Korman Relief & Wellness Center
Laura R. Korman, DC, DACBN
16954 Toledo Blade Blvd. Port Charlotte, FL 33954
941-629-6700

PEDIATRIC NEW PATIENT INFORMATION

Today's Date: _____/_____/_____

Child's Name: _____ Birth Date: ____/____/____ Age: _____ Sex: M / F

Birth Weight: _____ Current Weight: _____ Birth Length: _____ Current Length: _____

Address: _____ City: _____ State: _____ Zip:_____

Child's Race (check all that apply): _____ White _____ American Indian or Alaskan Native _____ Asian
_____ Black or African American _____ Hispanic or Latino _____ Native Hawaiian or Other Pacific Islander

Reason for your appointment today: _____

Mother's Name: _____ Phone: _____

Father's Name: _____ Phone: _____

Any additional children you may list here: _____

_____

Insurance Provider: _____ Policy #: _____

Type of Birth (circle all that apply): Vaginal / Forceps / Breech / Cesarean / At Home / Birthing Center / Hospital

Was there a presence at birth of: Jaundice (yellow) / Cyanosis (blue) APGAR Scores: _____ _____

List problems during pregnancy: _____

_____

List problems during labor and/or delivery: _____

_____

Name of Obstetrician / Midwife: _____

Name of Pediatrician / Family Doctor: _____

Infant Feeding: Breast / Bottle / Formula How Many Months? 2+ / 4+ / 6+ / 8+ / 10+ / 12+

Quality of sleep: Good / Fair / Poor Number of hours per night: 0 / 2+ / 4+ / 6+ / 8+ / 10+

Congenital anomalies or defects:

_____

Please list all immunizations:

_____

_____

Date of last doctor visit: _____/_____/_____ Reason: _____

Has your child ever been treated on an emergency basis? Yes / No

If yes, please explain: _____

_____

_____

How were you referred to our office? _____

PEDIATRIC CASE HISTORY

Pregnancy History:

_____

_____

_____

Date _____/_____/_____ Guardian Signature _____

PEDIATRIC CASE HISTORY (cont'd)

Delivery / Birth History:

_____

_____

_____

Present History:

_____

_____

_____

Surgeries: _____

Medications: _____

Allergies and Reactions: _____

Family History of Illness: _____

Accidents: _____

Developmental History: At what age did the child …

_____ Respond to sound _____ Hold Head Up _____ Sit Up _____ Walk

_____ Follow an object with his / her eyes _____ Crawl _____ Stand

Check if the child has had the following diseases:

____ Chickenpox ____ Mumps ____ Measles ____ Whooping Cough ____ Rubeola ____ Rubella

Has the child ever suffered from…

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

Authorization For Care Of A Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary for my son/daughter/ward (upon approval of parent/guardian).

Signed _____ Witnessed _____ Date _____

I realize that I am responsible for all fees charged by this clinic and that I will pay for services as they are performed. X-rays remain the property of the clinic.

Signed _____ Witnessed _____ Date _____

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Consent to Treatment of a Minor

I hereby authorize this clinic, its doctor(s), and/or staff to administer care and/or treatment, as they deem necessary, for my (circle one) son / daughter / other _____ upon the approval of the parent / guardian.

I am aware that, as the parent/guardian, I am responsible for all fees charged by this clinic, and that I will pay for services as they are performed.

Full name of minor (please print):_____

Full name of guardian (please print)_____

Signature of guardian _____ Date _____

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OFFICE & PAYMENT POLICY INFORMATION

OUR GOAL:
We believe that a clear definition of our office policies will allow you, the patient, and us, the doctor, to concentrate on the big issue - REGAINING AND MAINTAINING YOUR HEALTH. It is the goal of this office to provide you with the finest quality healthcare available. If you have any questions regarding your healthcare, or any of our policies, please let us know. We welcome your referrals and look forward to a mutually rewarding doctor-patient relationship.

FINANCIAL POLICY:
Payments for Healthcare Services provided in this office are due the day that services are rendered, unless other arrangements have been made prior to seeing the doctor. Patients are personally responsible for all charges.

This office uses a collections service to collect on unpaid, past due charges. Past due accounts will receive a notice from our office before the account is sent to collections. Once sent to collections, there will be an assessed fee of $30 *minimum* added to the past due account. The account holder is responsible for total past due balance, in addition to the collections fees added.

INSURANCE POLICY:
I understand, and agree, that health and accident insurance policies are an arrangement between my insurance company and myself, and ***not*** between my insurance company and this office.

Assignment of Insurance benefits will be accepted upon proper verification of coverage and at the discretion of this office, however **benefits quoted are not a guarantee of payment.** Benefits are determined at the time of processing. In the event that an "Explanation of Benefits" comes back stating patient responsibility, the patient will be sent a bill.

This office does not file for, or accept assignment for, out-of-network or secondary insurance benefits. We will, however, provide you with documentation to assist you in collecting from your insurance carriers.

APPOINTMENT POLICY:
We want to thank you for choosing us as your healthcare provider. Please remember that we have reserved appointment times especially for you, and we attempt to honor all appointments at the scheduled time. Therefore, in the event you are unable to keep an appointment for any reason, we request that you call immediately to reschedule your visit. This will enable us to schedule other patients for that time.

When you cancel your appointment at the last minute, everyone loses - you, the doctor, and other patients who would like to have utilized your appointment time. ***In the event that you do not contact our office to cancel or reschedule your appointment, at least 2 hours prior to your scheduled time, you may be billed a $20 missed appointment fee. Failure to comply may result in dismissal of care.***

I have read and understand the above policies. Any questions I had have been answered to my satisfaction, and I understand my responsibility as a patient. I also understand that if my insurance does not respond within 90 days, or if I suspend or terminate my schedule of care as prescribed by Korman Relief & Wellness Center, all fees will be due and payable immediately.

Should there be any instance of a bounced or returned check, I acknowledge that I will be charged a fee of $36 **per bounced check.**

PATIENT SIGNATURE: _____ **DATE:**_____

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INFORMED CONSENT FOR THERAPY TREATMENT

Physicians and physical therapists who perform soft tissue therapies and spinal manipulations are required by law to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative, non-invasive treatments to the joints and soft tissues. I understand that the procedures may consist of soft tissue and/or spinal manipulations involving movement of the joints and soft tissues.

Physiotherapies and exercises which may be used by this office include:

1. Class IV Deep Tissue Laser
2. Infrared Light Therapy
3. Vibration Plate and/or Whole Body Vibration
4. Back on Trac (Low Back Decompression and/or Cervical Decompression)
5. Knee Trac (Knee Decompression)
6. EMS
7. Ultrasound
8. Rebuilder
9. Specialized Myoneural Therapy

Although these treatments are considered to be safe for neuromuscular problems, I realize that there are possible risks and complications associated with these procedures, as follows:

- **Soreness:** I am aware that, like exercise, it is common to experience muscle and/or joint soreness after the first few treatments.
- **Physiotherapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering.
- **Bruising:** Mild bruising may occur as a result of the soft tissue therapies.
- **Joint Injury:** I further understand that, in isolated cases, underlying physical defects, deformities, or pathologies, such as weak bones from osteoporosis, may render a patient susceptible to injury. When osteoporosis, degenerative disc(s), or any other abnormality is detected, this office will proceed with caution.

TREATMENT RESULTS

I also understand there are beneficial effects associated with these treatment procedures, including decreased pain and inflammation, increased circulation, and mobility. However, I appreciate that there is no certainty that I will achieve these benefits.

I have read, or have had read to me, the above explanation of soft tissue treatment. Any questions have been answered to my satisfaction. I made this decision freely and voluntarily.

Signature_____ Date _____