ATHENS UPPER CERVICAL CHIROPRACTIC

Attached you will find the necessary forms you **must complete** and **bring with you** on your scheduled appointment date. If you cannot fill this form out before your appointment, please arrive 15 minutes early to complete it.
(Please be sure to bring your identification card with you as well.)

**Please DO NOT have any caffeine, sugar, medications (except insulin and other life sustaining medications),
or nicotine, 1-2 hours before your appointment time.
These chemicals can alter the tests that will be performed.**

In the event you are not able to keep your appointment time, we require a minimum of a 24-hour notice of schedule changes. Please call our office as soon as possible so that we may give that appointment to someone on our waiting list. At that time we will gladly reschedule your appointment. We have set aside special times for our new patient appointments, and if you are unable to make it, we can allow another person to fill that appointment.

Thank you for your consideration. If you have any further questions, please contact our office.

Dr. Adam Cave, and the AUCC Team

Contact Information:

Athens Upper Cervical Chiropractic

Phone: 770-271-8505 **Fax:**

Email: info@serenityfloatcenterga.com

3651 Mars Hill Rd, Ste.3200, Watkinsville, GA 30677

www.AthensUCC.com

ATHENS
UPPER CERVICAL
CHIROPRACTIC

Pediatric History Form

PATIENT DEMOGRAPHICS:

Name: _____ Today's Date: _____/_____/_____

DOB: ____-____- ____ Birth Height: _____ Birth Weight: _____ Current Height: _____

Current Weight: _____ Age: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone (Home): _____

Mother's Name: _____ Mother's Mobile #: _____ DOB: ____/____/____

Father's Name: _____ Father's Mobile #: _____ DOB: ____/____/____

Pediatrician/Family MD: _____ City/State: _____

Last Visit: ____/_____/_____ Reason for Visit: _____

Other Pertinent Information (Please Explain): _____

_____

CHILD'S CURRENT HEALTH STATUS:

Purpose for this visit: ❍ Wellness Check-up ❍ Injury or Accident ❍ Other Please Explain: _____

*If your child is experiencing **Pain/Discomfort please identify where and for how long:*** _____

1. When did the problem first begin? Date: ___/___/___ ❍ Unknown ❍ Gradual ❍ Sudden

2. Ever had this problem before? ❍ No ❍ Yes If yes, when? _____

_____

3. Any bowel or bladder problems since this problem began? If yes, describe: _____

4. Have you seen any other doctors for this problem? ❍ No ❍ Yes If yes, who? _____

_____

5. How long ago? _____Days _____ Weeks _____Months _____ Years

6. What were the results of the past treatment? _____

7. How is this problem ***NOW***: ❍ Rapidly Improving ❍ Improving Slowly ❍ About the Same ❍ Gradually Worsening ❍ On & Off

8. Please list any medication taken for this problem: _____

9. Has your child ever sustained an injury playing organized sports? ❍ Yes ❍ No If yes, please describe: _____

_____

10. Has your child ever sustained an injury in an auto accident? ❍ Yes ❍ No If yes, please describe: _____

_____

ATHENS UPPER CERVICAL CHIROPRACTIC

HAS YOUR CHILD EVER SUFFERED FROM: (Check all that apply)

___ Headaches	___ Orthopedic Problems	___ Digestive Disorder	___ Behavioral Issues
___ Dizziness	___ Neck Problems	___ Poor Appetite	___ ADD/ADHD
___ Fainting	___ Arm Problems	___ Stomach Aches	___ Autism
___ Seizures/ Convulsions	___ Leg Problems	___ Reflux	___ Asperger's
___ Heart Trouble	___ Joint Problems	___ Constipation	___ Growing Pains
___ Chronic Aches	___ Backaches	___ Diarrhea	___ Allergies
___ Sinus Trouble	___ Poor Posture	___ Hypertension	___ Asthma
___ Scoliosis	___ Anemia	___ Colds/Flu	___ Walking Trouble
___ Bed Wetting	___ Colic	___ Broken Bones	___ Sleeping Problems
___ Breastfeeding Problems	___ Fall from crib/bed	___ Fall from couch	___ Fall off swing
___ Birth Trauma	___ Fall from high chair	___ Fall from slide	___ Fall down stairs
___ Fall from changing table	___ Fall from jungle gym	___ Fall off skates/board	___ Other: _____

BIRTH EXPERIENCE:

Normal/Natural Birth? ❍Yes ❍ No If No, please explain: _____

_____

Medical Intervention: ❍ None ❍ C-Section ❍ Epidural ❍ Forceps

❍ Vacuum ❍ Other: _____

Birth Trauma? ❍Yes ❍ No If No, please explain: _____

Vaccine Schedule: ❍ None ❍ Delayed Schedule ❍ Full Schedule Up to Date

Any complications from immunization? _____

I understand that I am directly and fully responsible to Athens Upper Cervical Chiropractic, for all fees associated with chiropractic care my child receives.

The risks associated with exposure to ionization and spinal adjustments have been explained to me to complete satisfaction, and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby request and authorize imaging studies and chiropractic adjustments for the benefit of my minor child for whom I have the legal right to select and authorize health care services on behalf of.

❍ Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or guardian is not required. If my authority to so select and authorize this care should change in any way, I will immediately notify this office.

_____ _____/_____/_____

Parent or Legal Guardian's Signature Date

3651 Mars Hill Rd. Ste.3200 Watkinsville, GA 30677 - 770-271-8505 - info@serenityfloatcenterga.com

For Office Use Only

1)_____

_____

_____

2)_____

_____

_____

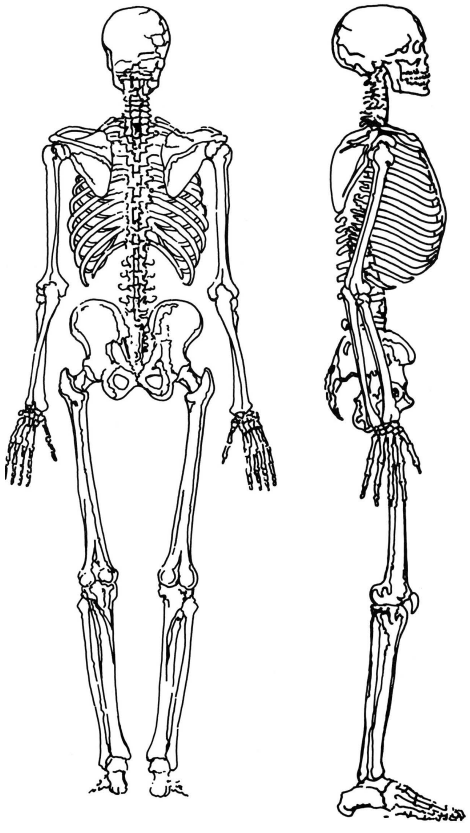
3)_____

_____

_____

Objective:

B/L Weight Scales L:_____ R:_____



X-Ray Consent

During your examination, the doctor may feel that x-rays will be needed. In order to perform x-rays on any patient, our office requires the patients consent for such tests.

Patient Consent to X-Ray

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests and x-rays.

_____ _____

Patient Signature (or Parent/Guardian) Date

Females Only: Regarding Possibility of Pregnancy

I understand that x-rays may be needed at some point and that by signature on this form, I do hereby state that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this particular time. If determined at a later date that I am pregnant, I do not hold the doctor, this establishment or anyone associated with this establishment accountable in any way.

_____ _____

Patient Signature (or Parent/Guardian) Date

Consent For Treatment of Minors

I (We) being parent, guardian or custodian of _____, a minor the age of _____, do hereby authorize, request and direct Dr. _____ to perform any exam, x-ray and chiropractic treatment for their condition as he deems necessary.

_____ _____

Parent, Guardian or Custodian Date

_____ _____

Parent, Guardian or Custodian Date

Financial Policy

1. All patients are on direct-pay status within the office. A valid credit card must be on file for patient care payments and incidents.

2. The Doctor will give you an estimate of the fees for service before they are performed or rendered.

7. This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.

8. Any services not covered or coverage reduction by your insurance will be the patient's responsibility.

11. If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, unless other arrangements are agree upon.

13. This office accepts all major Credit Cards, most Health Savings Accounts, Cash and Personal Checks.

14. Patient understands that if they wish to stop care prior to utilizing all credits, client's account credit will be returned for any unused services (at the un-discounted rate). Any balance that remains is due immediately unless another payment arrangement is made.

I have read and understand the Financial Office Policy and agree to abide by these terms.

_____ _____

Patient (Parent/Guardian) Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

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, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs 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. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

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.

Parent or Guardian: _____ Signature: _____ Date: _____

CANCELLATION & NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if a cancellation is necessary, you provide more than 24-hour notice. This will enable a person on the wait list to be scheduled in that appointment slot.

Cancellations made with less than 24-hour notice are subject to a $50.00 cancellation fee, which is not applied towards your care plan. Patients who do not show up to their appointment will be considered a NO SHOW and will be subject to a $50.00 fee.

The Cancellation and No Show fees are the sole responsibility of the patient and will be charged to the credit card on file.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. In this instance, fees are subject to review by management and may be waived.

Athens Upper Cervical Chiropractic firmly believes that a good doctor/patient relationship is based upon clear communication. Thank you for your understanding and cooperation.

Parent or Guardian: _____ Signature: _____ Date: _____