Yarmouth Spinal Care

Cancellation & Missed Appointment Policy

The treatment that is planned for you is specific to you. It is important of you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three people the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

Therefore, we ask for at least 24 hour advance notice for cancelling or rescheduling an appointment, otherwise a $50 fee will be assessed to your account. If you are 20 minutes late to your scheduled appointment your account will be charged a $50 fee.

*All broken and cancelled appointment fees must be paid prior to scheduling another appointment.

I have read and fully understand the information provided

Patient print name:_____

Patient signature: _____Date_____

Thank you for *NOT* using perfume, cologne or scented products!

Please refrain from using these before your appointment

Many of our practice members have severe allergic reactions to scented products.

Thank you for your consideration

PEDIATRIC HISTORY FORM

Patient Name: _____ S.S.# _____
Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____
Birth Date: ____/_____/_____ Work Phone: _____ Mother / Father
Sex: _____ Weight: _____ Height: _____ Referred By: _____
Names of Parents/Guardians: _____
Purpose For Contacting Us? _____
Other Doctors seen for this condition _____N _____Y. Doctor's Names and Prior Treatments: _____
_____
Other Health Problems? _____
Check any of the following conditions your child has suffered from during the past six months:

[] Ear Infections	[] Scoliosis	[] Seizures	[] Chronic Colds	[] Headaches
[] Asthma/Allergies	[] Digestive Problems	[] ADHD	[] Recurring Fevers	[] Colic
[] Growing/Back Pains	[] Bed Wetting	[] Car Accident	[] Temper Tantrums	

[] Other: _____
Family History: _____
Previous Chiropractor: _____
Date of Last Visit: _____/_____/_____ Reason: _____

Name of Pediatrician: _____
Date of Last Visit: _____/_____/_____ Reason: _____

Number of doses of Antibiotics your child has taken:
During the past six months: _____. Total during his/her life _____

Number of doses of Other prescription medications your child has taken:
During the past six months: _____ Total during his/her life _____. List: _____
_____

Prenatal History:
Name of Obstetrician/ Midwife: _____
Complications during pregnancy? ____N ____Y, List _____
Ultrasounds during pregnancy? _____N ____Y, Number _____
Medications during pregnancy/Delivery? (i.e. epideral) ____N ___Y, List _____
Cigarette/Alcohol use during Pregnancy? ____N _____Y

Birth History:
Location of the Birth: _____Hospital _____Birthing Center _____Home
Birth intervention: _____Forceps _____Vacuum Extraction _____C-Section _____
Complications during delivery? ____N ____Y, List: _____
Genetic Disorders or disabilities: ___N ____Y, List: _____
Birth weight: _____ Birth length: _____ APGAR Score: _____/_____

Feeding History:
Breast Fed: _____N _____Y, How Long? _____
Formula Fed: ____N _____Y, How Long? _____
Introduced Solids at: _____Months, Cow's Milk at _____Months
Food/Juice allergies or intolerances: _____N _____Y, List: _____

Developmental History:

During the following times your child's spine is most vulnerable to stress and should routinely be checked by a Doctor of Chiropractic for the prevention and early detection of Vertebral Subluxations (spinal nerve pressure). At what age was your child able to:

_____Respond to Sound
_____Respond to Visual Stimuli
_____Hold Head Up
_____Sit up
_____Cross Crawl
_____Stand Alone
_____Walk Alone

According to the National Safety Council, Approximately 50% of children fall head first from a high place during their first year of life (i.e. a bed, changing table, down stairs, etc.) was this the case with your child?
_____N_____Y

Is/has your child been involved in any high impact or contact sports (i.e. soccer, football, gymnastics, cheerleading, martial arts, baseball, etc.)?_____N_____Y, List:_____

Has your child ever been involved in a car accident?_____N_____Y, List:_____
Other traumas not described above?_____N_____Y, List:_____
Prior Surgery:_____N_____Y, List:_____
Menarche:_____N_____Y, Age:_____

Childhood Vaccinations:

Polio_____N_____Y
DaPT_____N_____Y
Meningitis__N____Y
Influenza___N____Y
MMR _____N_____Y
Chicken Pox___N_____Y
Hep. B_____N_____Y
Polio_____N_____Y
Hib_____N_____Y
Hep.A____N_____Y

Childhood Diseases:

Chicken Pox N/Y, age_____
Rubella N/Y, age_____
Rubeola N/Y, age_____
Mumps N/Y, age_____
Whooping Cough N/Y, age_____
Other:_____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Back Cove Family Chiropractic, Inc. and Dr. Scott Glocke to administer care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company:_____Policy #_____

Signed:_____Date:_____Witness:_____

Informed Consent to 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, 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: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

YARMOUTH SPINAL CARE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able 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.

Health: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

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 its maximum health potential.

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

Regardless of what the 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. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
(Signature) (Date)

X-Ray Release (signature required)

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

_____ _____
(Signature) (Date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) (Date)

Patient Consent For Use & Disclosure Of Protected Health Information

With my consent, Yarmouth Spinal Care (YSC) may use and disclose protected health information (PHI) to carry out treatment, payment and healthcare options (TPO). Please refer to Yarmouth Spinal Care Notice of Privacy for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. YSC reserves the right to revise its Notice of Privacy Rights at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to YSC. With my consent, YSC may call my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my chiropractic care. With my consent, YSC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. By signing this form, I am consenting to YSC's use and disclosure of my PHI to carry out 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, YSC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Authorization To Pay Doctor/Clinic

I hereby authorize and direct payment of any medical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photo static copy of this agreement shall serve as the original.

Signature

Date

Authorization to Pay/Release Is Granted to:

Yarmouth Spinal Care

APPOINTMENT REMINDERS and COMMUNICATION

I hereby consent and state my preference to have my physician, Dr. Scott Glocke, and other staff at YSC communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number_____

Email_____

Text_____

I give permission to contact me, relative to appointment reminders only, by the following methods:

Phone message at the following number_____

Email messages at the following email address_____

Text messages at the following phone number_____