Youth Patient Information

First Name: ________________ Last Name: _________________ DOB: __/__/____ Age: ____ SSN: ___/__/____

Sex at Birth: __________ Pronouns: ____________ Home Phone: _____________ Cell Phone: ________________

Email: ______________________ Mailing Address: ______________________________

City: _________________ State: ____ Zip: ____________

Mother's Name: _______________ Father's Name: ____________________ Legal Guardian: _______________

Patient's Personal Physician: _____________________ Type of Dr._________________

Who can we thank for referring you in? ____________________________ Relationship: __________________

Emergency Contact: ______________________ Relationship: _______________________________________

I choose to decline a receipt of my clinical summary after every visit (these summaries are often blank as a result of the nature and frequency of chiropractic care.)
Patient Signature:____
Date:_________________________

Consent of Treatment of a minor

I hereby authorize Dr.___________ and whomever he/she so designate as their assistant, to administer chiropractic care as he/she deems necessary to my son/daughter, ____________________, dated at San Luis Obispo this ___________ day of ___________, of 20__________.

Print: ______________________________ Signature: ________________________________ Date:______________

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Witness Name:__________________________ Witness Signature:___________________ Date:_____________

Health History and Wellness

What is the reason for this visit?

____

____

When did this condition begin? ________________ Did it begin: □Gradual □Sudden □Progressive over time

Have you experienced this before? □ Yes □ No

Is there anything that relieves your symptoms? ____

Have you sought any other treatment before this? □ Yes □ No If so, please describe: ____________________________

Have you ever seen a chiropractor before? □ Yes □ No if so whom: ____________________ Where: ________________

Who is your primary treating physician? (MD)____

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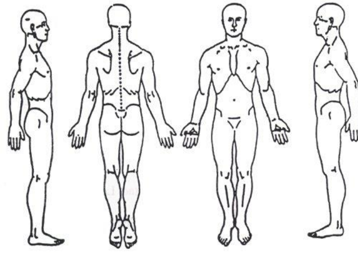
Please show us where you are experiencing pain and/or discomfort by putting circling the body:



Are there any known allergies:

Medication Name	Reaction	Onset Date	Additional Comments

Was your child colicky as an infant? □ No □ Yes

How was your child fed as an infant? □ Breast □ Bottle If, so, what brand or kind of formula?________________________

Please indicate any history of antibiotic use, listing when, what and for what purpose:

____

____

Has your child had any respiratory infections? □ No □ Yes If yes, How often? _________________________________

Does your child ever complain of headaches? □ No □ Yes

How often?____

Has your child had ear infections? □ No □ Yes

Age of the first occurrence and frequency:____

Do they typically occur in the same ear? □Yes □No Which ear? □Right □Left □Both

Has your child been vaccinated? □Yes □No Recently? □Yes □No

Please describe any reactions that your child has had to past or recent vaccinations:

____

Please list any other concerns you have regarding your child's health:

____

____

List supplements, herbs, remedies, including athletic performance supplements that your child is currently taking:

Supplement Name	Dosage and Frequency

Do you suspect your child to use recreational drugs? If so, what?

____

List any hospital procedures/surgeries that your child has had: __________________________________

Medical Condition	Surgeries	Serious Accident/Trauma

Please list your health and wellness related goals

Physical Goals	Nutritional/Biochemical Goals	Psychological Goals

Lifestyle Indicator

Does your child consume any of the following?

Food	None	< 2 Cans/Day	>2 Cans/Day
Soda			
Sweets/Carbs			
White Flour			
Milk/Dairy Products			
Juice			
Meat and Fish			

How much water does your child drink each day? ____

Are there smokers in the child's home? □ Yes □ No

Does your child exercise often? □ Yes □ No How often? □1X □2X □3X □4X □5 per week

Please list any regular exercise or sports that your child participates in:

____

____

Sleep Habits

How well does your child sleep:

□ Well □Trouble falling asleep □ Trouble staying asleep □ Insomnia

Does your child wake up tired? □ No □ Yes

How many hours does your child sleep on an average night? ________________________________

Does your child take naps? □No □ Yes If so, how long and often? ______________________________

Does your child have nightmares? □ No □Yes □Sometimes □Often

FINANCIAL OPTIONS

SLO Wellness Center is a Patient Centered Practice. We provide care based on a patients desire to obtain optimum health. We also offer simple solutions for understanding and using your insurance benefits. Please follow the flow chart below to understand more about your specific insurance benefits.

INSURANCE	
In Network Insurance	**Out of Network Insurance**

In Network Insurance	Out of Network Insurance
Blue Shield PPO United Health Care Multi Plan Marian (dignity health)	*Blue Cross Aetna Cigna Health Net Medicare All HMO Plans & Blue Shield ASHP

As a courtesy we will bill your insurance for your treatment

In Network Insurance	Out of Network Insurance
Deductible: __________ Left: __________ Estimated copay/co-insurance:_________ Visits (Per Year): ________ Estimated Initial Visit: $88 -$125 Estimated Follow up Visit: $52	Deductible:_________ Left:_________ Initial Visit: $150 Follow up visits: $65 Your plan covers:_________________ Visits (per year):_____ *Blue Shield, Blue Cross SISC, PG&E or Anthem plans managed by ASHP allow 5 visits per year
*If your deductible is met, it will be your responsibility to pay your copay or co-insurance at time of service **	*If your plan has out of network benefits, any reimbursement for treatment will come directly to you**

NO INSURANCE	
Initial Visit: $150	**Follow up Visit: $65**
Please inquire about our package rates or family plans and check with your doctor to see what would be the best option for your treatment plan.	

Please initial below:

____ **There is a $5.00 late fee for all unpaid bills over 30 days**

____ **There is a $25.00 fee for missed appointments and those not cancelled 24 hours in advance**

____ **I understand that SWC can bill my insurance as a courtesy and that I am ultimately responsible for my payment of services provided**.

Signature____ Date_____________________

**In order to receive insurance benefits, the member must be covered at the time of service.*

The amounts above are only estimates; we will know the exact amount when we receive the explanation of benefits from your insurance. As quoted by your insurance company, this is not a guarantee of payment or coverage. This information does not pre-authorize payment. Benefits are subject to change. Other terms and limitations may apply even though such provisions are not indicated on your insurance company's web site. All claims are subject to medical review according to the information submitted by the provider of the service and are subject to benefit maximums and other terms of the member's contract. Please refer to the applicable benefit agreements to determine the appropriate payment amounts and any limitations or exclusions. If this is HMO coverage, benefits must be authorized by the member's assigned medical group.

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CONSENT FOR BILLING AND TREATMENT

PLEASE READ CAREFULLY AND INITIAL EACH SECTION

SLO Wellness Center (SWC) is a partnership between Stevens Chiropractic Inc., Sachs Chiropractic Inc., and Casparian Chiropractic Inc. SWC invites you to discuss with us any questions regarding your care and our services.

____ I consent to the performance of chiropractic adjustments and other chiropractic procedures by SWC D.C.'s including: Dr. Molly Stevens, Dr. Rex Stevens. Dr. Sandy Sachs, Dr. Aram Casparian and Dr. David Johnson as well as authorize SWC and whomever they designate to administer treatment as they deem necessary.

____ I authorize my provider(s) and/or managed care organization to release my information to provide other health care providers with information related to my care as well as to process insurance claims.

____ I have read, or have had read to me, the above consent. By signing below I agree to chiropractic services and intend this consent form to cover the entire course of treatment for my present condition(s) and for any further condition(s) for which I seek treatment in this office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand and have been provided with the opportunity to review a Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of SLO Wellness Center health care operations. The Notice of Privacy Practices also describes my rights, SLO Wellness Center duties with respect to my protected health information. The Notice of Privacy Practices is posted by the front desk.

SLO Wellness Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

SLO Wellness Center may need to use my name, address, phone number, and my clinical record to contact me with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to me. If this contact is made by phone and I am not at home, a message will be left on my answering machine. By signing this form, I am giving SLO Wellness Center authorization to contact me with these reminders and information.

Patient Name:_______________________ Patient Signature:_________________________ Date:____________

If patient is under 18 years of age

Legal Guardian Name:_________________ Legal Guardian Signature:___________________ Date:_____________

For Office Use Only

Witness Name (office staff):_____________ Witness Signature:________________________ Date:____________

INFORMED CONSENT FOR CHIROPRACTIC CARE

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PLEASE READ CAREFULLY AND SIGN BELOW

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:________________________ Patient Signature:__________________________ Date:_____________

If patient is under 18 years of age

Legal Guardian Name:_________________ Legal Guardian Signature:___________________ Date:_____________

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