Pinnacle Chiropractic & Wellness
10126 Brooks School Road, Fishers IN 46037
Phone: 317-288-4514 · Fax: 317-288-4517

ABOUT THE CHILD

Name of Child_____ Age _____Date of Birth_____

Gender ❑ M ❑ F Height _____ Weight _____

Whom may we thank for referring you to our office? _____

Parental Contact

Name of Parent: _____

Home Address _____City _____ State ____ Zip _____
Cell phone (_____) _____ E-mail _____

Cell phone provider for text reminders: AT&T Verizon Sprint T-Mobile Boost

☐ Contact info same as Parent's contact information on file with Pinnacle Chiropractic & Wellness

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Pinnacle Chiropractic & Wellness can address for your child? _____

_____

Related to: ❑ Sports ❑ Auto ❑ Fall ❑ Chronic ❑ Home Injury ❑ Wellness
Please describe how these concerns are affecting your child's quality of life. _____

_____

Check all that apply

❑ School
❑ Playing
❑ Communication
❑ Exercise/Sports
❑ Sleep
❑ Eating
❑ Walking
❑ Attention/Focus
❑ Daily Routine

EXPECTATIONS OF CARE

I would like my child to experience the following benefits from Chiropractic Care:

Check all that apply

❑ Symptomatic relief of pain or discomfort
❑ Correction of the cause of the problem as well as relief of symptoms
❑ Prevention of future problems
❑ Healthier spine and nerve system
❑ Optimal health on all levels
❑ Nutritional Support/Analysis

PATIENT NAME _____

PARENT SIGNATURE _____

PLEASE READ AND SIGN

1. I have been informed that a copy of Pinnacle Chiropractic & Wellness's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review both in the office and on the website at www.pinnacleatgeist.com.

2. I consent to receive communication from Pinnacle Chiropractic & Wellness via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.

3. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if my care is suspended or terminated, any fees for professional services rendered will become immediately due and payable. Should the account be referred to an attorney or collections agency for collection, I understand that I am fully responsible for any collections fees, attorney's fees, interest, and any other expenses incurred in the collection of past due accounts.

4. I understand and agree that insurance policies are an arrangement between myself and the insurance company. I am personally responsible for any cost of care not paid for by the insurance policy. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. I hereby authorize assignment of insurance rights and benefits (if applicable) directly to the provider for services rendered to me. I agree it is my responsibility to understand my insurance coverage in relation to chiropractic care, and not the responsibility of Pinnacle Chiropractic.

5. I understand that the purpose of chiropractic care, nutritional and massage care is to improve my health and wellbeing. Chiropractic does not claim to be a cure for any condition but vertebral subluxation. Chiropractic, massage and nutritional care is not a replacement for medical care. Though our chiropractors will evaluate your condition and refer to the proper physician if necessary, he/she will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. As with any health care, there are some risks to receiving chiropractic care, nutritional advise and/or massage therapy. These risks apply especially to elderly patients, those with a history of smoking, general poor health, and heavy medication usage. These risks include common, but not limited to issues such as muscular soreness or joint soreness, and more rare conditions such as fracture and vertebral artery dissection. If you have any questions about these rare adverse events, please ask your doctor.

The information I have provided on this case history form is true and accurate to the best of my knowledge.
I give Dr. Kathleen Wiemold and Dr. Korey Wiemold permission to render chiropractic care and/or Katie Nord LMT permission to perform massage therapy.

Name: (Printed)_____

Signature _____ Date:_____

Thank you for trusting Pinnacle Chiropractic & Wellness