



Please place a check next to any medications the child is taking now or has taken in the past:

<u>NOW</u>	<u>PAST</u>		<u>NOW</u>	<u>PAST</u>		<u>NOW</u>	<u>PAST</u>	
___	___	Aspirin	___	___	Ibuprofen	___	___	Other: _____
___	___	Decongestants	___	___	Tylenol	___	___	Other: _____
___	___	Antihistamine	___	___	Antibiotics	___	___	Other: _____

If applicable, please list any foods, drugs, or substances the child is hypersensitive or allergic to (include reaction):

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Please circle any of the following conditions that the child has experienced:

Chicken Pox	Rubella	Frequent Colds	Ear Infections
Allergies	Asthma	Pertussis (whooping cough)	Measles
Rheumatic Fever	Strep Throat	Mumps	Scarlet Fever
Pneumonia	Tonsillitis	Asthma	Croup
Heart Conditions	Tuberculosis	Diabetes	Cancer
Rheumatoid Arthritis	ADD/ADHD	Autism	Constipation
Chronic Loose Stools	Colic	Abdominal Pain	Headaches

Other: \_\_\_\_\_

Date of child's last physical exam: \_\_\_\_\_ Any unusual/abnormal findings: \_\_\_\_\_

Dental work done (include dates): \_\_\_\_\_

Has your child ever had any of the following? (please include when, why, and results)

Electroencephalogram (EEG): \_\_\_\_\_

Psychological evaluations: \_\_\_\_\_

Hearing test: \_\_\_\_\_

Speech/language tests: \_\_\_\_\_

Injuries/surgeries/hospitalizations (please list): \_\_\_\_\_

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Please circle any immunizations the child has had: (please include dates/ages)

MMR	DPT	Polio	Hib. Flu	Hep. A
Measles	Diphtheria	Chicken Pox	Flu virus	Hep B
Pertussis	Mumps	Tetanus	Small Pox	Other: _____

Adverse Reactions? Y/N

If so, what? \_\_\_\_\_

Does the child have a family history of any of the following? (please circle, if known)

Heart Disease	Mental Illness	Allergies	Tuberculosis
Hypertension	Diabetes	Osteoporosis	Asthma
Cancer	Arthritis	Birth defects	Other: _____

Prenatal History (if known):

Mother's age at child's birth: \_\_\_\_\_ Prenatal care? Y / N  
Difficulty conceiving? Y / N Infertility treatments used? Y / N \_\_\_\_\_

Mother's health during pregnancy (please circle, if known):

Bleeding	Nausea	Physical or emotional trauma	Diabetes
Drug or alcohol dependency	Thyroid issues	Hypertension	Illnesses: _____
Medication: _____		Other: _____	

Birth History (if known):

Weeks gestation at birth: \_\_\_\_\_ Vaginal or C-section (please circle) Weight at birth: \_\_\_\_\_  
Length of labor: \_\_\_\_\_ Complications: \_\_\_\_\_

Were forceps or vacuum extraction used? \_\_\_\_\_ Did the mother experience anxiety, sadness, or depression after the birth? \_\_\_\_\_

Did the child have any of the following shortly after birth?

Rashes	Birth injuries	Cerebral Palsy	Colic
Jaundice	Seizures	Birth Defects	Fever

Dietary History:

Breast fed? Y / N How long? \_\_\_\_\_ Formula fed? Y / N How long? \_\_\_\_\_ What type? \_\_\_\_\_

Food intolerances/reactions? \_\_\_\_\_

Age began solids: \_\_\_\_\_ Which foods? \_\_\_\_\_

Does the child have any dietary restrictions? (religious, vegetarian, etc.) \_\_\_\_\_

Describe Child's Typical Daily Diet:

Breakfast:

\_\_\_\_\_

Lunch:

\_\_\_\_\_

Dinner:

\_\_\_\_\_

Snacks:

\_\_\_\_\_

Drinks:

\_\_\_\_\_

Number of bottles given per day (include bottle size):

\_\_\_\_\_

Nursing frequency:

\_\_\_\_\_

*Health and Development:*

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit Up: \_\_\_\_\_ Crawl: \_\_\_\_\_ Walk: \_\_\_\_\_ Talk: \_\_\_\_\_

Describe your child's sleep pattern:

\_\_\_\_\_

\_\_\_\_\_

*Social/Environment:*

Is your child in:

School (grade \_\_\_\_\_) Daycare Homecare Other: \_\_\_\_\_

Who is/are the child's primary caregiver(s)?

\_\_\_\_\_

What are your child's favorite activities?

\_\_\_\_\_

Please describe the child's temperament:

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What are the child's strengths and challenges?

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Does your child exercise regularly? Y / N How much and how often? \_\_\_\_\_

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Does anyone in the house smoke? Y / N

How much television does your child watch? \_\_\_\_\_ hrs per (please circle: day / week)

Are there any animals in the house? Y / N Type: \_\_\_\_\_

How would you describe the emotional climate of the child's

home? \_\_\_\_\_

#### DECLARATION AND CONSENT TO TREATMENT OF A CHILD

Child's name: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, hereby give my consent for the practitioners of Benevolence Healing Arts to treat my child or ward. I take responsibility for all fees incurred.

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

Relationship to child: \_\_\_\_\_

Witness' signature: \_\_\_\_\_ Date: \_\_\_\_\_

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#### Acknowledgement of Receipt of Privacy Policy

Your signature below acknowledges that you have received Notice of our Privacy Practices.

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

**For Insurance Patients Only**

**Auto/Worker's Comp Insurance**

Is condition due to accident?   Auto   Work   Accident date: \_\_\_\_\_

Claim filed?   Y   N

Claim # \_\_\_\_\_

Insurance company: \_\_\_\_\_

**Group Insurance**

Insurance company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Policy holder's ID# \_\_\_\_\_

Group Plan # \_\_\_\_\_

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company. I assign all insurance benefits, if any, otherwise payable to me for services rendered, directly to my practitioner at Benevolence Healing Arts. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Gaurdian signature: \_\_\_\_\_ Date \_\_\_\_\_

**Financial Policy**

**Unless prior arrangement is made, full payment is due at the time of service.** Payment may be made by cash or personal check. For patients paying **in full** at the time of services, there is a 20% discount on all services. This does not apply to supplements, insurance co-pays or deductibles.

For your convenience, we will bill your insurance provider. We will contact your insurance company for verification of benefits. However, insurance companies may reimburse differently than the information they initially provide to us. You are responsible for and will be billed for any resulting unpaid balance. If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service. You are expected to pay your deductible if it is still due, your co-payment, for any non-covered services, and for all supplements and products at the time of service.

Please provide us with notice of cancellation at least 24 hours in advance of your scheduled appointment. If cancellation notice is less than 24 hours, or you fail to come for a scheduled appointment, there will be a \$25.00 fee.

**Accounts greater than 30 days past due will be charge a \$10 administrative fee. Accounts greater than 90 days overdue will be sent to a collections agency,** unless you are making timely payments on an approved payment plan. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service. There will be a \$35.00 fee for a returned check.

**Financial Agreement:**

- I have read the policies above and understand them.
- I understand that I will be provided a copy of this policy at my request.
- I agree to promptly pay all fees and charges for treatment provided to me and/or my family.
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full.
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance.
- I understand that if I disagree with any charges, I will contact this office in writing within 30 days of the billing date.
- Should legal action be taken by this office to collect an unpaid balance due for services provided, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

These policies are subject to change without notice.

I have read, understood and agree to the policies described above:

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

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