Child Intake

AGADA
CHIROPRACTIC &
INTEGRATIVE HEALTH CENTER

Name:_____ Date:_____

Age:_____ DOB: _____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Parents Name(s)_____

Pediatrician's Name/Clinic Name:

Reason For Seeking Chiropractic Care:

_____

_____

CONSENT TO TREATMENT OF MINOR

(I)(We), _____ the undersigned, parent(s)/person having legal custody/legal guardianship of, _____ a minor, do hereby authorize Drs. Jean M. Ciola AGADA Chiropractic, LLC to consent to any x-ray examination and chiropractic diagnosis or care, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor. It is understood that this authorization is given in advance of any specific diagnosis or care being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and care which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. This authorization shall remain effective unless sooner revoked in writing delivered to the agent(s) noted above.

Signature:_____
(parent/legal guardian/person having legal custody) (circle relationship) Date:_____

[Type text]

BIRTH HISTORY

LABOR AND DELIVERY

How long was the labor from the first regular contractions to the birth? _____ hours

How long was the 2nd stage (the pushing phase) of the labor? _____ hours

Hospital Birth	☐ Yes	☐ No
Home Birth	☐ Yes	☐ No
Midwife assisted	☐ Yes	☐ No
Vaginal Delivery	☐ Yes	☐ No
Planned C-section	☐ Yes	☐ No
Emergency C-section	☐ Yes	☐ No
Was Birth Induced (Pitocin)	☐ Yes	☐ No
Forceps delivery	☐ Yes	☐ No
Vacuum extraction	☐ Yes	☐ No
Anesthesia administered	☐ Yes	☐ No
Fetal distress	☐ Yes	☐ No
Meconium staining	☐ Yes	☐ No
Head presentation	☐ Yes	☐ No
Face presentation	☐ Yes	☐ No
Breech presentation	☐ Yes	☐ No

BABY'S CONDITION IMMEDIATELY AFTER BIRTH

Apgar Scores: At 1 minute ____ /10 At 5 minutes _____ /10

Baby's Crying Baby Cried Immediately After Birth ☐

Cried Strongly ☐ Weak Cry ☐ Did Not Cry for _____minutes

Baby's Color Pink all over ☐ Blue Face ☐ Blue Hands/feet ☐

Baby's Activity Arms and legs actively moving ☐ Floppy baby ☐

Intensive Care Was required ☐ Days in Neonatal Intensive Care Unit_____

Medication given at birth? _____ Vaccines administered _____

Birth weight _____Lbs Birth length _____ins Baby home on day _____

3311 County Road 101 Suite 2 Minnetonka, MN 55391
Phone: 952-405-6263 Fax: 952-406-8060
www.AGADAChiropractic.com

Dr. Jean M. Ciola
Chiropractor
Acupuncture Certified

[Type text]

Office Policies and Privacy Statement

The following is a statement of our policies.
We require that you read, agree to, and sign prior to any care in our office.

CASH OFFICE
Your initial visit consists of a complete history, orthopedic, neurologic, and chiropractic examination, nervous system scans and full spine x-rays. The cost of this service is $95 unless otherwise arranged. Full payment is expected at the time of the dated service.

FINANCIAL POLICY
You assume financial responsibility for the care given. Outstanding balances will be billed monthly and considered past due 30 days after the invoice date. All past due balances are subject to a $5 late fee. Balances beyond 120 days may be directed to a third party collections agency. At this time, a 30% increase to your total bill will be added to cover the collection fees. If you need to make financial arrangements other than those listed above, you must contact our office promptly for assistance in the management of your account.

MISSED APPOINTMENTS
It is very important to your care plan that you keep your scheduled appointments. We realize that things come up. We will do our best to reschedule you at a time that is convenient for you. However, please contact us as soon as possible, so that we may schedule another patient during that time. If you miss 3 appointments without notice, your account will be billed for the date of the 3rd missed appointment.

CONSENT TO USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge
There are several circumstances in which we may have to use or disclose your health care information:
We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. We may need to use your health information within our practice for quality control or other operational purposes. We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization
You may revoke your consent to us at any time in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read and fully understand the above policies:
I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this authorization.

Printed name _____

Signature _____ Date_____

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