Preston Peacock DC DABCO
408 SW HWY 80
Pooler, GA 31322

Phone 912-748-0350
Fax 912-450-0350
Email: advancedchiro912@gmail.com

Pediatric Complaint Questionnaire

(Please Print Legibly)

Name:____Date:______________________

Address:____

City:________________________State:______________Zip:_____________________

Home #:__________________Cell #:__________________Work #:_________________

Date of Birth:__________________ E-mail Address:____________________________

Insurance Carrier:____

State your current present complaint:_______________________________________
When did this occur:____

Please circle all that apply. It feels like:
Burning Sharp Achy Dull Shooting Throbbing

Describe any other pain:____
What makes it better:____
What makes it worse:____

Have you had the same or similar condition? Yes No
Have you visited any other doctors for this condition? Yes No
Name of Doctor:____
Treatment Provided:____

Is this condition due to an injury or sickness arising from an employment or auto accident? Yes No
If yes, please state when:____

Please list all medication:____

ADVANCED
Chiropractic Center

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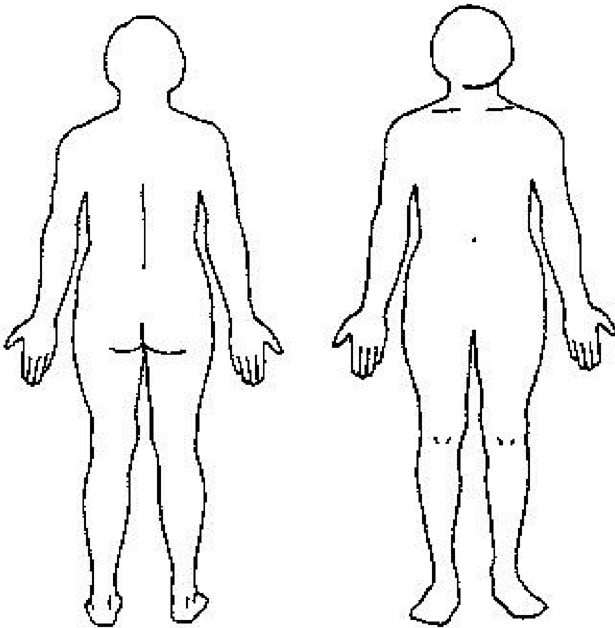
RATE YOUR PAIN

Place an "X" on the drawings where you have pain and indicate the type of pain you are experiencing:

A= Ache B=Burning
N=Numbness P=Pins and Needles
ST=Stabbing SP=Spasm
T=Throbbing



Additional notes:

____
____
____
____
____
____
____
____
____
____
____

Pain Scale

Please circle the number that best describes your **OVERALL** pain:

0 1 2 3 4 5 6 7 8 9 10 10+

None Little Moderate Severe Excruciating

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMAITON TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Advanced Chiropractic Center has the right to use and/or disclose information about me (or someone else for whom I have the authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations. I understand they will not release any record without written authorization by me or persons elected.

The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge by asking for it.

I have the right to request restriction on how my information is used and/or disclosed in order to execute treatment, payment or healthcare operations. While the Practice is not required to agree to restrictions, the Practice is bound to adhere to any such restrictions to which is has agreed.

I have the right to revoke this consent in writing. Revocations will be honored from the time written and delivered to the Practice, but revocation cannot affect action already taken in reliance upon the consent given.

I realize that my personal information that is protected by federal privacy law may be used and/or disclosed at my consent and that the information may be subject to re-disclosure by the recipient.

The Practice may communicate confidential information to me, including invoices for services, e-mail, and call for appointment times or missed appointments, birthday cards and Holiday cards.

I also realize that I may be overheard or may hear other patients talking while in the therapy bay.

____

Authorizing Patient Name (Please Print)

____

Signature Date

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The following is a statement of our financial policy. We require you to sign and read this document prior to treatment by this facility.

Patients without Insurance:
We request that 100% of the first visit be paid at the time of service. We do offer a time of service discount for follow-up visits. We are happy to accept your cash/check, MasterCard, Visa or Discover Credit Card. **Initial ____________**

Group or Individual Insurance:
Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are **not a guarantee of payment.** As a courtesy to you, our office will file your claim with your insurance carrier. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, co pays or deductibles. It is the patient's responsibility to understand their insurance coverage.
Initial____________

Patient Responsibility
When you receive a statement from our office you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, please contact our office. Do not ignore the bill as it may result in turning the balance over to an outside collection agency.

I understand that I am financially responsible to Advanced Chiropractic Center for any balance not covered by the insurance carrier. **Initial____________**

Assignment of Benefits
I authorize this office to release any medical information relating to my treatment to any insurance companies, which may be responsible for paying benefits to me. I hereby assign and authorize my insurance benefits to be paid directly to Advanced Chiropractic Center.

____
Patient name (please print)

____
Patient or Responsible Party's Signature
Date

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CREDIT GUARANTEE
INSURANCE ASSIGNMENT

INSURANCE ASSIGNMENT

Our Insurance Assignment Program is designed to keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. As a prerequisite, we ask that you leave a credit card to guarantee payment.

FILING PROCEDURE

Claims for initial services are submitted within 5 days after your first visit.

If the bill has not been paid by your insurance company within 3 months, we will contact you to discuss the issue. If the issue cannot be resolved with your insurance company, the liability will then fall to you and we will make 3 attempts to collect the payment with you. If no payment can be collected, we will then charge your credit card.

PERSONAL BALANCES

Estimated personal portions are paid at the time of service unless you prefer to pay weekly. Weekly payments also require this credit card guarantee, and any personal balance not paid by Friday will also be automatically charged to your designated card below.

CREDIT CARD: ❒VISA ❒ MC ❒ DISCOVER

CARDHOLDER NAME ____

CARD # ________________________________ EXP. DATE___________

CVC #:_______________

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 90 days after submission of my claim, or should I terminate care before being dismissed by your physician, I will be charged the amount due.

_____________________________________ ___________________
SIGNATURE DATE

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Consent to Treat Minor

Patient Name: ________________________

I hereby request and authorize **Dr. Preston Peacock** to perform diagnostic tests and physical examination to____________________.
(name of minor)

As of the date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date: ____________________

____
Signature

____
Witness

____
Printed Name

____
Relationship to Patient