Gabel Chiropractic **Today's Date: _____**

PEDIATRIC HISTORY FORM

PATIENT NAME: _____ DATE: _____ DOB: _____ SEX: ____ SS#: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

MOTHER'S NAME: _____ EMAIL ADDRESS: _____

FATHER'S NAME: _____ REFERRED BY: _____

Primary Phone Contact: _____ Type: Cellphone Home Phone Work Phone

Secondary Phone Contact: _____ Type: Cellphone Home Phone Work Phone

REMINDER: _____Phone call _____ Text Message; Cell Phone Carrier _____(Required for Text)

Medications/Vitamins: _____ **Allergies: _____**

_____ _____

Surgeries: _____ **Injuries: _____**

_____ _____

PURPOSE FOR CONTACTING US: _____

Other doctors seen for this condition: _____ N _____ Y Doctor's names and prior treatment _____

_____

Other health problems? _____

Check any of the Following conditions your child has suffered from during the past six months:

□ Ear infections	□ scoliosis	□ seizures	□ chronic colds	□ headaches
□ Asthma/allergies	□ digestive problems	□ ADHD	□ recurring fevers	□ growing/back pains
□ Colic	□ bed wetting	□ car accident	□ temper tantrums	□ other _____

Previous chiropractor: _____

Date of last visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____

Date of last visit: _____/_____/_____ Reason: _____

Number of doses of antibiotics your child has taken:

During the past six months: _____, Total during his/her lifetime: _____

Number of other prescription medication your child has taken:

During the past six months: _____, Total during his/her lifetime: _____ List: _____

Do you vaccinate? ____no ____ yes; last vaccination & date _____

Prenatal History:

Name of obstetrician/midwife: _____

Complications during pregnancy: _____ N _____Y List: _____

Ultrasounds during pregnancy: _____ N _____ Y How many? _____

Medications during pregnancy/delivery? _____ N _____ Y List: _____

Cigarette/alcohol use during pregnancy? _____ N _____ Y

Location of birth: _____ Hospital _____ Birthing Center _____ Home

Birth Intervention: _____ Forceps _____ Vacuum Extraction _____ Caesarian Section Emergency or Planned?

Complications during delivery? _____ N _____ Y List: _____

Genetic disorders or disabilities: _____ N _____ Y List: _____

Birth Weight: _____ Birth Length: _____ APGAR scores: _____, _____

Feeding history:

Breast Fed: _____ N _____ Y, how long? _____

Formula Fed: _____ N _____ Y, how long? _____ Type: _____

Introduced solids at: _____ months, Cows' milk at _____months

Food / Juice Allergies or intolerances: _____ N _____ Y, List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

_____ Respond to Sound _____ Crawl

_____ Respond to Visual Stimuli _____ Stand alone

_____ Hold head up _____ Walk alone

_____ Sit up

According to the National Safety Council, approximately 50% of children fall head first from a high place during their first year of life (ie. bed, changing table, down stairs, etc.) Was this the case with your child? _____ N _____ Y

Has your child ever been involved in a car accident? _____ N _____ Y, List _____

Has your child been seen on an emergency basis? _____ N _____ Y, List _____

Other traumas not described above? _____ N _____ Y, List _____

Prior Surgery: _____ N _____ Y, List _____

Childhood diseases:

Chicken pox	N/Y, AGE _____	Mumps	N/Y, AGE _____
Rubella	N/Y, AGE _____	Whooping cough	N/Y, AGE _____
Other	N/Y, AGE _____		

We are here to serve you, and encourage you to ask questions.

Your participation is vital and will help determine your results.

Signature of parent/guardian Date

GABEL CHIROPRACTIC

MINOR AUTHORIZATION FORM

INFORMED CONSENT UNDER IOWA CODE SECTION 147.137

INTRODUCTION

The profession of chiropractic, dentistry, medicine and surgery, nursing, optometry, osteopathy, osteopathic medicine and surgery, pharmacy, physical therapy, podiatry, psychology, and other are regulated in the state of Iowa under Iowa Code Chapter 147. Patient care provided by those above listed professions, including chiropractic, have known risks which may include death, brain damage, quadriplegia, paraplegia, the loss of function of any organ or limb, or disfiguring scars associated with such care and treatment. For your information, the following is routinely furnished to all who consider chiropractic care at this clinic.

Gabel Chiropractic is staffed with a licensed doctor of chiropractic. Chiropractic is a science, which concerns itself with relationship between structure (primarily the spine) and function (primarily the spine) of the body as the relationship may effect the restoration and preservation of health.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentations, laboratory tests, radiology examinations, physical therapy and related rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession -- the chiropractic spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s).

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome (VAS), including stroke and perhaps, death through complicating factors.

AUTHORIZATION FOR CHIROPRACTIC CARE OF A MINOR OR PERSON UNABLE TO CONSENT

I have been informed of the nature and purpose of chiropractic care, the possible consequences of the care, and the risks of the care, including the risk that care may not accomplish the desired objective. Reasonable alternative treatments have been explained, including risks, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE PRECEEDING PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME AND ALL QUESTIONS, WHICH I HAVE ASKED, HAVE BEEN ANSWERED TO MY SATIFACTION.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE DR. ANGELA GABEL TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATED _____, CLINTON, IOWA

A: PATIENT IS A MINOR _____ WEEKS OLD
B: PATIENT IS A MINOR _____ MONTHS OLD

PATIENT'S NAME: _____

PERSON AUTHORIZED TO SIGN FOR PATIENT: _____
Signature of authorized person

RELATIONSHIP TO PATIENT: _____

SIGNATURE OF DOCTOR: _____

Gabel Chiropractic Financial Policy

INSURANCE
If you have health insurance we will need a copy of your insurance card. We will verify your benefits and once they are verified we will then submit your claims on a timely basis.

You are responsible for paying co-payment and non-covered supplements and supplies at the time they are rendered. Deductible and co-insurance will be billed once we have received an explanation of benefits from your insurance company. If you are being seen more than once a week arrangements can be made to pay your portion at the last visit of the week or you can have the payment made by using your credit card.

OR

If you wish to bill your insurance, we ask you pay 100% of your services at the time of each visit. We will provide you with a receipt with the necessary billing information, which you can send your insurance carrier for reimbursement.

NON-INSURED
We request 100% of the first visit be paid at the time of the first visit. All future visits are to be paid on a weekly basis.

WORKER'S COMPENSATION
Chiropractic services are covered by Worker's Compensation Law, and you should be covered 100%, as long as your employer is aware you were injured on the job, you have completed the required papers with your employer, and your employer has no objection to your receiving care here, and is covered by Worker's Compensation insurance. You are responsible for non-covered items such as supplements and supports that are not a direct result of the accident. These items are to be paid for at the time they are received.

IT MUST BE UNDERSTOOD:

1. This clinic DOES NOT promise that an insurance company will pay. Nor does the clinic promise that an insurance company should pay the fees as charged.
2. The clinic will not enter into a dispute with an insurance company for reimbursement or the amount of reimbursement. This is the patient's obligation.

_____ I do not have health insurance and I will pay at time of service.

_____ I have Iowa Medicaid

_____ I have Medicare, and I understand that Medicare does not pay for examinations. Therefore, I will be responsible for such charges.

_____ I have health insurance that covers chiropractic care.

_____ I have been injured at work and will furnish all the necessary information to Dr. Gabel and staff.

_____ I have been injured in an auto accident. I will furnish all information to bill for this accident

_____

Guarantor Signature Date

PATIENT PRIVACY POLICY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

□ Home phone_____ _____
- □ Leave a message with detailed information
- □ Leave a message with call-back number only

□ Written Communication
- □ Mail to my home address
- □ Mail to my work address

_____

□ Fax to this number

_____

□ Cell phone _____
- □ Leave a message with detailed information
- □ Leave a message with call-back number only
- □ Text a message

□ Other _____

_____

_____ _____

Parental Signature Date

_____

Print Parental Name

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by and individual.