BANNOCKBURN CHIROPRACTIC & SPORTS INJURY CENTER

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**

Primary Physician:_____ **Referred By**:_____

***** *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( )

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 and *INITIAL* in the space provided indicating you have read and understand, and will comply with our Practice Policies and Procedures.

CHOOSE *ONE* OF THE FOLLOWING: Health Insurance, Self Pay OR Automobile Accidents/Worker's Compensation

► **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 and Sports Injury Center offers a reduced Self Pay fee for services provided. In accordance with **Health Insurance Regulation**, patients are **NOT** permitted to pay the Self Pay fee, and submit to the insurance company simultaneously. Please inquire if you have any further questions.

***Bannockburn Chiropractic & Sports Injury Center reserves the right to change service and treatment fees at any time

► **Automobile Accidents / Workers Compensation** _____

BCSIC DOES NOT BILL 3rd PARTY AUTO INSURANCE

BCSIC requires a credit card to be kept on file and will ONLY be charged if services are denied by either the AA or WC.

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. Any treatment costs that exceeds the benefit levels or are denied is **PATIENT RESPONSIBILITY.**

► **Account Balances** _____

BCSIC requires that ALL balances must be part 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** _____