

# Welcome To Back In Motion Chiropractic

## PEDIATRIC PATIENT INFORMATION

Today's Date \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Middle Name \_\_\_\_\_  
 SS# \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sex  M  F Age \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Parents:  Single  Married  Widowed  
 Separated  Divorced  Other \_\_\_\_\_  
 School/Daycare \_\_\_\_\_  
 School Address \_\_\_\_\_  
 School Phone (\_\_\_\_) \_\_\_\_\_  
 Mother's Name \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 SS# \_\_\_\_\_  
 Father's Name \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_  
 Subscriber's Name \_\_\_\_\_  
 Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
 Subscriber ID # \_\_\_\_\_  
 Group # \_\_\_\_\_

Is the patient covered by additional insurance?

Yes  No Insurance Co. \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the above-named insurance company and assign directly to Kenneth C. Morris, D.C., DACBSP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Kenneth C. Morris, D.C., DACBSP may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

Signature of Patient, Parent, Guardian, or Personal Rep. \_\_\_\_\_

Printed name \_\_\_\_\_

Date \_\_\_\_\_ Relationship to patient \_\_\_\_\_

## PHONE NUMBERS

Home Phone (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_  
 Best time and place to reach you \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_\_  
 Cell Phone (\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition related to an accident  Yes  No

If Yes, Please obtain additional form from receptionist

Type  Auto  Work  Home  Other

Date of accident \_\_\_\_\_

To whom have you made a report of your accident

Auto Insurance  Employer  Worker Comp.

## PATIENT CONDITION

Reason for visit \_\_\_\_\_

When did child's symptoms appear? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of pain on a scale from 0 (No Pain) to 10 (Severe Pain) \_\_\_\_\_

Type of Pain: Mark all that apply  Sharp  Dull  Throbbing  Numbness

Aching  Shooting  Burning  Tingling  Cramps  Stiffness  Swelling

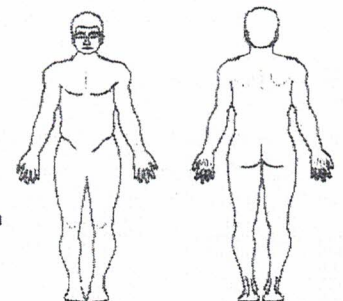
How often does child have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your  Play  Sleep  Daily Routine  School

Activities that are painful  Sitting  Standing  Walking  Bending  Lying Down

Please mark on the picture  
where your symptoms are located



**PLEASE COMPLETE THE BACK SIDE OF THIS FORM**

## HEALTH HISTORY

What treatment has child already received for this condition?

- Medications \_\_\_\_\_  
 Surgery \_\_\_\_\_  
 Physical Therapy Name of Therapist \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 Previous Chiropractic Care Name of Chiropractor \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 Name of any other doctor you have seen for this condition \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 Date of last: Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_ Spinal Exam \_\_\_\_\_  
 Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_ Dental X-Ray \_\_\_\_\_ MRI, CT Scan, Bone Scan \_\_\_\_\_

**Place a mark on "Yes" or "No" to indicate if your child has had any of the following:**

ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No Autism <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bed Wetting <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No Concussion <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Ear Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Eating Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No Eye/ Vision Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Food Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No Genetic Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No Herniated Disc <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Hip Dysplasia <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Infection <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No Overweight <input type="checkbox"/> Yes <input type="checkbox"/> No Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No Polio <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Scoliosis <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Strep Throat <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors/ Growths <input type="checkbox"/> Yes <input type="checkbox"/> No Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No UTI <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccinations <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccine reaction <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Other Medical History _____ _____
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**EXERCISE/SPORTS:**

- None \_\_\_\_\_  
 Moderate \_\_\_\_\_  
 Daily \_\_\_\_\_  
 Heavy \_\_\_\_\_

**INFANT MILESTONES:**

- Sitting Age: \_\_\_\_\_  
 Crawling Age: \_\_\_\_\_  
 Standing Age: \_\_\_\_\_  
 Walking Age: \_\_\_\_\_

**BIRTH/PREGNANCY:**

- Vaginal Delivery \_\_\_\_\_  
 C Section \_\_\_\_\_  
 Breast Fed \_\_\_\_\_  
 Formula \_\_\_\_\_

**Learning Disabilities**  Yes  No \_\_\_\_\_ **Speech Difficulties**  Yes  No \_\_\_\_\_

**INJURIES/ SURGERIES:**

<u>DESCRIPTION</u>	<u>DATE</u>
Falls/Accidents _____	_____
Head Injuries _____	_____
Broken Bones _____	_____
Dislocations _____	_____
Surgeries _____	_____

<p><b><u>MEDICATIONS</u></b></p> _____ _____ _____	<p><b><u>ALLERGIES</u></b></p> _____ _____ _____	<p><b><u>VITAMINS/HERBS/MINERALS/HOMEOPATHY</u></b></p> _____ _____ _____
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**PLEASE REVIEW AND SIGN ALL ATTACHED POLICY FORMS**

# Back In Motion Chiropractic Electronic Health Records Intake Form

*In compliance with requirements for the government EHR program*

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Gender (Circle one): Male / Female Preferred Language: \_\_\_\_\_

Email address: \_\_\_\_\_@\_\_\_\_\_

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

*CMS requires providers to report both race and ethnicity*

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Back In Motion Chiropractic**  
**Kenneth C. Morris, D.C., DACBSP**  
**10515 Bells Ferry Rd Suite 100**  
**Canton, GA 30114**

**Financial Policy**

In order to accommodate the needs and requests of our patients, Back In Motion Chiropractic is contracted with numerous insurance companies. While we are pleased to be able to provide this service to you, it is not possible for our staff to keep track of all the individual requirements of each plan. Every plan has different stipulations regarding access to care and payment for services received. Within the same insurance company, benefits may differ depending upon the type of contract your employer negotiated with that carrier on your behalf.

***Providing quality chiropractic care for our patients is our primary concern.***

We are happy to provide care for our patients, within their insurance contract guidelines, but we ask that our patients come prepared at the time of service to let us know what those guidelines are. In most of our contracts, Back In Motion's personnel are not permitted to interpret insurance benefits for the patient. We are expected and obligated to provide quality care to each insured person, but it is the insured person's responsibility to understand their benefits.

Should your insurance company require a **specialist referral** from your primary care physician before you can be seen by our physicians, it is your responsibility to obtain that referral **prior to your appointment.** You should bring the referral with you to your appointment. Our contracts with the insurance companies prohibit us from seeing you without a referral and billing them for the services. If you are seen without a referral, **you must be prepared to pay for all services in full at the time they are rendered.** *If a referral is required and you are unsure how to obtain one, please let the staff know and we will be happy to provide assistance.*

If you do not inform us of any special requirements in your insurance contract, *such as referrals or preauthorization for treatment*, and we subsequently order services that are not covered, we will have no choice but to bill you directly for those charges. In the event that services are provided and your insurance coverage is not in effect on that day, or if your contract contains a pre-existing clause, your insurance carrier will probably deny payment for services received and you will be responsible for paying for the denied services.

**Please remember that you, the patient, are ultimately responsible for payment on your account.**

**Payment is expected on the day services are rendered. In the event that credit is granted, it shall be paid promptly in accordance with terms and agreements. Back in Motion Chiropractic may add one and one half percent (1 ½ %) per month to any balance owed and in the event of default to pay reasonable collection charges and/or attorney fees may also be applied.**

All treatments and services rendered at Back In Motion Chiropractic will be billed according to our contracts with the insurance companies. **The act of waiving deductible, co-insurance, and co-pay amounts is strictly prohibited.** According to our insurance contracts as well as the insured's, if you have an insurance policy that covers chiropractic services, we are required to bill the services to the insurance policy. You may not elect to not use your insurance benefits. We are required to bill "self-pay" patients and insurance policies the same rates for all services.

With your cooperation and help, you should be able to receive all of the insurance benefits offered to you, and we will be able to concentrate on caring for your chiropractic needs.

**I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO FINANCIAL RESPONSIBILITY AS DESCRIBED.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

If Guardian, print name of patient \_\_\_\_\_

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**MISSED APPOINTMENT POLICY**

Our appointment policy will include a charge of \$30.00 for a missed appointment with **NO NOTICE GIVEN** to the office prior to any given time.

When possible, a notice of 24 hours is appreciated.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

If Guardian, print name of patient \_\_\_\_\_

# Back In Motion Chiropractic

**Kenneth C. Morris, D.C., DACBSP**

**10515 Bells Ferry Rd, Suite 100**

**Canton, GA 30114**

## Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree with those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request had been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and agree to these policies and procedures.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

If Guardian, print name of patient \_\_\_\_\_

Back In Motion Chiropractic  
Kenneth C. Morris, DC, DACBSP  
10515 Bells Ferry Rd Suite 100  
Canton, Ga 30114

Release of Information Authorization

Patient Name: \_\_\_\_\_

I hereby authorize release of my personal medical information to the following individual(s):

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Name Relationship

I hereby authorize the release of personal medical information on my voicemail at the following numbers:

(\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_ (\_\_\_\_)\_\_\_\_-\_\_\_\_

This authorization will remain in effect until further notice and it is my responsibility to update this authorization if any contact information should change.

\_\_\_\_\_  
Patient/Guardian Signature Date

Back in Motion Chiropractic  
Kenneth C. Morris, D.C., DACBSP  
10515 Bells Ferry Rd, Ste 100  
Canton, GA 30114  
770-704-0114

**Informed Consent to Chiropractic Treatment**

**The Nature of Chiropractic Treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, mechanical traction, therapeutic ultrasound, therapeutic exercises or hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures, fractures to the rib cage, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Some patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, falls or other minor complications.

**Other Treatment Options Which May be Considered** may include the following:

- *Medical care*
- *Orthopedic care*
- *Physical therapy*

The risks and types of other treatment options will need to be discussed and reviewed with the healthcare provider providing those treatments.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, decrease function in the nervous system and induce chronic pain cycles. It is quite probable that delay of treatment may complicate the condition and make future rehabilitation more difficult.

**Unusual Risks:** I have had the following unusual risks of my case explained to me.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, with the above stated risks and hereby give my full consent to treatment.**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness' Printed Name

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Date

# Back in Motion Chiropractic

Kenneth C. Morris, D.C., DACBSP

10515 Bells Ferry Rd, Ste 100

Canton, GA 30114

(770)704-0114

I hereby request and authorize Back In Motion Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatments to my son/daughter \_\_\_\_\_.

This authorization extends to all doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

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Guardian Signature

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Printed Name

---

Relationship to patient

---

Date

---

Witness

---

Date