the law of this jurisdiction, involved the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one million times each day by doctors of chiropractic in the United States alone.

D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify and spinal health problems and chiropractic needs. if during this process, any condition or question outside the scope of chiropractic is identified, you will recieve a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.

E. Chiropractic does not seek to replace or comete with your medical, dental, or other type(s) of health professionals. They retain responsibility for care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.

F. Your compliance with care plans, home, and self-care, etc., is essential to maximize healing and optimal health through chiropractic.

G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration, or cost, in what we work to maintain as a supporting, open environment.

**By my signature below, I have read and fully understand the above statements.**

**All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my satisfaction. I therefore accept chiropractic care on this basis.**

e-signature

Signature: Date:

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRATICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclosed to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

e-signature

Signature: Date:

## INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care, while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occuring at a rate between one instance per one million to one instance per two million cervical spine (neck) adjustments, may be a vertebral injury that could lead to a stroke.

Prior to recieving chiropractic care in this chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific conditions, your overall health, and in particular your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care

provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

**I understand and accept that there are risks associated with chiropractic care and give consent to the examination that the doctor deems necessary and the chiropractic care, including spinal adjustments, as reported following my assessment.**

e-signature

Signature: Date:

## WRITTEN CONSENT FOR A CHILD

I authorize Dr. Troy Hayes and Dr. Ashley Hayes and any and all Express Life Chiropractic staff to perform diagnostic procedures, radiographic evauations, render chiropractic care, and perform chiropractic adjustments to my minor/child. As of this date, I have legal reight to select and authorize health care services for my minor/child. If my authority to select and authorize care is revoked or altered, I will immediately notify Express Life Chiropractic.

e-signature

Signature: Date:

## Appointment Policy

In our office, we reserve our time to serve you and your family. We understand that life happens and appointments may need to be changed or cancelled for **emergent** reasons. In this event, we request that you give our office a call or message us via SKED within a minimum of **1 hour** prior to your scheduled appointment.

**Two** "no call, no shows" *in a row* are granted to a practice member in the event of an emergency, but there is no tolerance for chronic "no call, no shows." Following your **third** "no call, no show," our billing department will automatically apply a one-time **$100 NCNS fee** to the credit or debit card on file **per family member** at the end of the business day. Following this fee, the practice member and associated family members' calendars will be deleted from our schedule. If the practice member at this point wishes to continue with their care, we will be happy to rebuild your care visits, but remember, you have already exhausted our cancellation policy, and there will be no more tolerance for missed visits. If you wish to restart care, the cancellation policy will reset, and the **$100 fee will be applied to the first "no call, no show"** of your new calendar.

**Being consistent** with your care will get you the best results in our office!

In order to discontinue care, we require that you come into the office to go over your account with a team member. This should be scheduled 24 hours in advance to allow ample time to audit your account. At that time, we will either schedule a refund (within 15 days) or take payment for any balance left on the account.

I understand the above cancellation policy as well as the penalty fees that could be applied to my credit or debit card.

Signature: Date:

## MEDIA RELEASE FORM

I grant permission to Express Life Chiropractic, hereinafter known as the "Media" to use my image (photographs and/or videos) for use in Media publications including Social Media Posts, Videos, Email Blasts, Educational Brochures, Newsletters, Handouts, Magazines, General Publications, and/or Affiliates.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjuction with them now or in the future, whether that use is known to me or unkown, and I waive the right to royalties or other compensation arising from or related to the use of the image.

I am the parent or legal guardian of the above named child. I have read this release before signing below, and I fully understand the contents, meaning and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of terms of this release.

e-signature

Type Signature:

## X-RAY AUTHORIZATION

As your helthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request we will provide you with a copy of your x-rays in our files. However, the reproduction of x-rays there will be $15 surcharge for the duplication of x-rays.

Please Note: If clinically necessary, x-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctors of Express Life Chiropractic do not diagnose or treat medical conditions; however, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

**By signing below, you are agreeing to the above terms and conditions.**

e-signature

Signature: Date: