Scherping
Chiropractic

Chiropractic Adolescent Health Questionnaire

Welcome to our office! It is well known that families who maintain healthy, properly functioning spines have improved health and long lasting vitality. People whose spines are not functioning correctly are more likely to develop health disorders, immune compromise such as getting sick easier or allergies, pain, low energy, arthritis, and set themselves up for even worse health challenges.

Patient Name: ______________________ Date: __________

Address: ______________________

City: ______________ State: ________ Zip: __________

Sex: ______ Date of Birth: __________ Social Security #: ______________

Mother: ______________ Home Phone: ________ Work Phone: ________

Mother Address: (☐ Same As Above)

____

Father: ______________ Home Phone: ________ Work Phone: ________

Father Address: (☐ Same As Above) ______________________

Siblings Names: ______________ Age: ______ Sex: ______

______________ Age: ______ Sex: ______

______________ Age: ______ Sex: ______

______________ Age: ______ Sex: ______

Major Complaint Information

What is your reason for contacting us? ______________________

When did this begin? __________ ☐ Yes ☐ No – Have you had this before?

What aggravates it? ______________ What helps it? ______________

☐ Yes ☐ No – Does this condition interfere with your sleep? If so, how many times do you wake from pain per night? ______

☐ Yes ☐ No – Do any other symptoms accompany this? Please list: ______________

____

☐ Yes ☐ No – Have you seen another Doctor for this? Doctors name and specialty: ________

______________ Date consulted: ______ Diagnosis: ______________

☐ Yes ☐ No – Have you experienced these symptoms before? When? ______________

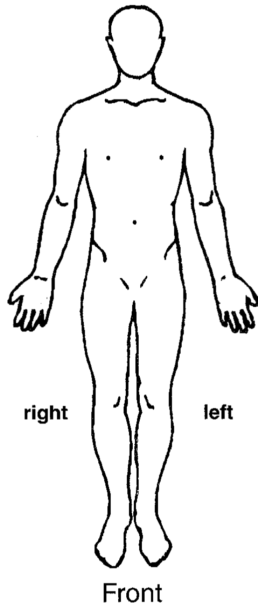
Did this develop from? ☐ an auto accident ☐ a work injury ☐ don't know (chronic) ☐ other

Childhood

Please check any problems the patient had during childhood:

☐ Falls or Injuries ☐ Respiratory problems ☐ Ear Infection
☐ Allergy/Asthma ☐ Bedwetting ☐ Digestive problems
☐ Medication ☐ Hyperactivity ☐ Hospitalization
☐ Convulsion ☐ Immunization ☐ Extremity or back pain
☐ Gait problems ☐ Antibiotic use ☐ Medications
☐ Other: ______________________

PLEASE MARK ANY AREAS WHERE SYMPTOMS ARE PRESENT AND DESCRIBE BELOW (type of pain [sharp, dull, achy, throbbing] and the intensity on a 1-10 scale when it is worst, i.e. sharp, shooting – 6):



Front

Description: ____________________

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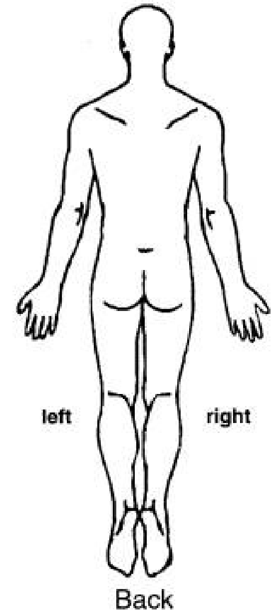

Back

If there were an affordable way to correct your Child's health problem, would you be willing to do what it takes to accomplish this now? ☐ Yes ☐ No

I hereby authorize this office and its doctors to administer chiropractic care to my son/daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

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Parent/Legal Guardian Date

For Office Use Only:

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Financial Policy

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions. In this Agreement, "Office" and "Clinic" shall refer to Scherping Chiropractic Pa located at 9664 663rd Avenue North, Maple Grove, MN 55369.

Personal Responsibility for My Charges. I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that any partial payments received by the Office towards my Charges, or any delay by the Office in collecting from me, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full upon demand, and shall not constitute an "accord and satisfaction" of my Charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment. I understand that there may be many other situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the office. I agree that if I have any questions about the Terms of Non-Coverage, I can ask to see copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I further agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may in my opinion not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any Payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall I hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize and direct the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers including, without limit, my health benefit plan. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, "Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws. In the event that no Mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "by Scherping Chiropractic PA, shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions. I have reviewed the Office's "Assignment & Lien" and Health Insurance Election forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference.

I have read, understood, and agree to the terms of this Agreement.

Patient Name (print): ____

Patient Signature: ______________________________________ Date: _____/_____/_____

Parent/Guardian Signature: ________________________________ Date: _____/_____/_____