



NEW PATIENT CONFIDENTIAL INFORMATION

Date: _____ Patient Name: _____ Patient Birth Date: _____

Patient Injury and/or Chief Complaint: _____

► **Contact information for patient:**

Home Address: _____

City: _____ State: _____ Zip: _____

*Email: _____

**Phone - Home: _____ Wk: _____ Cell: _____

► **Contact information for patient's Parents / Legal Guardians (minors only):**

Mother's Name: _____ **Phone - Cell: _____

Father's Name: _____ **Phone - Cell: _____

► **Other information**

Emergency Contact: _____
Name Relationship to Patient **Phone

Who may we thank for referring you: _____

** Email is not used to communicate details concerning your treatment, diagnosis or condition, or specific details regarding your account balance. Should we be unable to reach you by phone, we may send an email as a final attempt to reach you, and/or to send general updates regarding office policy etc.*

** *We do not leave detailed messages on answering systems or with individuals other than yourself. We will leave a message as to the general purpose of our call, and request that you contact the office.*

Medication Allergies: _____

Current Prescription Medications: None

_____ mg() _____ mg() _____ mg()
_____ mg() _____ mg() _____ mg()
_____ mg() _____ mg() _____ mg()

CONTINUE ON THE REVERSE

Please read each section listed below, and **INITIAL** in the space provided indicating you have read and understand, and will comply with our Practice policies and procedures.

► **Consent to Be Treated** _____

A patient willfully choosing to be treated by the chiropractic physician gives the doctor permission and authority to care for him/her in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures, including physical therapy, are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. In no way will the treating Chiropractor provide treatment or care if he/she is aware that such care may be contra-indicated.

It is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever it is he/she is suffering from; latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Furthermore, any risk involved regarding chiropractic treatment will be explained to you upon your request. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen.

► **Consent to Be Treated Alone** (*minors only*)

I hereby give my consent to have _____ seen and treated by Bannockburn Chiropractic & Sports Injury Center without my presence.

Signature (Parent / Legal Guardian) _____ **Date** _____

► **General Office Policies** _____

1. **Cancellation or No-Show** - All "no-shows", and/or a cancellation made with less than 24 hour notice will be charged a \$60.00 fee. This fee is expected prior to your next appointment.
2. **Late for Appointment** - If you are running late by 10 minutes or more, please give us a call. In some cases we may need to reschedule your appointment.
3. **Cell Phones** - Out of respect and courtesy for other patients as well as for our front office staff, please silence your phone and take your cell phone calls outside the waiting area.

I have willingly provided the information requested on page 1 and 2 of this document and confirm that the information provided is accurate and true to the best of my knowledge.

Signature (Patient / Parent / Legal Guardian) _____ **Date** _____



NEW PATIENT FINANCIAL RESPONSIBILITY

Please read the section below CAREFULLY, that best describes your financial status, and INITIAL in the space provided indicating you have read and understand, and will comply with our Practice Policies and Procedures.

▶ Health Insurance _____

I, the undersigned, have insurance and/or employee health care benefits coverage and hereby assign and convey directly to Bannockburn Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim.

****Your insurance is a contracted agreement between yourself and/or your employer, and the insurance company. It is YOUR responsibility to be aware of your IN AND/OR OUT OF NETWORK COVERAGE DETAILS and any Limitations set forth by your insurance. Please read your explanation of benefits mailed by your insurance to your home. This document assists you in tracking your Chiropractic coverage details. We do not track individual patient policy information.**

****Copays are DUE at the time of service**

▶ Self Pay _____ (____)

Bannockburn Chiropractic & Sports Injury Center reserves the right to change service and treatment fees at any time. You may contact our office to verify our *current* fee schedule prior to making an appointment and/or receiving services. Self Pay patients are offered a "courtesy, time of service discount". This fee is required at the completion of each treatment session.

In accordance with health insurance regulation, our practice is not permitted to collect the private pay fee from you, **AND** submit to the insurance company simultaneously. Your financial status is "health insurance" **OR** "private pay". If at any time you wish to use your health insurance, any past treatment and fees are not eligible for submission. Upon changing your financial status to insurance, only that date of service and future dates of service are eligible for submission.

A. I do not have insurance and therefore willingly elect to privately pay for services rendered.

B. I have insurance however I willingly elect to privately pay rather than process my treatment costs through my insurance plan. I understand I **CAN NOT** submit payment to my insurance as a claim.

C. I have **OUT OF NETWORK INSURANCE** and understand that Bannockburn Chiropractic & Sports Injury Center is not responsible for submitting my claims on my behalf. I willingly elect to pay for the visit, in full, at the insurance rates for services rendered.

▶ Automobile Accidents / Workers Compensation _____

BCSIC DOES NOT BILL 3RD PARTY AUTO INSURANCE.

Our office will generate the claims for your treatment and forward those claims to the responsible party using the claim number and billing information you provided. Please understand that your claim number and claim submission is **NEVER** a guarantee of payment. The responsible agency will request documentation of your treatment and progress for which we are required to provide. Upon completion of their medical review, a determination will be made and payment will be generated. Any treatment cost that exceeds the benefit levels you were quoted, or are denied is **PATIENT RESPONSIBILITY.**

▶ Account Balances _____

BCSIC requires that ALL balances must be paid within thirty days of receipt of your statement.

Patients with balances over **\$300.00** and/or that fall within 90-120 days past due, and no effort has been made to address your balance, **NO FUTURE APPOINTMENTS WILL BE MADE AND** your account will be forwarded to our third party collector and you will not be permitted to continue treatment with us. We only wish to assist you in living a strong and active life, and very much appreciate your cooperation with our policies that enable us to continue to provide our services to you and so many others.

Signature (Patient / Parent and/or Legal Guardian) _____ Date _____