KNIGHT FAMILY CHIROPRACTIC

☐ DURANT, OK	☐ DENISON, TX	☐ SHERMAN, TX	☐ ANNA, TX
1004 N. 19th Ave., Bldg. 2	3230 S. Eisenhower Pkwy.	2021 N. Heritage Pkwy.	1108 W. White St., Ste 100
Durant, OK 74701	Denison, TX 75020	Sherman, TX 75092	Anna, TX 75409
P: 580.448.4412	P: 903.465.1881	P: 903.892.3471	P: 469.840.4111

PATIENT INFORMATION:

DATE: _____

CHILD'S NAME: _____ DOB: _____

PARENT/GUARDIAN'S NAME: _____

CELL #: _____ CELL CARRIER: _____

ADDRESS: _____

EMAIL ADDRESS: _____

HAS YOUR CHILD HAD PREVIOUS CHIROPRACTIC CARE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DR'S NAME: _____ LAST DATE SEEN: _____

WERE X-RAYS TAKEN? ☐ YES ☐ NO

WHO IS YOUR MEDICAL PEDIATRICIAN? _____

PRENATAL HISTORY:

IS YOUR CHILD ADOPTED? ☐ YES ☐ NO

DID YOU HAVE ANY COMPLICATIONS? ☐ YES ☐ NO IF YES, PLEASE ELABORATE: _____

_____

DID YOU SMOKE? ☐ YES ☐ NO DID YOU CONSUME ALCOHOL? ☐ YES ☐ NO

DID YOU TAKE MEDICATION? ☐ YES ☐ NO REASON FOR MEDICATIONS: _____

_____

BIRTH HISTORY:

DID YOU HAVE AN ULTRASOUND DURING PREGNANCY? ☐ YES ☐ NO

WHAT WAS THE FREQUENCY: _____

PLACE OF BIRTH: ☐ HOME ☐ BIRTHING CENTER ☐ HOSPITAL

PROVIDER: ☐MIDWIFE ☐OB/GYN ☐ OTHER _____

TYPE OF BIRTH: ☐VAGINAL ☐ C-SECTION

WERE PAIN MEDICATIONS USED? ☐ YES ☐ NO EPIDURAL? ☐ YES ☐ NO

WAS LABOR INDUCED? ☐ YES ☐ NO IF YES, WHY: _____

WHAT POSITION DID YOU DELIVER IN? ☐SQUATTING ☐ ON BACK ☐ OTHER _____

BIRTH TRAUMA? ☐ DOCTOR ASSISTED ☐ TWISTING &/OR PULLING ☐VACUUM EXTRACTION
☐ FORCEPS ☐ CORD AROUND NECK

NEWBORN TRAUMA (MEDICAL PROCEDURES & TESTS):

APGAR SCORE: BIRTH ____/10 5-MINS ____/10 ☐ UNSURE

DID YOUR CHILD HAVE A MISSHAPEN SKULL/HEAD? ☐ YES ☐ NO

WERE THERE PURPLE MARKINGS ON THEIR FACE? ☐ YES ☐ NO

DID YOU BREAST FEED YOUR CHILD? ☐ YES ☐ NO

DOES YOUR CHILD PREFER ONE BREAST OVER THE OTHER? ☐ YES ☐ NO

IF YES, WHICH SIDE: ☐ RIGHT ☐ LEFT

DOES YOUR CHILD HAVE FOOD ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE LIST: _____

HAS YOUR CHILD BEEN IMMUNIZED? ☐ YES ☐ NO

REASON FOR VACCINATION? ☐ INFORMED CONSENT ☐ RECOMMENDED ☐ DIDN'T KNOW I HAD A CHOICE

DID YOUR CHILD HAVE ANY ADVERSE REACTIONS TO THE VACCINATIONS? ☐ YES ☐ NO

WERE THEY REPORTED? ☐ YES ☐ NO

HAS YOUR CHILD EVER HAD ANY SURGERIES? ☐ YES ☐ NO

IF YES, PLEASE ELABORATE: _____

HAS YOUR CHILD BEEN ON ANTIBIOTICS? ☐ YES ☐ NO

IF YES, HOW OFTEN & FOR WHAT? _____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? ☐ YES ☐ NO IF YES, WHAT: _____

IS YOUR CHILD CURRENTLY TAKING ANY VITAMINS? ☐ YES ☐ NO IF YES, WHAT: _____

BABY/TODDLER (0-4):

HAVE ANY OF THE FOLLOWING OCCURRED?

☐ FALL FROM A CHANGING TABLE	☐ FREQUENT CRYING SPELLS	☐ TUMBLE DOWNSTAIRS
☐ CAR ACCIDENT	☐ FALL OUT OF A CRIB	☐ FALL OFF PLAYGROUND EQUIPMENT
☐ PLAY IN A JOHNY JUMPER	☐ FREQUENT EAR INFECTIONS	☐ TONSILLITIS
☐ REACTION TO VACCINES	☐ FREQUENT FEVERS	☐ FREQUENT DIARRHEA
☐ CONSTIPATION	☐ SLEEPING PROBLEMS	☐ REPEATED INFECTIONS (IE: STREP)
☐ COLIC	☐ (+ OR -) WEIGHT GAIN	☐ LATCHING/BREAST FEEDING DIFFICULTY

☐ OTHER (PLEASE EXPLAIN)_____

CHILD (5-12):

HAVE ANY OF THE FOLLOWING OCCURRED?

☐ FALL FROM A TREE	☐ FALL OFF A BICYCLE	☐ SPORTS ACCIDENT/INJURY
☐ CAR ACCIDENT	☐ STOMACH PAINS	☐ FALL OFF PLAYGROUND EQUIPMENT
☐ BED WETTING	☐ HYPERACTIVITY/AUTISM	☐ SCOLIOSIS
☐ LEARNING DIFFICULTIES	☐ ASTHMA	☐ ALLERGIES
☐ LEG/KNEE PAINS	☐ OTHER (PLEASE EXPLAIN) _____	

_____

ALL AGES:

WHICH OF THE ABOVE BOTHERS YOUR CHILD THE MOST? _____

WHEN DID IT BEGIN? _____

IS IT GETTING WORSE? ☐ YES ☐ NO

IS THE PAIN: ☐ CONSTANT ☐ INTERMITTENT ☐CYCLIC

AFFECT ON ACTIVITY: ☐ NOT AT ALL ☐ SOMEWHAT ☐ ALWAYS

DOES YOUR CHILD PARTICIPATE IN ANY OF THE FOLLOWING?

☐ SOCCER	☐ FOOTBALL	☐ GYMNASTICS	☐KARATE
☐ HOCKEY	☐ LACROSSE	☐ BASKETBALL	☐ DANCE
☐ WRESTLING	☐ BASEBALL/SOFTBALL	☐ VOLLEYBALL	☐ TENNIS
☐ SWIMMING	☐ RUGBY	☐ OTHER: _____	

HOW WOULD YOU RATE YOUR CHILD'S DIET? ☐ WELL BALANCED ☐ AVERAGE ☐ HIGH SUGAR/PROCESSED FOODS

DOES YOUR CHILD COMSUME ARTIFICIAL SWEETNERS? ☐ YES ☐ NO

FLOURIDATED WATER? ☐ YES ☐ NO

NUMBER OF HOURS YOUR CHILD SLEEPS? _____ PER DAY

SLEEP QUALITY? ☐ GOOD ☐ FAIR ☐ POOR

AUTHORIZATION TO TREAT A MINOR

I, _____, THE UNDERSIGNING PARENT/GUARDIAN HAVING LEGAL CUSTODY/GUARDIANSHIP OF _____, A MINOR, DO HEREBY AUTHORIZE, REQUEST AND DIRECT KNIGHT FAMILY CHIROPRACTIC AND WHOMEVER THEY MAY DESIGNATE AS AN ASSISTANT TO PERFORM IN JUDGEMENT ANY EXAMINATION AND CHIROPRACTIC DIAGNOSIS OR TREATMENT WHICH IS DEEMED NECESSARY.

ANY SPECIFIC WRITTEN AUTHORIZATION YOU PROVIDE MAY BE REVOKED AT ANY TIME BY WRITING TO OUR OFFICE.

PATIENT: _____ SIGNATURE: _____

PRINT NAME PARENT/LEGAL GUARDIAN

DATE: _____

Knight Family Chiropractic
FINANCIAL POLICY

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'll 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

We request that 100% of the first visit be paid at the time of the visit. For future visits, we will discuss payment options to make your chiropractic care affordable.

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.** 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 of any non-covered services, deductibles or co-pays.** You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay/Personal Injury Protection portion of your auto insurance.
3. We will accept a Letter of Protection from an Approved attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred if they accept liability.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for 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 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.

MANAGED CARE PLANS

We are preferred providers for the most insurance companies. Some plans require you to pay a co-pay at the time of service. Other plans may have a deductible amount to be met first. After the deductible is satisfied, you and your insurance company will share a percentage of the cost that varies from plan to plan. A referral from your primary care physician may also be necessary. Out of network benefits are usually available if a referral is not obtained.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

CREDIT CARD GUARANTEE/ELECTRONIC DEBIT
ALL patients with ALL types of cases (Patients without Insurance, Group or Individual Insurance, Personal Injury & Medicare) are required to have a Credit Card Guarantee and/or an Authorization for Electronic Debit on file.

FINANCING OPTIONS
Our clinic works hard to give you affordable care that has been recommended to you. We offer the following financing options: *Care Credit*, *HealthCare Payment Solutions/Cleargage*.

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 you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Knight Family Chiropractic**. I understand that my insurance is an arrangement between me and my insurance company, and NOT between Knight Family Chiropractic and my insurance company.** I request that Knight Family 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 Knight Family Chiropractic that fees will be due and payable immediately.

_____ _____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR
PRIVATE/GROUP ACCIDENT AND HEALTH INSURANCE

Patient:_____

Insured SS#/ID#_____

Claim/Group #:_____

I hereby instruct and direct the payment of all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy to:

Knight Family Chiropractic

as payment for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Ryan L. Knight, D.C.
Knight Family Chiropractic
3230 S. Eisenhower Parkway
Denison, Texas 75020

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at _____ this _____ day of _____,_____

_____ _____
Insured Witness