Great Choice Chiropractic

15810 S. 45th St. Suite 160
Ahwatukee, AZ 85048

Patient Information Sheet

(All information you provide is confidential)

CHILD INFORMATION

Today's Date: ____/____/____ Age:________ Date of Birth:____/____/____
Name:__________________ ☐Female ☐Male Social Security #:____-____-____
(For insurance purposes)
Address:__________________ City:__________ State:_____ Zip:______
Have you ever been to a Chiropractor? ☐Yes ☐No When?________ Were X-rays taken?: ☐Yes ☐No
How were you referred to Dr. Greg Hauser?__________________

PARENT INFORMATION

Name:__________________ Relationship to child:__________________
Home:(____)__________ Cell:(____)__________ Work:(____)__________
Smoker: ☐Mother ☐Father ☐Neither Any relevant family history:__________

CURRENT HEALTH CONDITION

Do you (Child) suffer from, or have you recently suffered from any of the following:

☐ADD or ADHD	☐Diarrhea	☐Learning Disorders
☐Allergies	☐Ear Infections	☐Night Terrors, Seizures
☐Asthma	☐Emotional Disorders	☐Repeated Infections or Colds
☐Bed wetting	☐Frequent colds / flu	☐Scoliosis
☐Change in bowel / urinary habits	☐Growing, Back or Neck Pains	☐Sleeping difficulty
☐Colic	☐Headaches	☐Tantrums
☐Constipation	☐Irritability	Other:

Other doctors / professionals seen for these conditions:__________________
Who is your regular pediatrician?:__________________ Last Check-Up:__________
Has your child been vaccinated?: ☐Yes ☐No Which vaccines?__________
How often has your child been treated with drugs?(Other than vaccines):__________
How many rounds of antibiotics has your child taken in the last 6 months?:________ Lifetime?:______
Is your child currently on any medications?: ☐Yes ☐No Please list:__________

TRAUMA (other than birth)

☐Learning to walk (especially head impacts) ☐Involved in Motor vehicle accident (Passenger)
☐Falls (i.e. bike, down stairs, from tree, sports, etc.) ☐Broken bones Please list:__________
Any surgeries?: ☐Yes ☐No Please list:__________________

BIRTH PROCESS

Traumas at birth: ☐Natural ☐Cesarean ☐Induced ☐Doctor intervention (Forceps / Vacuum Etc.) ☐ Premature
How long was the labor?:____Hours ☐Drugs used Please list:__________
Describe any other complications (during or after delivery):__________________

____

Breast feed: ☐Yes ☐No How long?____ Months Reason for stopping:__________

Notice of Privacy Practices for Protected Health Information

Great Choice Chiropractic has my permission to discuss my: case history, payment history / schedule, and appointment scheduling with the following individuals:

Name:________________________________ Relationship to Patient:__________________________

Name:________________________________ Relationship to Patient:__________________________

Name:________________________________ Relationship to Patient:__________________________

Name:________________________________ Relationship to Patient:__________________________

This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have read and understand ***Notice of Privacy Practices for Protected Health Information***.

____
Patient Printed Name

____
Date

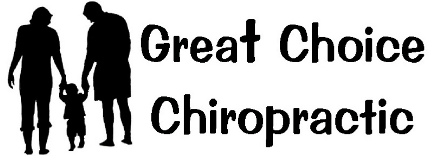
____
Patient Signature

____
Authorized Provider Representative

____
Personal Representative Printed

____
Personal Representative Signature

____
Description of Personal Representative’s Authority to Act for the Patient.



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(480) 704-6600

Informed Consent Form

I, ________________________________ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Greg Hauser, D.C., F.I.C.P.A. and **Great Choice Chiropractic.**

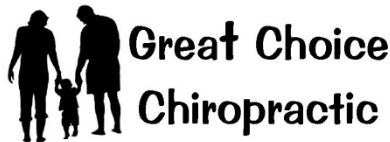
I have had an opportunity to discuss with the doctor and the clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that neither the practice of chiropractic nor medicine is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results had been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care including, but not limited to, fractures, disc injuries, stroke, dislocations, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read or have had explained to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Patient Signature:____ Date:______________

Patient name (print):______________________________________



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Service Fee Schedule and Financial Policy

Service	Regular Fee	Time of Service Discounted Fee
Initial Consultation	No charge	No charge
Initial Exam with Computer Scans	$110-225	$60-175
X-Rays (per view)	$30- 55 per view	$30-55 per series
Reporting of Doctor's Findings	$50-80	$50
Periodic Dynamic Exam	$60	$40
Adjustment	$55-95	$55
Therapeutic / Rehabilitative Services	$30-40 per service	$30-40 per visit
Individual Lifestyle Adjustment Plans	Not applicable	$50 - $200 per month
Family Lifestyle Adjustments Plans	Not applicable	$100+ per month

Financial Policy and Chiropractic Active Life Plans

We are committed to providing you with the best Chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your care at the time the service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible. They include Corrective Adjustment Plans (CAP) and Lifestyle Adjustment Plans (LAP). Details of these plans will be discussed with you during your Chiropractic report. **Please read and initial both of the following fee options:**

_____Regular Fees: If you have health insurance that covers Chiropractic and choose to use it, you will be charged the regular fees listed above. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. Any and all insurance payments sent to you and accompanying paperwork will be brought to our office for proper processing of claims and distribution of funds.

_____Time of Service Discounted Fees: If you do not have health insurance, choose not to use your health insurance, or are participating in a Lifestyle Adjustment Plan, you will be eligible for the Time of Service Discounted Fees above. You may request a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for Chiropractic care during the year. There is no insurance documentation given with these receipts.

If a special situation arises, such as an auto accident or a worker's compensation injury, you will be charged our regular fees until the claim is settled. We will help you get reimbursed as quickly as possible on these claims. Once the claim is complete, you can begin to pay the discounted fees again.

*Please note that all "health insurance" coverage (including Medicare) is NOT allowed to be used for Lifestyle Adjustment Plans (see your insurance contract for details).

Regardless of the financial arrangements or method of payment, it is **Great Choice Chiropractic's policy to **collect only $79 on the first visit**, which will be applied toward the balance of the first visit charges.

_________________________________ _____________________

Patient signature Date