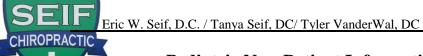
Phone: (616) 891-8153

Fax: (616) 891-0060 seifchiro@gmail.com

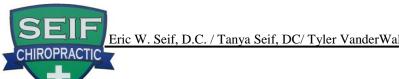


<u>Pediatric New Patient Information – 6 years – 10 years</u>

Patient Name:				Nickname:		
П М	□F	Date of Birth:	Age:		□F	
Addre	ss:					
<u>Famil</u>	y Infor	mation:				
Mothe	er's Nan	ne:	Cell #:	W	ork #:	
Father's Name:			Cell #:	W	Work #:	
Who i	s to be t	he guarantor (person respo	onsible for payment) on the	account? Mother	☐ Father ☐ Other:	
Parent	's Mari	tal Status: □Single □Ma	rried Divorced Dwid	lowed		
Who r	nay we	thank for referring you?				
Reaso	on for v	visit today?				
Please As	thma/A	any of the following your callergies Scoliosis Recurring Fo	□Seizures □Chronie		daches Digestive problems per Tantrums	
-	ır child		11 6 0			
ПY	□N	Complaining of pain or If yes, was onset \square Sudo	discomfort? len □Gradual □Constan	t DIntermittent		
ΠY	□N	Have they ever had this problem before?				
□Y □Y	□N □N	Been treated for this problem? Is so, by whom?				
ΠY		Previously had chiropractic care? Is so, by whom?Have/Had ear aches. At what age did first earache occur?				
\Box Y	ΠN	Does ear ache usually ten to occur in the same ear? $\square R$ $\square L$ $\square Both$				
ΠY	□N	Ever complain of neck or back pain				
□Y □V		Ever complain of pain in the arms and legs				
□Y □Y	□N □N	1				
ŪΥ	□N	Ever been to a hospital or emergency room for evaluation or treatment? Is so, what?				
ПY	□N	Received vaccinations				
ПY	□N					
1.	Please					
2.	Please	Please list any surgeries your child had had.				
3.		Do you have any other concerns about your child's health?				
.7.	DO YO	ou mave any other concer	ans about voui cilliu s fiet	arur:		

Parent/Legal Guardian Signature

Date



649 Emmons St. & Caledonia, MI 49316 Phone: (616) 891-8153

Fax: (616) 891-0060 seifchiro@gmail.com

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Patient Name: DOB:
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by Eric W. Seif DC, Tanya Seif DC, and/or Tyler VanderWal DC, who now or in the future treat me while employed by Seif Chiropractic, including those working at the clinic or office.
I have had the opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.
I understand and I am informed that, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts known, and is my best interest.
I have read, and/or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
 Minor Children: Being the parent or legal guardian of this child, I hereby authorize this office and its doctors to examine and administer care to my son/daughter as the examining/treating doctor deems necessary. □Y □NInitial I also give permission for my son/daughter to be seen without me present. □Y □NInitial
Primary Care Physician: 1. I authorize Seif Chiropractic to update my medical doctor regarding my care at this office. □Yes □No Initial
Patient/Parent/Legal Guardian Signature Date

SEIF E

Parent/Legal Guardian Signature

649 Emmons St. & Caledonia, MI 49316
Phone: (616) 891-8153

Phone: (616) 891-.8153 Fax: (616) 891-0060 seifchiro@gmail.com

Date

HIPAA Notice of Privacy Practices

Patie	ent Name: DOB:
Our O	bligations
	required by law to:
•	Maintain the privacy of protected health information.
•	Give you the notice of your legal duties and privacy practices regarding health information about you.
•	Follow the terms of our notice that is currently in effect.
How V	Ve May Use and Disclose Health Information
1.	<u>Treatment</u> . We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
2.	Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services. We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health related benefits and services that may be of interest to
3.	Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosure to prevent or control disease, injury, or disability; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law. Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities
Your I	
You ha	ve the following rights regarding Health Information we have about you:
 2. 	Right to Inspect and Copy. You have the right to inspect and copy Health Information that we may use to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this information, you must make your request in writing, to our Privacy Officer. Right to Request Confidential Communication. You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to our Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
3.	Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You must ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by contacting our office.
Compl	
	believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of
	and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. ill not be penalized for filing a complaint.
Author	rization:
	You give permission to the following individuals to receive information about your healthcare and/or records:
	a. Name Relationship:
	b. Name Relationship:
	c. Name Relationship:
2.	I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. Which means, the individual you authorize could talk to another individual about your treatment and that would not be covered under the HIPAA law.
	dersigned does hereby consent to the use of his/her information in a manner consistent with the Notice of Privacy Practices not to HIPAA, the HIPAA Compliance Manual. State and Federal Law.



Parent/Legal Guardian Signature

seifchiro@gmail.com

Date

Financial Policy

Patient Name:	DOB:
plans. Most of our patients that have health or accident insura	rell and stay well. Chiropractic care is covered under many insurance nce will fall under one of the plans discussed in this policy. Regardless nink you need. We ask that you read and understand our policy as it
	e time of service. We do offer a payment plan after your first visit. ce. We do offer a "Time of Service discount" on your adjustments but
your insurance company and our office. We cannot be certain coverage. The amount they pay varies from one policy to ano	is an agreement between you and your insurance company, not between if your insurance covers chiropractic, although most policies do provide ther. When possible, we will call to verify benefits on your insurance rany are not a guarantee of payment. A deposit is required for any services.
	you, our office will complete any necessary insurance forms at no to help you collect. It is to be understood and agreed that any service ponsible for payment.
for the first 28 days. After that you may see whomever you chyour employer's Worker's Compensation insurance. You will	have to follow the rules of WC and see your employers chosen docto nose. If you are injured on the job, your care should be paid for unde need to inform your employer of the accident and obtain the name and s not provide us with this information, if a settlement has not been made and services are due immediately.
that Medicare will cover which for Chiropractors is <u>ONLY</u> much allowable fee once the deductible has been met. You are recovered are <u>NON-COVERED</u> . These services include, but and/or nutritional supplements. Medicare patients are fully remay or may not pay for these non-covered services. Our office	e check is usually sent directly to our office in payment of the service annual manipulation (adjustments) of the spine. Medicare pays 80% of equired to pay the deductible and the remaining 20%. All other service at are not limited to, x-rays, examinations, therapies, orthotics, support esponsible for charges of non-covered services. Secondary insurance completes and files the forms for Medicare at no charge. In dary insurance you may have. We will assist you if you need help in
at this office or a request of more information regarding your keep your file as up to date as possible. Occasionally, either	ce from your insurance carrier pertaining to the care you have received care, please bring it in as soon as possible. It is very important that we by mistake or due to provisions in your policy, the check issued by the ffice may come to your instead of our office. If you should receive an represent payment of your bill here.
Wellness Care: Most insurance plans do not cover for welln plan, the doctor will let you know and we will discuss with you	ess or maintenance care. When you get to this point in your treatment at that time your options for treatment cost.
and my insurance company, NOT between Seif Chiropractic a customary forms at no charge so that I may obtain insurance be 60 days, or if I suspend or terminate my schedule of care as possible immediately.	actic. I understand that my insurance is an arrangement between mysel and my insurance company. I request that Seif Chiropractic prepare the enefits. I also understand that if my insurance does not respond within prescribed by the doctors at Seif Chiropractic that fees will be due and
	to be paid upon receipt of services. ***
	wever, you are responsible <u>at the time of service</u>
For the <u>deposit</u> of your co-pay	, deductible and non-covered services.