A BETTER LIFE CHIROPRACTIC

Pediatric Entrance Form

Welcome to our practice! Please complete all questions for your child. Thank You.

Patient Name:_____ Date:_____ SS#: _____

Date of Birth: _____ Age: _____ ❒ Boy ❒ Girl

Local Address: _____

Telephone (h)_____/(c)_____ Email:_____

How were you referred to our office?_____

Parent/Guardian: Name & Address _____

_____ Parent SS # _____

Who is financially responsible for this bill? _____

Method of Payment: ❒ Cash ❒ Credit Card ❒ Health Insurance

Birth History: ❒ C-Section ❒ Vaginal ❒ Traumatic ❒ Non-Traumatic

❒ Forceps ❒Vacuum ❒ Premature ❒ Full Term

Complications : _____

_____ Birth Weight: _____

Has the patient ever had any Traumas _____ Slips/Falls _____

Automobile Accidents _____ Fractures _____

Health Conditions (current or in the past):

❒ Chronic Ear Infections	❒ Frequent Cold/Flu	❒ Sinus Problems
❒ Allergies	❒ Asthma	❒ Neck Pain
❒ Headaches	❒ Colic	❒ Mid Back Pain
❒ Diarrhea	❒ ADD/ADHD	❒ Low Back Pain
❒ Poor Appetite	❒ ADHD	❒ Bedwetting
❒ Digestive Problems	❒ Behavioral Problems	❒ Irritability
❒ Constipation	❒ Scoliosis	❒ Recurring Fevers
❒ Seizures	❒ Temper Tantrums	❒ Growing Pains

Childhood Diseases: ❒ Chicken Pox ❒ Measles ❒ Mumps ❒ Whooping Cough ❒ Rubella

CONFIDENTIAL: Has the patient ever been diagnosed with: ❒ HIV ❒ Hepatitis ❒ Tuberculosis

Has he/she ever been seen on an emergency basis? _____

Please list all surgeries: _____

VACCINATIONS:

Has the child been fully vaccinated? ❒ Yes ❒ No

When was the last shot given? _____ Which One: _____

Adverse reactions (ie: fever, chills, irritability, flu like symptoms, hearing loss, neurological problems, or other?)

_____

In case of emergency, please notify:_____ _____
Name/Relation Telephone Number

3 SIGNATURES FOLLOW:

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize A BETTER LIFE CHIROPRACTIC to administer treatment as they so deem necessary to my

❒ Son ❒ Daughter ❒ Ward Named: _____

x _____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____
PRINTED NAME OF PARENT OR LEGAL GUARDIAN

All first visit charges are payable when services are rendered.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand A BETTER LIFE CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to A BETTER LIFE CHIROPRACTIC will be certified upon receipt. HOWEVER, I clearly understand and agree that I am personally responsible for payment. Interest in the amount of 18% per annual or 1.5% per month will be charged on your account if it becomes past due.

x_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

_____
PRINTED NAME OF PARENT OR LEGAL GUARDIAN

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I_____HAVE READ A COPY OF **PATIENT NOTICE OF PRIVACY PRACTICES.** *(A Copy of A BETTER LIFE CHIROPRACTIC Notice of Privacy Practices included in this package of new patient intake forms)*

x_____ _____
SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

***Doctor* Signature**: _____ Date: _____

HEALTH HISTORY

Check the following conditions that apply (past/present). Please add your comments to clarify the condition.

Musculo-Skeletal

__ *Neck Pain*
__ Shoulder/Arm/Hand Pain
__ Headaches/ Migraines
__ Jaw Pain/TMJ
__ *Mid Back Pain*
__ Chest/Rib/Abdominal Pain
__ *Low Back Pain*
__ Hip Pain
__ Sciatic Pain
__ Leg/foot pain
__ Problems Walking
__ Joint Stiffness/Swelling
__ Spasms/Cramps
__ Broken/Fractured bones
__ Strains/Sprains
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Bone or Joint Disease
__ Other: _____

Circulatory and Respiratory

__ Dizziness
__ Shortness of Breath
__ Fainting
__ Cold Feet or Hands
__ Cold Sweats
__ Swollen Ankles
__ Pressure Sores
__ Varicose Veins
__ Blood Clots
__ Stroke
__ Heart Condition
__ Allergies
__ Sinus Problems
__ Asthma
__ High Blood Pressure
__ Low Blood Pressure
__ Lymphedema
__ Other: _____

Digestive

__ Nervous Stomach
__ Indigestion
__ Constipation
__ Intestinal Gas/Bleeding
__ Diahrrhea
__ Diverticulitis
__ Irritable Bowel Syndrome
__ Crohn's Disease
__ Colitis
__ Adaptive Aids
__ Other: _____

Nervous System

__ Numbness/Tingling
__ Twitching of Face
__ Fatigue
__ Chronic Pain
__ Sleep Disorders
__ Ulcers
__ Paralysis
__ Epilepsy
__ Chronic Fatigue Syndrome
__ Multiple Sclerosis
__ Parkinson's Disease
__ Spinal Cord Injury
__ Other: _____

Skin

__ Rashes
__ Allergies
__ Athlete's Foot
__ Warts
__ Moles
__ Acne
__ Cosmetic Surgery
__ Other: _____

Reproductive System

__ Pregnancy:
___ Current _____ Previous

Date of Last Menstrual Cycle:

_____/_____/_____

__ PMS
__ Menopause
__ Pelvic Inflammatory Disease
__ Endometriosis
__ Hysterectomy
__ Fertility Concerns
__ Prostate Concerns

Other

__ Loss of Appetite
__ Forgetfulness
__ Confusion
__ Depression
__ Difficulty Concentrating
__ Drug Use _____
__ Alcohol Use _____
__ Nicotine Use _____
__ Caffeine Use _____
__ Hearing Impaired
__ Visually Impaired
__ Burning upon Urination
__ Bladder Infection
__ Eating Disorder
__ Diabetes
__ Fibromyalgia
__ Post/Polio Syndrome
__ Cancer
Type: _____
Date Diagnosed _____

Infectious Disease (Confidential)

__ HIV __ TB __ Hepatitis

Other congenitial or acquired disease: _____

Surgeries:_____

_____

Please list any additional comments regarding your health and well-being: _____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Patient Signature: _____ Date: _____

***Doctor* Signature**: _____ Date: _____

A BETTER LIFE CHIROPRACTIC
661 Goodlette Road North; Suite 108; Naples, FL 34109
Tel (239)263-3369 Fax (239) 263-8842

Dr. Deanna Barbaro
Chiropractor

TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those for findings, we will recommend that you seek the services of all health care providers who specializes in that area.

Chiropractic has only one goal. It is important that each patient understand both the *objective* and the *method* that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

_____ _____
Signature Date

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Deanna Barbaro of A Better Life Chiropractic to use and disclose **PROTECTED HEALTH INFORMATION (PHI)** about me to carry out **TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).**
I have the right to review the Notice of Privacy Practices prior to signing this consent. A Better Life Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Deanna Barbaro, A Better Life Chiropractic, 661 Goodlette Road North, Suite 108; Naples, FL 34102 or send an email to cris@ablchiro.com.
With this consent, A Better Life Chiropractic **may call me, may email me, may mail** my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

By signing this form, I am consenting to A Better Life Chiropractic's use and disclosure of my Protected Health Information (PHO) to carry out Treatment, Payment and Health care operations (TPO).
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, A Better Life Chiropractic may decline to provide treatment to me.**

_____ _____
Signature of Patient or Legal Guardian Date

A BETTER LIFE CHIROPRACTIC
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Dr. Deanna Barbaro
Chiropractor

INSURANCE PATIENTS

**** PLEASE NOTE ****

While our office makes every effort to obtain coverage information, unfortunately, we cannot guarantee that your insurance will pay benefits. This is due to the fact that insurance companies NEVER guarantee benefits until they review the file.

This office does discount the PPO "contracted discounted amount" from the final payable patient portion.

However, we are not responsible for disputed amounts which fall outside the contracted PPO allowed amount.

Please realize it is the responsibility of each patient to contact his/her employer or benefits office for details of personal coverage. While we do make every effort to ensure your benefits, insurance coverage disputes are not the responsibility of our office.

Insurance coverage is a contract between the patient and the insurance company. All charges incurred are the responsibility of the patient.

Please review your Explanation of Benefits received from insurance to review payment on services.

Signature: _____ Date: _____

Please only fill out the highlighted areas

A Better Life Chiropractic
661 Goodlette Rd N #108
Naples, FL 34102
(239) 263-3369

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

A BETTER LIFE CHIROPRACTIC
661 Goodlette Road North; Suite 108; Naples, FL 34109
Tel (239)263-3369 Fax (239) 263-8842

Dr. Deanna Barbaro
Chiropractor

Dear Patients:

Massage therapy is a separate entity within our office. A minimum of 24 hours advanced cancellation is required. If notification is not received within this time period, you will be responsible for fees charged to our office.

Full massage session fees will apply if you are late for your appointment.

No future massage appointments will be scheduled if you have an outstanding bill for massage fees.

I understand the above stated massage cancellation policy:

Signature: _____

Print Name: _____

Date: _____

MASSAGE THERAPY CLIENT WAIVER *Client Name* _____

I do hereby consent to having Massage Therapy performed by the therapists of A Better Life Chiropractic, Dr. Deanna Barbaro. I understand treatment may include *various massage techniques* involving movements of joints and soft tissues. I am aware that it is common to experience *muscle soreness* within the first few treatments. I do understand that underlying pathology, perhaps unknown to me or the therapist may render me more susceptible to injury. I further understand that **I will inform the therapist if any unusual physical discomfort occurs during or after treatment.**

I do understand that some of the therapy methods used in the office generate *heat*, such as hot stones, hot towels, hot shells and can rarely cause burn. **During treatment I will inform the therapist my level of temperature comfort to avoid burns.** I freely assume any risk on my chosen treatment.

Please initial each statement, then sign and date below:

_____ I understand that massage therapy and bodywork are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.

_____ I understand that the bodywork practitioner does not diagnose illness, disease or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear that massage therapy and bodywork are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.

_____ I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes only, and is not diagnostically prescriptive in nature.

_____ I have stated all of my known medical conditions on the Client Information Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

_____ I realize it is solely my responsibility to keep the bodywork practitioner updated on any changes in my physical health and I understand that **A Better Life Chiropractic and Dr. Deanna Barbaro** shall not be liable should I fail to do so.

_____ I understand that all massage therapy and bodywork offered is strictly non-sexual.

_____ By signing this release, I hereby waive and release **A Better Life Chiropractic** and its staff, massage therapists and bodywork practitioners from any and all liability, past, present and future relating to massage therapy and bodywork.

Treatment Results:

I do understand there are beneficial effects associated with massage therapy including, but not limited to, decrease pain, improved mobility, reduced muscle spasm as well as relaxing effects. However, I do understand that massage therapy is not an exact science and I acknowledge that *no guarantee has been made to me regarding the outcome of this care.* Over all I do agree with the treatment and am responsible for my decision to have massage therapy.

Client Signature _____ Date _____