

**Active Life Chiropractic 6401 Douglas Ave. Suite 12 – Urbandale, IA 50322
(515) 278-0363**

Pediatric Patient Information

Chiropractic care for your child is safe and effective. You have taken the right step towards a healthier, happier child. We look forward to working with you in maintaining your family's health.

Child's Name _____
Last First MI

Birth Date _____ Age _____ Sex M / F SS# (If known) _____

Parent/Guardian Name _____

Social Security Number _____

Address _____

City _____ Zip _____

Home Phone# _____

Insurance Information - If you wish to file insurance on your child a copy of your insurance card must be obtained by the front desk with the name and full information of the insured member.

Pediatric History

Check boxes for both current and past issues:

- Ear Infections Colic Back Pain Neck Pain
- Digestive Issues Poor Sleeping Scoliosis Headaches
- Growing Pains Asthma/Respiratory Broken Bones Surgeries
- Check Here for Preventative Check – No current issues

Describe other complaints or symptoms _____

Surgeries _____

_____ Pediatrician _____

Consent to Treat Minor

I hereby acknowledge that I am the legal parent and/or guardian of this child and authorize Active Life Chiropractic and whomever they may designate as doctors and assistants to examine and administer treatment as they deem necessary.

Parent/Guardian Signature: _____ Date: _____

WELCOME TO OUR OFFICE

In compliance with the Federal and State Consumer Protection and Informed Consent Laws, we present a basic outline of usual and customary procedures and fees:

Initial Examination 45.00 - 85.00 Therapy 15.00 - 60.00

Adjustments 35.00 & up X-rays 50.00 & up

IF NO INSURANCE : Payment is due when service is rendered. We gladly accept Master Card, Visa and Discover.

INSURANCE: DEDUCTIBLES, CO-PAYS AND PROCEDURES NOT COVERED ARE EXPECTED TO BE PAID FOR AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. If you fail to keep your scheduled appointment or discontinue care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any insurance claim submitted.

TREATMENT PERMISSION: I understand that I am accepted as a patient and if I agree to be treated, that I give permission to the clinic to administer treatment and perform such procedures as deemed necessary in the diagnosis and treatment of my condition. Furthermore, any risk regarding treatment will be explained to me upon my request.

PAYMENT RESPONSIBILITIES: I understand that I am personally responsible for all charges whether or not paid by any third party. I agree that all charges are payable and collectable in Polk County. An interest charge of 11/2 % monthly, 18% annually, minimum finance charge \$.50 may be charged on any unpaid balance over 60 days old. If I do not make payment after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. All portions of any bill sent me by this chiropractic clinic shall be assumed valid unless disputed in writing within 30 days of receiving the bill. I agree to arbitrate any disagreement, controversy, or claim which cannot be otherwise resolved to my satisfaction, arising out of or relating to any services provided by this clinic and to settle any disputed by arbitration in accordance with the rules of the American Arbitration Association, which provides dispute resolution services.

ASSIGNMENT OF RIGHT TO PAY/LIEN AGAINST BENEFITS: I hereby authorize this clinic to file my claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney of third party for professional services rendered by this clinic. I convey a lien against any funds and authorize any direct and third party to withhold sums from any benefits, judgements,, verdicts, settlements of recoveries, and to adequately protect and to make payment for these services directly to this clinic pursuant to this assignment and lien.

ASSIGNMENT OF CAUSE OF ACTION: In the event that any insurance company or other third party that may be obligated to making payment to me or this clinic for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer and convey to this clinic the cause of action that might exist in my favor against any such company or person. I authorize this clinic to prosecute said action either in my name or their name to collect fees due for services rendered to this clinic and legal expenses and to resolve said claims as they see fit.

AUTHORIZATION TO PROCESS DRAFTS: I agree that this clinic shall be appointed as my agent to endorse drafts or to sign my name on any checks of payment of my bill for services rendered at this clinic.

LIMITED RELEASE OF MEDICAL INFORMATION: I authorize this clinic to make inquiries and to release any pertinent information to any insurance company, adjuster, medical facility, doctor, or attorney to facilitate collection under these assignments.

Our goal is to relieve your pain as quickly as possible, and then to correct the cause of your problem. If you have any question with regard to your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit

SIGNATURE _____ DATE: _____