Dr. Sarah Rowden, D.C.
Dr. Josh Rowden, D.C.
www.nwahealthsolutions.com
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nwa HEALTHSOLUTIONS
"Beyond Traditional Medicine"

5300 S. Southern Hills Ct., Ste 200
Rogers, AR 72758
P 479.636.1324
F 479.631.0014

Registration Form for Minor (Newborn to 10 years of age)

Child's Full Name:_____ Preferred Name :_____Date:_____

Mother's Full Name:_____ Father's Full Name:_____

Address:_____ City/Town:_____ State: _____ Zip: _____

Home Phone #: _____ Mother's Cell Phone: _____ Father's Cell Phone:_____

Mother's Occupation:_____ Mother's Employer:_____

Father's Occupation:_____ Father's Employer:_____

Birth Date: ____/____/____ Birth Weight: _____ Birth Length: _____ No. of Siblings:_____

Age:_____ Sex: M F Current Weight:_____ Current Length: _____

Insurance Provider:_____ Policy Number: _____

How did you hear about us?

CHECK ALL THAT APPLY _____Friend/Family _____Physician/Midwife _____Newspaper ____Radio

_____Event _____Internet/Google _____Phone Book _____Close to home/work ____Magazine

_____Other _____Malco Theatre _____Facebook _____Mail

Name of person who referred you: _____

Type of Birth: Normal Vaginal_____ Forceps_____ Breech_____ Cesarean_____

Home_____ Birthing Center_____ Hospital_____

Was there presence at birth of: _____Jaundice (yellow) _____Cyanosis (blue) Apgar Score:_____

Problems during Pregnancy:_____

Problems during Labor/Delivery:_____

Congenital Anomalies/Defects: _____

Infant Feeding: _____Breast _____Bottle _____Formula

No. of Hours Sleep per night: _____ Quality of Sleep: _____Good _____Fair _____Poor

Obstetrician/Midwife: (name)_____ (location)_____

Pediatrician/Family MD: (name)_____ (location)_____

Date of last visit to MD:_____ Purpose:_____

Immunization History:_____

Purpose of this Appointment:_____

Has your child ever been treated on an emergency basis? Y N Describe:_____

In Case of Emergency Contact: (Local Friend or Relative, not living at same address)

Full Name:_____ Relationship to Patient:_____

Work Phone #:_____ Cell Phone #:_____

Please provide a copy of parent's driver's license to the receptionist, for our records.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection and payment of medical bills from the insurance company. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to_____ are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate the care and treatment of _____, any fees for professional services rendered to me will be due immediately.

Guardian's Signature: _____ Date: _____

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Pediatric Case History

What is the current complaint? _____ How long has this been present? _____

Circle any other symptoms that may be present:

- Anxiety
- Back Pain
- Back Stiffness
- Colic
- Depression
- Dizziness
- Ear Infections
- Gassy
- Headaches
- Irritability
- Neck Pain
- Neck Stiffness
- Nausea/Vomitting
- Numbness in Arms
- Numbness in Legs
- Pins & Needles Arms
- Pins & Needles Legs
- Reflux
- Teething
- Tension
- Trouble Sleeping

Have you had similar symptoms before? Yes_____ No_____ How long ago? _____

Symptoms other than above _____

Have you seen another doctor for this condition? Yes_____ No_____ If yes, Dr. _____

Developmental History: At what age did the child:

_____Hold Head Up
_____Sit Alone
_____Crawl
_____Stand
_____Walk Alone

If any of the following are pertinent to your medical history, please indicate:

- Allergies
- Anemia
- Asthma
- Backaches
- Bedwetting
- Behavioral Problems
- Broken Bones
- Chronic Ear Infections
- Concussion
- Constipation
- Convulsions
- Diabetes
- Diarrhea
- Digestive Disorders
- Dizziness
- Epilepsy
- Fainting
- "Growing Pains"
- Heart Problems
- Hernia
- Hyperactivity
- Nervousness
- Sinus Problems
- Stomach Aches

Medications_____
Surgeries_____
Accidents_____
Relevant Family History_____
Is there anything else we need to know? _____
_____

Patient Signature: _____ Date: _____

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Consent to Treat

The information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of NWA Health Solutions to administer such procedures and treatment as they deem necessary. I have read and understand the Informed Patient document. I also understand any nutritional counseling I may receive in this clinic is strictly a recommendation of the doctor. I am aware that the doctors here at NWA Health Solutions are chiropractors, and their nutritional recommendations are based on the education they received through Parker College of Chiropractic. The doctor has answered any questions I may have. The doctor has implied no guarantee of cure.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Consent to Treat Minor

The information I have given this office pertaining to _____ is truthful and complete to the best of my knowledge. I authorize the doctors and staff of NWA Health Solutions to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. I also understand any nutritional counseling my child/ward in my legal custody may receive in this clinic is strictly a recommendation of the doctor. I am aware that the doctors here at NWA Health Solutions are chiropractors, and their nutritional recommendations are based on the education they received through Parker College of Chiropractic. I have read and understand the Informed Patient document. The doctor has answered any questions I may have. The doctor has implied no guarantee of cure.

Parent or Guardian Signature: _____ Date: _____

Relationship to Minor: _____

Doctor Signature: _____ Date: _____

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Informed Patient

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions of the patient. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When VSCs are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no Doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT TO CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a Chiropractic adjustment if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or learn from healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention to the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions that do not respond to Chiropractic care, may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the Doctor **BEFORE** signing the Consent to Treat.

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**

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We appreciate all of our patients and want to give each one of you the one-on-one time that is needed for your appointment. When you schedule an appointment with our providers, we take that time to devote to you so we can give you the best treatment possible. When you are late, miss your appointment, or cancel an appointment without 24 hour notice, you are taking a time slot away for another patient.

We enjoy all of our patients and want to continue to grow and work with each one of you. With that being said:

NWA Health Solutions will apply a $25 fee for:

- Missed appointments
- Cancelled appointments that are not cancelled without 24 hour notice
- Late arrivals- if you arrive 15 minutes after your appointment time.

Thank you,

NWA Health Solutions

Patient Signature _____

Date: _____

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Patient Billing Acknowledgement Form Maintenance/Elective Care/Non-covered**

Under your health plan, you are financially responsible for co-payments, co-insurance or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

If you have United Health Care, UMR or Golden Rule your insurance will only cover up to $50.00 of your care- any charges after the $50.00 is **not** able to be billed to your insurance and will be considered for our cash prices.

If you have Medicare or Medicaid Dr. Josh and Dr. Sarah Rowden have opt out as being in network providers. Please be aware that we have to have a signed consent from the patient before Dr. Josh or Dr. Sarah treat any Medicare and Medicaid patient's. This consent form acknowledges that you have been informed of NWA Health Solutions option to opt out of being a Medicare/ Medicaid provider and you have the understanding that we will not be billing your insurance for services rendered in our office.

P R O V I D E R

Services to be provided are listed below:

- Chiropractic Manipulative Therapy: 98940; 98942; 98941 (spinal manipulation) 98943 (Extra Spinal manipulation ex: knee, arm, shoulder etc.)
- Modalities/Procedures: 97012 (Roller Table), 97014 (electrical Stimulation), 97140 (Manual therapy) 97110 (therapeutic exercise), Spinal Decompression, and Cold Laser
- DME: Posture Pump, TENS Unit, Lumbar support, lumbar support belt, knee strap, my pillow or Tri pillows
- Other: Xrays

P A T I E N T

I _____, acknowledge that I have been told in advance that the services/
Patient Name – Printed or Typed provider

Products listed above may or are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature Date

_____ _____