Eric W. Seif, D.C. / Tanya Seif, DC/ Tyler VanderWal, DC
649 Emmons St. Caledonia, MI 49316
Phone: (616) 891-8153
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Pediatric New Patient Information - Newborn to 2 Months

Patient Name: _____ **Nickname:** _____

❑M ❑F Date of Birth: _____ Age: _____ ❑M ❑F

Address: _____

Family Information:

Mother's Name: _____ Cell #: _____ Work #: _____

Father's Name: _____ Cell #: _____ Work #: _____

Who is to be the guarantor (person responsible for payment) on the account? ❑ Mother ❑ Father ❑Other: _____

Parent's Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Who may we thank for referring you? _____

Birth History

How long was labor from the first regular contraction to birth? _____Hours _____ Minutes
How long was the 2nd stage (pushing phase) of labor? _____Hours _____Minutes

Please check all that apply:

❑Hospital Birth	❑Vaginal Delivery	❑Induced Birth	❑Anesthesia Admin	❑Head Presentation
❑Home Birth	❑Planned C-section	❑Forceps Delivery	❑Fetal Distress	❑Face Presentation
❑Midwife Assisted	❑Emergency C-section	❑Vacuum Extraction	❑Meconium staining	❑Breech Presentation

Baby's condition immediately after birth: Birth Weight: _____ Birth Length: _____ Home on day: _____
Apgar Scores: at 1 minute _____/10 at 5 minutes_____/10

Baby's crying after birth: ❑cried immediately ❑cried strongly ❑cried weak ❑did not cry for _____mins

Baby's color: ❑pink all over ❑blue face ❑blue hands/feet

Baby's activity: ❑arms and legs actively moving ❑baby was floppy

Intensive care: ❑was not required ❑was required _____days in neonatal ICU

Medication given at birth? ❑Yes ❑No Vaccines Administrated? ❑Yes ❑No

Reason for visit today? _____

How many hours does your baby sleep between feedings? During the day _____ At night? _____

Does your baby……..

❑Y	❑N	Go to sleep easily	❑Y	❑N	Spit up after feeding
❑Y	❑N	Have preferred sleeping position	❑Y	❑N	Cry a lot _____ hours each day
❑Y	❑N	Cry if change sleeping position	❑Y	❑N	Intestinal gas
❑Y	❑N	Any feeding difficulties	❑Y	❑N	Preferred head position
❑Y	❑N	Breast fed	❑Y	❑N	Frequently arch head and neck backwards
❑Y	❑N	Preferred breast L or R	❑Y	❑N	Cry or become irritable during diaper change
❑Y	❑N	Formula Fed which kind _____	❑Y	❑N	Ever have a fever
❑Y	❑N	Had any falls	❑Y	❑N	Been in a car accident or near miss
❑Y	❑N	Other Trauma			

Parent/Guardian Signature **Date**

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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:

1. 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 ❑N _____Initial
2. I also give permission for my son/daughter to be seen without me present. ❑Y ❑N _____Initial

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

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HIPAA Notice of Privacy Practices

Patient Name: _____ DOB: _____

Our Obligations

We are 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 We May Use and Disclose Health Information

1. **Treatment**. 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 you.
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 Rights

You have the following rights regarding Health Information we have about you:

1. **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.
2. **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.

Complaints:

If you believe your privacy has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our Privacy Officer. All complaints must be made in writing. You will not be penalized for filing a complaint.

Authorization:

1. 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.

The undersigned does hereby consent to the use of his/her information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State and Federal Law.

_____

Parent/Legal Guardian Signature **Date**

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Financial Policy

Patient Name: _____ DOB: _____

Our recommendations are based on a desire to see you get well and stay well. 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. Regardless of your coverage, we will suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE: Payment is due at the time of service. We do offer a payment plan after your first visit. Your first visit is expected to be paid in full at the time of service. We do offer a "Time of Service discount" on your adjustments but it is only offered at the time of service.

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. 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. A deposit is required for any deductibles, co-pays and non-covered services upon receipt of services.

NON PARTICIPATING INSURANCE: As a courtesy to you, our office will complete any necessary insurance forms at no additional charge and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment.

"ON THE JOB" INJURY (Worker's Compensation): You have to follow the rules of WC and see your employers chosen doctor for the first 28 days. After that you may see whomever you choose. 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, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately. .

MEDICARE: We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is **ONLY** manual manipulation (adjustments) of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are **NON-COVERED**. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these 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.

Insurance Forms/Payment: If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office may come to your instead of our office. If you should receive an unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

Wellness Care: Most insurance plans do not cover for wellness or maintenance care. When you get to this point in your treatment plan, the doctor will let you know and we will discuss with you at that time your options for treatment cost.

I have read and understand the payment policy of Seif Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Seif Chiropractic and my insurance company. I request that Seif 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, or if I suspend or terminate my schedule of care as prescribed by the doctors at Seif Chiropractic that fees will be due and payable immediately.

******I understand that fees are to be paid upon receipt of services. ******

Yes, we do bill your insurance company however, you are responsible at the time of service
For the deposit of your co-pay, deductible and non-covered services.

_____

Parent/Legal Guardian Signature Date