



Fee Policy

Initial Consultation Adult - \$85

Initial Consultation Child - \$75

Regular Health Check-up Adult - \$50

Regular Health Check-up Child - \$45

Progress/Re-Examination Adult - \$65

Progress/Re-Examination Child - \$55

Cancellation and "No Show" Policy

Kauri Chiropractic accepts cancellations until 24 hours of your scheduled appointment. Beyond this Kauri Chiropractic reserves the right to charge the patient in full for the appointment time. Unless it's an emergency, a strict 'no show' fee is in place where if that patient fails to turn up for a scheduled appointment, without 24 hours' notice, payment for the service will be charged in full. Patients that are 10 minutes late past their scheduled appointment time are deemed "no shows" and will be charged for their appointment in full. Please note that if you are 10 minutes late and past your appointment time, you may no longer be able to be treated by the Chiropractor, and it is up to the clinic staffs discretion whether you will be able to proceed with an appointment. This policy is to respect all scheduling of patients who have appointments booked and the Chiropractors schedule. Staff want to work with you to reschedule your appointment, provided you give adequate notice.

Signature_____

Chiropractor_____

New Practice Member Health Profile - Child

It is our pleasure to welcome you to our family of happy and healthy chiropractic members. Please let us know if there is any way we can make you and your family feel more comfortable. Many types of stressors (physical, mental and chemical) can interfere with your child's growing brain, spine and nervous system. To help us serve you better, please complete the following history information about your child. We look forward to working with you to build a better future for your family.

Name _____ DOB _____ Age ____ M / F

Address _____ City _____ Prov ____ Postal Code _____

Height _____ Weight _____ Parent / Guardian Name(s) _____

Ph. Home _____ Cell _____ Email _____

Do you prefer Text OR Email reminders? TEXT DAY OF EMAIL TWO DAY BEFORE

Who may we thank for referring you? _____

My child is here for:

Wellness Overall Health Improvement Specific Health Concern(s) _____

Check any of the following that currently or previously apply:

Abnormal Posture Back Pain Colic Headaches Temper Tantrums
 ADD / ADHD Bedwetting Constipation Language Delay Torticollis
 Allergies Behavioral Issues Digestive Problems Recurring Fevers Other _____
 Asthma Car Accident Ear Infections Scoliosis _____
 Autism Chronic Colds Growing Pains Seizures

How are these concerns affecting your child's quality of life? Please check all that apply:

Attention/Focus Daily Routine Playing Sports
 Communication Eating School Walking
 Crawling Exercise Sleep Other _____

If there is a present health concern, how has it been progressing?

Rapidly Improving Quickly Worsening About the Same
 Slowly Improving Gradually Worsening On and Off

Who else have you seen for the concern(s) ? _____

Previous chiropractic care? YES / NO If so, who and when? _____

Name of pediatrician _____ Last Visit _____

Are you satisfied with the care your child has received at the pediatrician? YES / NO

of doses of antibiotics your child has taken in the past 6 months _____ Total in lifetime _____

Present prescription drugs / dosage _____

Previous prescription drugs / dosage _____

Over the counter drugs (Tylenol, cough syrup, laxatives, etc) _____

Signature of Parent / Legal Guardian

Date

Family Health Profile

This form is to assist the doctors by providing family history information for their review

	Siblings	Mother	Father
Abnormal Posture			
Acid Reflux			
ADHD			
Allergies			
Alzheimer's			
Anxiety / Nervousness			
Arthritis / Joint Pain			
Asthma / Breathing Difficulties			
Autism Spectrum Disorder			
Autoimmune Disorders			
Back Pain			
Bed Wetting			
Blurred / Double Vision			
Cancer			
Carpal Tunnel			
Depression			
Diabetes			
Digestive / Stomach Problems			
Disc Problems			
Dizziness			
Ear Infections			
Fatigue			
Fibromyalgia			
Frequent Colds / Illness			
Headaches			
Hearing Issues			
Heart Problems			
High- / Low- Blood Pressure			
Hip / Leg Pain			
Infertility			
Jaw / TMJ Pain			
Kidney Condition			
Menstrual Problems			
Migraines			
Neck Pain			
Numbness / Tingling			
Sciatica			
Scoliosis			
Shoulder Pain			
Sinus Issues			
Sleeping Difficulties			
Stiffness			
Stroke			
Thyroid Issues			
Ulcers			

Photo and Promotional Release Consent

We love sharing pictures of the healthy children of Kauri Chiropractic! If you would allow us to take, use, and share your child's photograph and/or testimonial/comments, please sign below. For valuable consideration, I hereby irrevocably consent to and authorize the use for the purposes of marketing and promotion by Kauri Chiropractic, or anyone authorized by Kauri Chiropractic, of any and all photographs/videos which we taken of myself and my child, which may include, but are not limited to promotional materials such as social media, website, and/or print ad whatsoever, for an indefinite period of time without further compensation to me. All media shall constitute the property of Kauri Chiropractic, solely and completely. Any information voluntarily provided by a practice member shall also be used in conjunction with the above information for the purposes previously mentioned. Confidentiality, in regards to any reported conditions, is also waived to the extent of information pertinent to the promotion material only. All other unrelated practice member information shall remain provide and protected (according to the Health Information Act).

Signature of Parent / Legal Guardian

Date

Written Consent For A Child

Name of practice member who is a child _____

I authorize the Doctor and any and all Kauri Chiropractic Staff to perform consultation, diagnostic procedures, radiographic evaluations, render chiropractic care, and perform chiropractic adjustments to my child/minor, according to their respective qualifications. As of this date, I have the legal right to select and authorize healthcare services for my child/minor. If my authority to select and authorize care is revoked or altered, I will immediately notify Kauri Chiropractic.

Signature of Parent/Legal Guardian

Relationship

Date