Burkhalter Chiropractic & Wellness 920 8th Avenue Baraboo, WI 53913 608-356-3811
Dr. Ronald J. Burkhalter * Dr. Melanie A. Burkhalter * Dr. Austin J. Burkhalter * Dr. Justin D. Huinker

Pediatric History Form

Dear New Patient,

It is a pleasure to welcome you to our family of happy and health chiropractic patients. Please let us know if there is any way we can make you and your family feel come 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 Name:_____Birthdate:_____
Name of Parents/Guardians:_____
Address:_____City:_____State_____ZIP_____
Phone: _____Work Phone:_____Email:_____
Sex M F Weight: _____Height: _____Number of Siblings:_____
How did you hear about our office?_____
Reason for seeking Chiropractic care:_____
Have you seen other Doctors for this condition? ___No ___ Yes Dr.'s Name_____
Prior Treatments for this condition:_____
Other Health Problems?_____
Has your child ever suffered form: (Check all that apply)

☐ Dizziness	☐ Digestive Disorders	☐ Paralysis
☐ Diabetes	☐ Rheumatic Fever	☐ Broken Bones
☐ Arthritis	☐ Hyperactivity	☐ Leg Problems
☐ Neuritis	☐ Convulsions	☐ Stomach Aches
☐ Anemia	☐ Walking Problems	☐ Chronic Earaches
☐ Poor Appetite	☐ Arm Problems	☐ Colds/Flu
☐ Bed Wetting	☐ Blood Disorders	☐ Allergies
☐ Fainting	☐ Heart Trouble	☐ Constipation
☐ Neck Problems	☐ Hypertension	☐ Diarrhea
☐ Joint Problems	☐ Asthma	☐ Behavioral Problems
☐ Backaches	☐ Sinus Trouble	☐ Muscle Jerking
☐ Tuberculosis	☐ Orthopedic Problems	☐ Ruptures/Hernias
☐ Headaches	☐ Sugar Concentration	☐ Growing Pains

☐ Other_____

Family Health History:_____
Previous Chiropractor:_____ Last Visit:_____
Reason:_____
Name of Pediatrician:_____ Last Visit:_____
Reason:_____
Are you satisfied with the care your child received there: ___No ___Yes
Number of doses of antibiotics your child has taken:
During the last 6 months_____ Total during their lifetime____
Number of doses of other prescription medications your child has taken:
During the last 6 months____ Total in their lifetime____
Vaccination History:_____

Prenatal History

Type of Birth Attendant: OBGYN CNM Lay Midwife Name of Attendant:_____

Location of Birth: ___Home ___Birthing Center ___Hospital
Complications during pregnancy: ___No ___Yes List:_____
Ultrasounds during pregnancy: ___No ___Yes How Many?____
Medications during pregnancy and/or delivery: ___No ___Yes List:_____
Cigarette and/or Alcohol use during pregnancy? ___No ___Yes
Birth Interventions: ___Forceps ___Vacuum ___Caesarian: Planned or Emergency _____
Complications during delivery: ___No ___Yes List:_____
Genetic disorders or disabilities: ___No ___Yes List:_____
Birth weight _____ Length_____ APGAR Scores_____

Feeding History

Breast Fed: ___No ___Yes How long? _____Formula fed: ___No ___Yes How long? _____Type_____
Introduced to solid foods at _____months; Cow's milk at ____months
Food/Juice allergies or intolerances ___No ___Yes List:_____

Development History

Number of hours sleeping per night: _____ Quality of sleep: ___Good ___Fair ___Poor
At what age was your child able to:

_____Respond to sound
_____Respond to visual stimuli
_____Hold head up
_____Sit up
_____Cross crawl
_____Stand alone
_____Walk alone

According to the National Safety Council, approximately 50% of children fall head first form 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? ___No ___Yes
Is or has your child been involved in any high impact or contact sports? ___No ___Yes Type:_____
Has your child ever been involved in a car accident? ___No ___Yes Date:_____
Has your child ever been seen on an emergency basis? ___No ___Yes Reason and Date:_____
Other traumas not described above? ___ No ___Yes Date:_____
Prior surgery: ___No ___Yes Type and Date: _____Menarche: ___No ___Yes Age:_____

Childhood Diseases

Chicken Pox N / Y Age_____
Rubella N / Y Age_____
Measles N / Y Age_____
Mumps N / Y Age_____
Whooping Cough N / Y Age_____
Other _____ N / Y Age_____

Insurance

Do you have medical insurance? ___No ___Yes Insurance company: _____
Policy Number_____ Insurance Phone Number_____
Policy Holder's Name _____Relation_____ Date of Birth_____
Policy Holder's Employer_____

We are here to serve you, and encourage you to ask questions.
Your participation is vital and will help determine your results.

Authorization for care of a minor

I hereby authorize this office and its Doctors to administer care to my child as they deem necessary.

Parent/Guardian Signature: _____ Date _____

Authorization for payment of a minor

I, the undersigned parent and/or Legal Guardian of:

_____,

a minor, do hereby authorize this office and its doctors to administer chiropractic care to my child, as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office, as stated below.

Parent or Legal Guardian (printed): _____

Parent or Legal Guardian (signature): _____

Witness's signature: _____

Date: _____

Agreement for Payment of Services

By signing the authorization above I affirm that I understand and agree that:

- Health and Accident Insurance policies are an arrangement between me and my Insurance carrier.
- This office will prepare any necessary reports and forms to assist me in making collection from the insurance company.
- Any amount that is authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse insurance payments to be applied to my account.
- All services rendered to me are charged directly to me and I am responsible for the payment of my account.
- It is the policy of this chiropractic office to collect for services as they are rendered, unless other financial arrangements are made.

Informed Consent

Every type of health care is associated with some risks of potential problems. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is a legal requirement in Wisconsin.

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a mechanical device or machine (drop table). Frequently adjustments create a "pop" or "click" sound/sensation in the area being treated.

In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor will treat you on that day.

Neck Artery Dissection and Stoke: *Dissection* is when the lining of the neck artery breaks down. This might happen spontaneously or from a trivial movement (hair shampooing, checking traffic, looking up, etc). Dissections tend to cause neck pain and/or headache. *Dissections* may form a clot that can dislodge and interfere with brain blood flow. If that happens, it is called a *stroke. Stroke* means that a portion of the brain or spinal cord does not receive enough oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The literature is mixed or uncertain as to whether chiropractic adjustments are associated with *stroke* or not. Recent evidence suggests that it is not (2008, 2015, 2016, 2019), although the same evidence suggests that the patient may be entering the chiropractic office for neck pain/headaches or other symptoms that may in fact be a spontaneous *dissection* of a neck artery. There are ***no*** in–the-office tests to diagnose a spontaneous neck artery *dissection* (2020), but they might be detectable with advanced imaging (CT/MRI, etc). If you think you may be suffering from a spontaneous neck artery *dissection* and/or associated *stroke*, you will be immediately referred to emergency services.

Anecdotal cases suggest that chiropractic adjustments may be associated with *dissection* and/or stroke that arise from the vertebral artery; this is because the vertebral artery is located inside the neck vertebrae. The adjustment that is suggested to increase the strain on the vertebral artery is called "extension-rotation-trust atlas adjustment." We do not do this type of adjustment on patients. Other types of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. It is estimated that the incidence of this type of complication ranges between 1 per every 400,000 – 10,000,000 neck adjustments (2004). A large 10-year study estimated an incidence of 1 per 5.85 million neck adjustments, equivalent to 1,430 years of clinical practice (2001). If you experience any of the "5 **D**s **A**nd 3 **N**s" (on a following separate page) before, during or after an adjustment, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Two other potential problems that are *not* quantifiable because they are extremely rare and may have no association with chiropractic adjusting are carotid artery injury, and spinal dural leak of cerebral fluid.

Disc Herniations: Both neck and back disc herniations may create pressure on the spinal nerve or on the spinal cord. They are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. Occasionally chiropractic treatment (adjustments, traction, etc.) may aggravate a disc/nerve problem and rarely surgery may become necessary for correction.

Cauda Equina Syndrome: Cauda Equina Syndrome occurs when a low back disc problem puts pressure on the nerves that control bowel, bladder, and sexual function. Representative symptoms include leaky bladder, or leaky bowels, or loss of sensation (numbness) around the pelvic sexual organs (saddle area), or the inability to start/stop

a bowel movement. Caudia Equina Syndrome is a medical emergency because the nerves that control these functions can permanently die, and those functions may be lost or compromised forever. The standard approach is to surgically decompress the nerves, and the window to do so may be a short as 12-72 hours, depending. If you have any of these symptoms, tell us immediately, and if we can't be reached, go to the emergency department immediately.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Rarely, chiropractic care may overstretch some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient.

Rib and other Fractures: Rarely a chiropractic adjustment may crack a rib bone, and this is referred to as a fracture. We adjust all patients very carefully, and especially those who have known osteoporosis. Other fracture locations are extremely rare but possible, especially in those aged over 65 years and/or on steroid drugs.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is a temporary increase in pain, and there may even be some blistering of the skin. Never put an ice pack directly on the skin, always have an insulating towel between. We use *cold (low-level) laser therapy* which produces no heat and cannot result in burn.

Soreness: It is common for chiropractic care to result in temporary increase in soreness in the region being treated. There is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of heath care delivery, and, therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We always give you our best care, and if results are not acceptable, we will refer you for additional diagnostic or to another provider whom we feel will assist your situation.

Alternatives to chiropractic care include: do nothing, drugs, surgery, acupuncture, massage, etc. Risks from these procedures should be discussed with that particular provider.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign below.

Patient's Name (printed)_____ Date:_____

Patient's Signature:_____

Parent or Guardian's Signature (for minor)_____

Doctor's Signature Verifying Discussion_____ Date:_____

BURKHALTER CHIROPRACTIC, SC

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FINANCIAL POLICY AGREEMENT

We believe a clear definition of our policies will allow both the patient and doctor to concentrate on the big issue – REGARDING AND MAINTAINING YOUR HEALTH.

1. Cash paying patients are expected to pay at the time of service. Patients' balances may not exceed **$150.00** at any time.

2. All insurance assignment patients must pay their deductible in full and the co-insurance at the time of service. An insured patients' balance may not exceed $200.00 at anytime.

3. Return check fees are $25.00. Balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month or a late charge of $25.00 per month. All collection fees incurred to collect a balance are due from the patient.

4. In Personal Injury cases the patient is ultimately responsible for all charges incurred. We will submit all charges from services rendered to the respective insurance company and will allow a grace period of no greater than 90 days after the patient is released from the doctor's care.

5. Missed appointments without the courtesy of a 24-hour cancellation notice will be subject to a $30.00 no show charge.

As a service to our patients, we handle all insurance billing and paper work. If you have any questions regarding insurance finances, we will be glad to help answer your questions to the best of our ability. As we do not work for your insurance company, it is recommended that you reach your insurance company personally to ensure your full understanding of your insurance coverage.

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ _____ and assign directly to Burkhalter Chiropractic, Inc. all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient signature: _____ Date _____

Patient's printed name: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

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 a 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.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

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 any of your authorizations at any time; however, your revocation must be 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 a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Authorized Provider Representative

_____ _____

Signature Date

_____

Date

WISCONSIN CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Wisconsin Chiropractic Association (WCA). This disclosure will be made if we need the WCA's assistance to receive reimbursement for your services or, we need the WCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the WCA this information. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the WCA at any time. (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal representative printed Personal representative signature

_____

Description of personal representative's authority to act for the patient.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. 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. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient Name Printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal Representative Printed Personal Representative Signature

_____

Description of personal representative's authority to act for the patient.