Champion Chiropractic and Wellness Center, Inc.
Pediatric Registration Form - *Birth to Age 12*

Dear New Patient,
It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Information

Date: _____

Patient Name: _____ _____ _____
Last First Middle Initial

Address: _____
Street Address City State Zip Code

Sex: Male ( ) Female ( ) Date of Birth: _____ Social Security Number: _____

Name(s) of Parents/Guardians: _____

Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____

Referred by: _____

Purpose for contacting us? _____
If your child is experiencing pain, is it: Sharp ___ Dull ___ Travels ___ Constant Comes and Goes ___
Since the issue started it is: About the Same ___ Getting Better ___ Getting Worse ___
What makes it worse? _____
What makes it better? _____
Is it interfering with: Appetite ___ School ___ Sleep ___ Walking ___ Sitting ___ Standing ___ Running ___ Hobbies ___
Other _____

Have other Doctors been seen for this condition?: Y ___ N ___
If yes, Doctor's Name: _____

Other health problems? _____

Circle any of the following condition your child has suffered from during the past six months:

Torticollis	Ear Infections	Scoliosis	Seizures	Chronic Colds	Chronic Cough
Asthma	Allergies	Digestive Problems	ADD/ADHD	Depression	Recurring Fevers
Growing Pains	Colic	Car Accident	Sports Accident	Rashes	Headaches
Temper Issues	Falls	Bed Wetting	Difficulty Breastfeeding	Sleeping Problems	Mouth Sores

Family History: _____

Previous Chiropractor: _____
Date of Last Visit? _____ Reason: _____
Are you satisfied with the care your child has received there? Y ___ N ___

Name of Pediatrician: _____
Date of Last Visit? _____ Reason: _____
Are you satisfied with the care your child has received there? Y ___ N ___

Number of doses of Antibiotics your child has taken: Last 6 months? _____ Lifetime? _____
List Antibiotics: _____
Number of doses other than Prescription Medication your child has taken: Last 6 months? _____ Lifetime? _____
List prescription Medications: _____

Vaccination History: _____

Prenatal History

Name of Obstetrician/Midwife: _____

Complications During Pregnancy: Y ___ N ___ List: _____

Ultrasounds During Pregnancy: Y ___ N ___ Number: ___ Did you have any falls? Y ___ N ___ When? _____

Were you in a car accident? Y ___ N ___ When? _____ Medications Used During Pregnancy? _____

Did you smoke during pregnancy? Y ___ N ___ Did you drink alcohol during pregnancy? Y ___ N ___ How much? _____

Location of birth? Hospital ___ Birthing Center ___ Home ___ Other _____

Birth and Delivery

Birth Intervention: Forceps ___ Vacuum Extraction ___ Caesarian Section ___ - Emergency ___ or Planned ___

Length of Labor: _____ How long was the delivery? _____

Complications during delivery? Y ___ N ___ List: _____

Genetic disorders or disabilities? Y ___ N ___ List: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Was oxytocin/pitocin used? Y ___ N ___ Was an epidural administered? Y ___ N ___

Feeding History

Breast Fed? Y ___ N ___ How Long? _____ Formula Fed? Y ___ N ___ Low Long? _____

What kind of formula? _____ Introduced to solids at _____ months, cow's milk at _____ months.

Food/Juice allergies or sensitivities? Y ___ N ___ List: _____

Developmental History

During the following times your child's spine is most vulnerable to stress and should be routinely checked by a doctor of chiropractic for prevention and early detection of vertebral subluxation (spinal nerve interference). At what age was your child able to:

Respond to Sound _____ Cross Crawl _____ Hold Head Up _____ Sit Up _____

Respond to Visual Stimuli _____ 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? Y ___ N ___

If yes, when was the fall? _____

Is/has your child been involved in any high impact or contact type sports (i.e., soccer, football, gymnastics, baseball, cheerleading, wrestling, martial arts, etc.)? Y ___ N ___

Has your child ever been involved in a car accident? Y ___ N ___ When? _____

Other traumas not described above? _____

Has the child had surgery? Y ___ N ___ List: _____

Menarche (start of menstrual cycle)? Y ___ N ___ Age: _____

Childhood Diseases:

Chicken Pox ___ Rubella ___ Mumps ___ Measles ___ Flu ___ Other _____

I acknowledge that the statements in this form are accurate, to the best of my recollection, and I request and give consent to this office to examine and administer chiropractic care for my child.

Parent or Guardian Signature: _____ Date: _____

Champion Chiropractic and Wellness Center, Inc.
Confidential Patient Complaint Form

Date: _____

First Name: _____ Last Name: _____

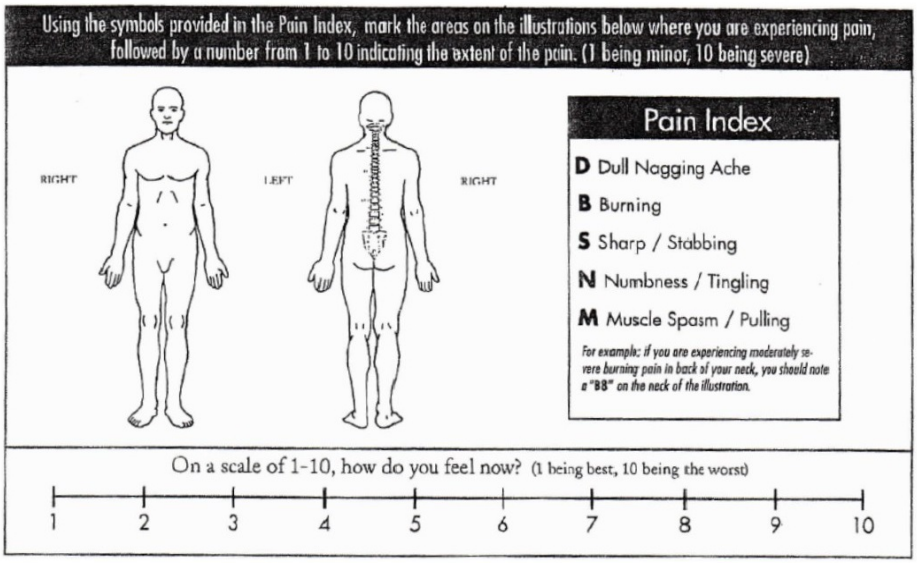
Major Complaint Information

What is your major complaint(s) and specific area(s) of pain? _____

_____

When did this symptom(s) begin? _____

If this is an injury, describe what happened? _____



Have you experienced these symptoms before? Yes ___ No ___ When? _____

What aggravates this condition? _____

What decreases the symptoms/pain? Ice ___ Heat ___ Stretching ___ Nothing ___ Other _____

Have you seen another doctor for this condition? Yes ___ No ___ Doctor's Name: _____

Date consulted: _____ Diagnosis: _____

Does this condition interfere with your sleep? Yes ___ No ___ If so, how many times do you wake up in pain per night? _____

In what position do you sleep? Back ___ Side ___ Stomach ___

Do you sleep with a pillow? Yes ___ No ___ If so, how many? _____

Does heat affect the pain? Yes ___ No ___ If so, how? _____

Does cold affect the pain? Yes ___ No ___ If so, how? _____

Do you wear a heel lift? Yes ___ No ___ If so, which side? Right ___ Left ___

Does it cause pain to cough, grunt, sneeze? Yes ___ No ___ If so, where? _____

Check the activities below that create difficulty or pain:

____ Lying on back	____ Getting in/out of car	____ Pulling	____ Sitting	____ Standing for periods of time
____ Lying on side	____ Dressing self	____ Reaching	____ Bending forward	____ Sneezing
____ Turning over in bed	____ Sexual activity	____ Kneeling	____ Bending backward	____ Coughing
____ Lying on stomach	____ Pushing	____ Stooping	____ Walking	____ Turning head side to side
____ Climbing stairs	____ Balance	____ Gripping	____ Chewing	

Other: _____

Does the pain radiate into the legs? Yes ___ No ___ Right ___ Left ___ Both ___ Does the pain radiate to the abdomen? Yes __ No __

Do you ever have impairment of bowel or urinary function? Yes ___ No ___ Explain: _____

Do you have numbness or tingling into the legs? Yes ___ No ___ Explain: _____

Neck Pain

If you have a neck injury, does it affect: (Check all that apply) Hearing ___ Vision ___ Balance ___ Ringing or vibration in your ears ___
Do you hear grating sounds? Yes ___ No ___ Do you feel pressure in the eyes? Yes ___ No ___
Does pain radiate into the arm? Yes ___ No ___ Right ___ No ___ Both ___
Are you at risk for a stroke? Yes ___ No ___ Don't Know ___
Do you have difficulty lifting or turning your head? Yes ___ No ___ If so, in which direction? Right ___ Left ___ Up ___ Down ___

Headaches / Migraines

Do you get headaches? Yes ___ No ___ Frequency: _____ Do you have a family history of headaches? Yes ___ No ___
Do you experience the following with your headaches/migraines:
Pain or cracking in your jaw? Yes ___ No ___ Nausea or vomiting? Yes ___ No ___ Do you see Sparks ___ Lights ___ Auras ___
Did you have oral surgery? Yes ___ No ___ Do you clench or grind your teeth? Yes ___ No ___
Do you wear a night guard? Yes ___ No ___ Have you had any major head trauma in your life? Fall ___ Auto Accident ___
Concussion ___ Hit/Blow to the head ___ When? _____
When was your last eye exam by a doctor? 1-6 months ___ 6-12 months ___ 1-2 years ___ Over 2 years ___
Blood pressure: ___ High ___ Low

Medical Information

If female, are you pregnant? Yes ___ No ___ Not Sure ___ If yes, what is your due date? _____
Have you ever had any surgeries or hospitalizations? Yes ___ No ___ Please List:

Type of Hospitalization / Surgery / Transplants	Date	Type of Hospitalization / Surgery / Transplants	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you been x-rayed in the last 12 months? Yes ___ Not Sure ___ When? _____ What views were taken?_____
Have you been seen by a chiropractor before? Yes ___ No ___ Name:_____ Date:_____
Do you have a family physician? Yes ___ No ___ Name:_____ Phone:_____
Address: _____ City:_____ State:_____ Zip:_____
Family Medical History: Please list any diseases or medical problems of siblings, parents, and grandparents:_____
_____
Have you ever had: ____ Motor Vehicle Injury ____ Work Injury ____ Slip and Fall Injury If yes, please explain:_____
_____

Additional Complaints and Diagnosis

Please check all that apply to you

___ Loss of Concentration	___ Shortness of Breath	___ Cold Hands	___ Arthritis	___ Autistic
___ Eyes Sensitive to Light	___ Irritable	___ Cold Feet	___ Cancer	___ Jaw Pain
___ Memory Loss	___ Upper Back Pain	___ Anxiety	___ Leg Pain	___ Speech Difficulty
___ Heavy Feeling of Head	___ Mid Back Pain	___ Hypertension	___ Diabetes	___ Dizziness
___ Right/Left Shoulder Pain	___ Insomnia	___ Seizures	___ Stroke	___ Fatigue
___ Ringing in Ears	___ Erectile Dysfunction	___ Sinus Problems	___ Heart Disease	___ Snore

___ Loss of Balance ___ Right/Left Arm Pain ___ Vision Problems ___ Diarrhea ___ Nausea
___ Pins & Needles ___ Hand/Finger Numbness ___ Pain Behind Eyes ___ Nervousness ___ Vomiting
___ Loss of Smell ___ Feet/Toe Numbness ___ Digestive Trouble ___ Constipation ___ Heart Palpitation
___ Sleep Disruption ___ Seizures ___ Bi-Polar ___ Depression ___ Headaches
___ Migraines ___Thyroid Condition ___ Skin Conditions ___ Ulcer ___ Sinusitis
___ Hepatitis ___ Heart Condition ___ Emphysema ___ Asthma ___ Lung Condition
___ Lung Issues ___ High Blood Pressure ___ Diverticulitis ___ Colitis ___ SIBO
___ Crohn's ___ Fibromyalgia ___ Arthritis ___ Gout ___ Slow Wound Healing
___ Alzheimer's ___ Dementia ___ Mold Poisoning ___ Neuropathy ___ Erectile Dysfunction
___ Bladder Disease ___ Kidney Disease ___ Polymyalgia ___ Lyme ___ Heavy Metal Poisoning
___ Burning Mouth Syndrome ___ Chronic Fatigue Syndrome

Any Other Complaints and Diagnosis:_____
_____

Any additional information you would like the doctor to know about before beginning care at Champion Chiropractic Center, Inc.: _____
_____
_____

I certify that the above information is correct to the best of my knowledge. By the signature below, I hereby authorize and consent to chiropractic treatment by Dr. Steven Sandifer of Champion Chiropractic Center, Inc. A photocopy of this authorization shall be considered valid as the original. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose said information to my insurance company, the Washington State Insurance Commissioner, and their agents for the purpose of obtaining payment for services, handling disputes and determining insurance benefits or the benefits payable for related services. I authorize that all payments go directly to Dr. Steven Sandifer.

Patient/Guardian Signature: _____

Relationship to Patient: _____

Please Print Name: _____

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately each visit you were seen for, the payments made by your insurance company to those dates, any contract adjustments, other adjustments if applicable, co-pays and other payments you have paid, and finance charges, if any. For any balance paid the previous billing cycle, these visits will not appear on future statements.

Payment if you have no insurance: Payment is due in full at the time of service for each service that you have per office visit.

Payment if you have insurance: We will bill your insurance if we are providers with them. Please check with us or your insurance company to see if we are providers. Not all of our providers are contracted with the same insurance companies. You are responsible for all charges not paid by your insurance company.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if not paid at the time of service.

Charges to Account: We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a copay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment or denial of payment from the insurance company. You are responsible for all charges not paid by your insurance company.

Non-Contracted Insurances: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of 1% per month **ANNUAL PERCENTAGE RATE** of 12% or $5.00 per month, whichever is larger. The finance charge on your account is computed by applying the periodic rate to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 30 days ago and then subtracting any payments or credits applied to the account during that time.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we must receive copays at the beginning of your visit. Unpaid copays will result in a $10 billing fee added to your monthly statement.

Returned Checks: There is a fee for any checks returned by the bank. Currently, this fee is $60.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections cost which we incurred. If we have to refer a collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Thurston County, Washington.

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce requires the other parent to pay for all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you're requesting your records to be transferred from another doctor organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require a written approval/authorization or your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you'll be responsible for payment in full.

Personal Injury: Our financial relationship is with you, not your insurance company. It is imperative that you understand that you are the one ultimately responsible for your bill. It is the patient's responsibility to dispute your insurance company's decision by calling your claims manager. If your insurance company has not made a payment within 60 days or is withholding payment, for any reason, you will be personally responsible for any outstanding balances on your account. You also authorize Champion Chiropractic Center, Inc. to turn your claims into the Washington State Insurance Commissioner for assistance on payment of unpaid claims. If you reach the maximum benefits for your personal injury claim, you'll be responsible for obtaining an attorney before any further treatment is provided. You will also be responsible for making a minimum monthly payment on your account until settlement of your claim. A payment plan will be created by the financial manager to meet patient and office needs.

Printed Name: _____ Date: _____

Signature: _____ Office Manager Initials: _____

Champion Chiropractic and Wellness Center, Inc.
Missed Appointment Financial Policy

Our doctors and therapists value your time and request that you value their's. We make every attempt to respect our patient's time by scheduling appropriate times for treatment and minimizing the amount of time a patient waits for care.

Everyone at Champion Chiropractic Center works very hard to provide excellent customer service. Since missed and late appointments greatly interfere with our ability to care for our patients, we have the following policies:

If a patient is unable to keep their scheduled appointment, they must notify the office 24 hours in advance for Chiropractic, Massage Therapy, Cold Laser Therapy, and Clinical Nutrition.

Appointments canceled the same day as they are scheduled is considered a missed appointment. While calling just before your appointment time is better than not showing up, the end result is the same.

If a patient arrives more than 10 minutes late for an appointment, they have missed their appointment. We will try to fit them in around other scheduled patients, but it may involve a wait.

Your failure to notify the office of your intention to cancel and reschedule within the listed time frame, for each profession, will result in the following fees:

- Chiropractic $52.00
- Cold Laser Therapy $52.00
- Clinical Nutrition $52.00

Please Note: Missed appointment fees must be paid at the next scheduled appointment. Medical Insurance, Auto Insurance, and Workers Compensation **WILL NOT** cover these charges.

All fees are subject to monthly finance charges. All fees are subject to change without notice.

Printed Name: _____ Date: _____

Signature: _____ Office Manager Initials: _____

Champion Chiropractic and Wellness Center, Inc.
Informed Consent to Chiropractic Adjustments and Therapeutic Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient names below, for whom I am legally responsible) by Dr. Steven L. Sandifer and/or his preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor names below and/or other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, stroke, dislocations, sprains/strains, physiotherapy burns, and soft tissue injury. These complications are extremely rare occurrences. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, 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, in my best interests. I understand that there are other forms of treatment, including, but not limited to, drugs, surgery, physical therapy, acupuncture or opting out of any and all treatment. But, at this time, I choose to have chiropractic care.

Chiropractic treatment involves science, philosophy and art of locating the correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that that chiropractor will use his hands or a mechanical device upon my body to adjust a joint, and there may be an audible “pop” or “click” as a result of joint movement. It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor’s interpretation thereof, as well as the doctor’s judgment and expertise in working with the cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation, will mail a copy of any revised notice to the address I’ve provided or forward a copy via email at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-names procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ _____

Name (Printed) Date Signed

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____

Witness to Patient’s Signature

Champion Chiropractic and Wellness Center, Inc.
Receipt of Privacy Practices

Your healthcare information is state mandated to be kept private from any and all parties. Champion Chiropractic Center, Inc. has a brochure that tells me how my health information is taken care of. This brochure is called "Notice of Privacy Practices." Champion Chiropractic Center, Inc. provided me with the most current "Notice" and may update this "Notice" at any time. Any updates to the "Notice" will be posted in the office. Please initial each statement that you agree upon:

1. _____ I have been given a current brochure of the "Notice of Privacy Practices which describes how my health care information will be used and disclosed to carry out treatment, payment, and health care options.

OR

2. _____ I have been informed how my health care records and information will be kept private, and I choose not to take a brochure at this time.

ALSO

3. _____ I give Champion Chiropractic Center, Inc. staff permission to call me on the phone to make reminder calls or to discuss my account information.
4. _____ I agree that messages may be left on my answering machine or voicemail.

The following people may obtain my medical information in case of my absence, hospitalization, or incapacitation:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ _____

Patient or Legally Authorized Individual Signature Today's Date

_____

Relationship to patient if signed on behalf of the patient by parent, legal guardian, etc.

Champion Chiropractic and Wellness Center, Inc.
2405 Evergreen Park Dr. SW #B1, Olympia, WA 98502
Phone: (360) 438-6559 Fax: (360) 352-4202

Current Medications / Supplements / Herbs

Please list all medications, supplements, herbal, injections, patches, drops and over the counter products, etc., you are taking, including the dosage. Please include the ones you take on occasion.

Medication Name	Dosage	How often do you take?	Reason	Start Date

**** Please use back of page if additional space is needed for medication / supplements**

Please list all known allergies: _____

_____

_____

_____