Child's Name _____ Parent(s)/Guardian(s) Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it okay to contact you at work? ❑ Yes ❑ No

E-mail _____ Child's Social Security # _____ Birthdate _____ Age _____

Have your or your child ever had chiropractic care before? ❑ Yes ❑ No

If yes, please tell us the doctor's name _____

Were you pleased with your care? ❑ Yes ❑ No

How did you find out about our office? _____

Is this appointment related to an auto accident? ❑ Yes ❑ No

If this injury is related to an auto accident, please fill out the Auto Accident Questionnaire

Is your child receiving care from other health professionals? ❑ Yes ❑ No

If yes, please name them and their specialty _____

Who is your family's primary care physician? _____

Please list any drugs or medications your child is taking _____

_____

Please list any vitamins/herbs/homeopathics/other your child is taking _____

_____

Please list any allergies your child has _____

_____

What health condition brings your child to our office? _____

_____

When did the symptoms first begin? _____

How did the problem start? ❑ Suddenly ❑ Gradually ❑ Post-Injury

Is this condition ❑ Getting Worse ❑ Improving ❑ Intermittent ❑ Constant ❑ Not Sure

What makes the problem better? _____

What makes the problem worse? _____

Has your child ever had a similar condition? ❑ Yes ❑ No

Please explain _____

Has your child been treated for this problem before? ❑ Yes ❑ No

Please explain _____

Does your child eat well? ❑ Yes ❑ No Does your child have regular bowel/bladder movements? ❑ Yes ❑ No

Has your child ever been checked for vertebral subluxations? ❑ Yes ❑ No ❑ Don't Know

Child's birth was ❑ At home ❑ At a birthing center ❑ At a hospital

My obstetrician/midwife/family physician was _____

Child's birth was ❑ Natural vaginal (no mediciations/interventions)

❑ Vaginal with interventions

❑ Induction ❑ Pain medication ❑ Epidural ❑ Episiotomy ❑ Vacuum extraction ❑ Forceps

❑ Other _____

❑ C-section

❑ Scheduled ❑ Emergency

Please list reasons for any interventions/complications _____

_____

Child's birth weight _____ Child's birth height _____ Current weight _____ Current height _____

APGAR score at birth _____ APGAR score after 5 minutes _____

Was your child alert and responsive within 12 hours of delivery? ❑ Yes ❑ No

If no, please explain _____

At what age did the child:

Respond to sound_____ Follow an object _____ Hold head up _____ Vocalize_____

Sit alone_____ Teethe _____ Crawl _____ Walk _____

Patient/Hospitialization/Surgical history (please list below all surgeries and hospitalizations, including the year)

_____

_____

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year

_____

_____

Is/was your child breastfed? ❑ Yes ❑ No If yes, how long? _____

Formula introduced at age _____ What type? _____

Introduction of cow's milk at age _____ Began solid foods at age _____

Please list any foods/juice intolerance _____

Did mother smoke during pregnancy? ❑ Yes ❑ No

Did mother drink alcohol during pregnancy? ❑ Yes ❑ No

Any illness of mother during pregnancy? ❑ Yes ❑ No

If yes, please explain including treatment/medications/supplements _____

_____

List any drugs/medications (including over the counter) taken during pregnancy _____

_____

List any supplements taken during pregnancy _____

Any exposures to ultrasound? ❑ Yes ❑ No If so, how many and what was the medical reason? _____

_____

Any pets at home? ❑ Yes ❑ No Any smokers at home? ❑ Yes ❑ No

GROWTH & DEVELOPMENT CONTINUED...

Has child received any vaccinations? ❑ Yes ❑ No

If yes, which ones and list any reactions _____

_____

Has child received any antibiotics? ❑ Yes ❑ No If yes, how many times and list reason _____

_____

Any difficulty with breastfeeding? ❑ Yes ❑ No If yes, please explain _____

_____

Any difficulty with bonding? ❑ Yes ❑ No If yes, please explain _____

_____

Any behavioral problems? ❑ Yes ❑ No If yes, please explain _____

_____

Any night terrors, sleepwalking or difficulty sleeping? ❑ Yes ❑ No If yes, please explain _____

_____

Age child began daycare _____ Average number of hours of TV per week _____

Does your child seem normal for their age? ❑ Yes ❑ No If no, please explain _____

_____

FAMILY HISTORY REVIEW

Check those involving immediate family and add identification: M=Mother; F=Father; S=Siblings; G=Grandparents

❑ Cancer, type _____ ❑ M ❑ F ❑ S ❑ G

❑ Depression ❑ M ❑ F ❑ S ❑ G

❑ Diabetes ❑ M ❑ F ❑ S ❑ G

❑ Back Problems ❑ M ❑ F ❑ S ❑ G

❑ Heart Disease ❑ M ❑ F ❑ S ❑ G

❑ Liver Disease ❑ M ❑ F ❑ S ❑ G

❑ High Blood Pressure ❑ M ❑ F ❑ S ❑ G

❑ High Cholesterol ❑ M ❑ F ❑ S ❑ G

❑ Lung Problems ❑ M ❑ F ❑ S ❑ G

❑ Scoliosis ❑ M ❑ F ❑ S ❑ G

❑ Neck Problems ❑ M ❑ F ❑ S ❑ G

❑ Osteoporosis ❑ M ❑ F ❑ S ❑ G

❑ Seizures ❑ M ❑ F ❑ S ❑ G

❑ Osteoarthritis ❑ M ❑ F ❑ S ❑ G

❑ Rheumatoid Arthritis ❑ M ❑ F ❑ S ❑ G

❑ Other _____

_____

DO YOU NKOW ABOUT CHIROPRACTIC?

Do you know what a subluxation is? ❑ Yes ❑ No

Do any of your friends or relatives see a chiropractor? ❑ Yes ❑ No

If yes, do they use chiropractic for ❑ Health maintenance/optimization ❑ Health problems ❑ Both

Are you seeking chiropractic for ❑ Health maintenance/optimization ❑ Health problems ❑ Both

What would you like to gain from chiropractic care? _____

_____

Are there other health concerns or anything else you'd like us to know about your child? _____

_____

McCann Family Chiropractic
11605 State Avenue, Suite 111, Marysville, WA 98271
360-657-7183

McCann Family Chiropractic Office Financial Policy

Welcome to McCann Family Chiropractic. Our goal is to provide you with excellent service, including transparent financial policies and procedures. Please read this policy carefully and do not hesitate to ask a member of our team if you have any questions.

Primary Contact: Billing Coordinator, Stephanie Lofton, backdesk@mfcwellness.com

Insurance Coverage

Your insurance policy is an agreement between you and your insurer, not between your insurer and this office. Like all types of care, coverage for chiropractic and massage services varies from insurer to insurer and plan to plan. Our office will call your insurer to verify your benefits, however, we are not responsible for your insurer's final payment and benefit determinations.

It is your responsibility to understand your benefit plan. You are responsible for any and all deductibles, co-payments, and co-insurances. Co-payments and co-insurance payments are due at the time of service. Deductible amounts are due immediately upon receipt of an Explanation of Benefits. You may keep a credit card on file for payment of services. Your credit card information will always be stored securely and this will help to ensure your account is current and not subject to late fees.

Additionally, not all services are covered by insurance. We will make every attempt to inform you of non-covered services so that you can make an informed decision; however, **you are ultimately responsible for all services rendered**.

Please inform us of any insurance changes as soon as you are aware of them, including auto accidents or work injuries.

Time Of Service Discount

If our providers do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. If you do not have insurance or we do not participate in your insurance plan, you may be entitled to a 20% time of service discount ("TOSD"). This discount reflects a reduction in our costs for not having to bill you or your insurance company. In order to be eligible to receive this discount, you **MUST** pay at the time of service and no balance may be outstanding on your account.

Wellness care and supplements are not covered by insurance and are not billed to third parties. Therefore, no TOSD applies.

Care Plan

You may be offered an estimated care plan with a monthly payment option. Care plans require a credit or debit card to be kept on file for monthly auto-payment. Further details regarding care plans will be discussed if this option applies to you.

Cancellation Policy

Please call our office to cancel your appointment by 8 AM the business day prior to your appointment. (Business day is Monday to Friday, regardless of whether the office is open for chiropractic or massage appointments over the weekend). There is no cancellation fee for chiropractic appointments, however, we greatly appreciate the courtesy of your notice.

Massage cancellations that do not adhere to the above policy are billed at $50. This fee is not billable to any insurance company, including work or auto injury, and is your direct responsibility.

Past Due Accounts

Any account with a balance of greater than 30 days may be charged a service fee of 12% per year, compounded monthly. Any account where no payment has been received for over 60 days, and has not made payment arrangements with the Billing Coordinator may be sent to a third party collections agency. Any additional collection fees will be the responsibility of the patient.

NSF checks or rejected credit card payment will be charged a service fee of $25 per occurrence.

Patient Name(s): _____

_____ _____

Responsible Party's Name Relationship

_____ _____

Responsible Party's Signature Date

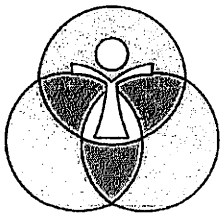
PATIENT ACKNOWLEDGMENT

I acknowledge I have received and read the Notice of Privacy Practices.

Name _____ Date _____

Signature _____

Relationship to Patient (if patient is a minor or not able to sign) _____



Consent to Evaluate and Adjust a Minor

I, _____, being the parent or legal guardian of

_____ have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care, consisting of evaluation and adjustments (if necessary) while I am not present.

Signature: _____ Date: _____

McCann Family Chiropractic

11605 State Avenue, Suite 111
Marysville, WA 98271

360-657-7183 p
360-657-7188 f

Date:_____

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, or other communications.

I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

_____ _____

Patient name

Patient Signature
(Parent/Guardian if patient under 18 years of age)

Text / Email (circle one and fill in space below)

Cell number: _____ Email: _____

If Text is preferred, cell phone provider: _____

Receive reminder how soon before appointment? (circle one)

1 hour
4 hours
1 day

McCann Family Chiropractic

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360-657-7183

McCann Family Chiropractic: COVID-19 Policies & Procedures Update

November 17, 2020

Our goal is to provide you with excellent service, including ensuring your safety during the ongoing COVID-19 pandemic.

Masks

A cloth face covering is required to be worn during the entirety of your office visit. We cannot make exceptions due to philosophical objections. We will provide you with a mask if you do not have one.

During your visit, you may need to lower your mask when:

1. Taking an upper neck x-ray. Dr. Matt or our Exam Technician will advise you when to remove your mask.
2. Lying face down on the adjusting table. Many patients find it difficult to breathe when a mask is on while lying face down. You may lower your mask during this time. Please ensure your mask is on during the rest of your adjustment.

What if I have a valid medical exemption?

If you have a ***valid medical exemption***, our strong preference is that you wear a face shield. In this case, you may proceed with your appointment as usual.

If you are unable to wear a face shield, **please call the front office when you arrive**. Our front desk CAs will advise you of other procedures and you will be taken immediately back to your appointment room, when it is ready. Please do not enter before your room is ready for you. All common areas, including lobby, should not be used by those who are unable to wear a mask or face shield.

Social Distancing

Please maintain 6 feet social distancing when in our office. Due to this requirement, the front lobby area is limited to a total of ***four*** patients at any time (this includes people from the same family).

- If there are more than 4 people in the lobby, please call the office to let us know you've arrived and wait in your car.
- If you are more than 10 minutes early to your appointment, please call when you arrive so we can be sure we can accommodate you in the lobby
- Please do not bring extra guests to your appointments. A parent may accompany a minor child.
- Please do not ***linger*** in the front desk area after your adjustment. We will take care of payment, scheduling, and any other needs on your way in. Please exit the facility directly after your treatment is complete.

Wellness Based Clinic

We are a symptom free office! No employees, patients, or others may have any symptoms of COVID-19 while in our facility. Please do not enter if:

- You or any member of your household have been advised by a medical professional to quarantine due to COVID-19 illness or exposure.
- You are awaiting COVID-19 test results.
- You or any member of your household are experiencing fever, sore throat, cough, shortness of breath, loss of smell or taste, or any other respiratory symptoms.

Other Procedures

1. Upon arrival, we will check your temperature.
2. Upon arrival, please sanitize your hands.
3. All pens and stylus' used for check-in are sanitized after each use. All high touch areas are sanitized frequently throughout the day. All treatment areas are sanitized after each appointment.
4. Hand sanitizer is available throughout the facility.
5. We have installed high quality HEPA air filters throughout the office to improve air quality and provide extra safety.

Thank you for helping us keep our facility safe for all!

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received and read McCann Family Chiropractic's Notice of COVID-19 Policies and Procedures, dated November 17, 2020

Name _____ Date _____

Signature _____

Relationship to Patient (if patient is a minor or not able to sign) _____