Brueggeman Chiropractic Center 108 Magnolia Dr., Suite A
Glen Carbon, IL 62034 (618) 692-0000

Date:_____ **Acct #**_____

Patient Information

Name:_____ _____
First **Middle Initial** **Last** **Called Name**

Address:_____ _____ _____ _____
Street City State Zip

Phone Number: ( )_____ ( )_____ ( )_____
Home **Work** **Cell**

Preferred Contact # Home/Work/Cell Email Address: _____

Sex: M / F **Marital Status:** M / S / D / W **Children:** Y/ N **Spouses Name:** _____

Birthdate: _____ **Soc. Sec. #:** _____

Work Status: Employed Full Time / Employed Part Time / Retired / Student / Other

Medications: **Allergies:**

1. _____**mg** **1.** _____
2. _____**mg** **2.** _____
3. _____**mg** **3.** _____
4. _____**mg** **4.** _____
5. _____**mg**

Did someone refer you to our office? Y/ N _____

Have you ever had chiropractic care before? Y/ N _____

Primary Care Doctor : _____

Phone Number:_____

Primary Care Doctor Address: _____

Other Information: _____

_____

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Consent to Chiropractic Services

PAYMENT AND INSURANCE Pt. Initials _____

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT TO TREATMENT OF A MINOR CHILD Pt. Initials _____

I authorize the licensed doctor to administer chiropractic care as deemed necessary to my
(Relationship) _____ Name _____

FEMALE PATIENTS Pt. Initials _____

This is to certify that to the best of my knowledge I am not pregnant and that Brueggeman Chiropractic Center has my permission to request or take x-rays.
Beginning date of your last menstrual period: _____

CONSENT TO RELEASE INFORMATION TO MEDICAL DOCTOR Pt. Initials _____

I authorize the release of any pertinent examination or diagnostic testing findings to my medical doctor. I understand communication of important health information between my physicians is necessary to provide me with the most comprehensive care possible.

SATURDAY APPOINTMENTS Pt. Initials _____

I understand Saturday appointments are available by appointment only. If I do not cancel a Saturday appointment by 5:00pm on Friday before the appointment, I may be charged a $20 missed appointment fee.

CONSENT TO CHIROPRACTIC SERVICES Pt. Initials _____

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physical therapy, diagnostic x-rays, and/or tests by Brueggeman Chiropractic Center and their staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the physician and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for the future conditions for which I seek treatment by this clinic and/or employed staff.

SIGNED _____ Date _____

Brueggeman Chiropractic Center, LLC
108 Magnolia Dr., STE A
Glen Carbon, IL 62034
Ph: 618-692-0000 Fax: 618-655-1550

Financial Policy

Welcome to Brueggeman Chiropractic Center LLC. Our goal is to provide our patients with the best possible care and to maintain a good physician-patient relationship. We believe that these objectives are best achieved when our patients are clearly informed of our financial policy. Please review this policy carefully. We encourage patients to freely communicate with our office and to review any questions with our staff.

Fees for Our Most Common Services

New patient exam fees: $65 - $78
Existing patient exam fees: $49 - $70
Chiropractic Adjustments: $39 - $45
Hot/Cold Packs: $10
Muscle Stimulation: $20
Ultrasound: $15
Acupuncture: $40
Rehabilitative Exercise Training: $45

Insurance Coverage

By receiving services from this office, you have created a legal obligation between you and this office, and you are agreeing to pay for our services. This legal obligation exists independently and regardless of insurance or health benefits you may have. Your insurance policy or health plan is an agreement between you and your insurer, not between your insurer and this clinic, even if this office is a participating provider in your insurance network, and even if we agree to bill your plan. You agree that you intend, to the full extent allowed by law, for the legal obligation between you and this office to take priority over any agreement between you and your insurer or health plan, or any agreement between your insurer or health plan and this office. In the event discrepancies exist in the agreements between and among you, this office and your health insurer or health plan, you intend for this Financial Policy to control. Therefore, you acknowledge your obligation to pay this office for any and all services rendered, regardless of whether insurance coverage is denied at any time and **for any reason**, including but not limited to the insurer's or plan's determination that a procedure is not medically necessary or is experimental and/or investigational.

Insurance coverage for the services we provide varies from insurer to insurer and plan to plan. Our clinic will contact your insurer or health plan to inquire about your benefits. However, most insurers and health plans provide that an initial "verification" of coverage is not a guarantee of payment. We are not responsible for your insurer's or health plan's final benefit determinations, and you are responsible to pay for any care that is determined to be non-covered, even after an initial verification of coverage.

Patients and/or this clinic may obtain information indicating that a contemplated service or services will not be covered by insurance or the health plan. Additionally, some plans require pre-authorization as a condition of payment for certain services, after which the plan may deny or limit authorization of the services requested. In any case in which a patient and/or this clinic know that contemplated services will not be covered by a patient's insurance, this office will ask the patient prior to service to sign a form acknowledging that the services will not be covered and that the patient will be personally responsible for payment.

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Most insurance policies and health plans require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our clinic requires the payment of these fees on the date of your visit. This office does NOT routinely waive co-insurance, co-payments or deductibles.

If your insurance or health plan requires you to obtain a written referral from your primary care provider as a condition to your receiving services from our clinic, it is your responsibility to obtain and present the referral prior to or at the time of your visit to our clinic. If you need assistance in obtaining the referral, our clinic will provide assistance at your request. If your plan requires our office to complete a referral for services outside of our office, we require 3 business days to complete the forms, except in emergencies. Please plan your visits accordingly.

Billing and Payment

This office accepts cash, checks, and the following credit cards: Visa, Mastercard, and Discover.

Our office will submit bills to your insurance if you are covered by a plan in which we participate. You will be required to sign an Assignment of Benefits as a condition to our billing your insurance. However, the Assignment of Benefits does not cancel your financial obligation to this office. Full payment is due at the time of service for uninsured patients; for patients who are covered by a plan in which our office participates but services are not covered; or for patients who are insured by a plan in which this office does not participate.

All remaining balances are due upon receipt of the billing statement. We will impose a $25 fee for returned checks. Any accounts not paid within 30 days of the statement date will begin to accrue interest at 9% per annum and will be turned over for collection.

In cases of separation, divorce and/or shared custody, any adult accompanying a minor child to an appointment is responsible for payment, regardless of the terms of the separation or divorce. It is the responsibility of family members, not this office, to resolve legal disputes, and terms of a divorce do not supersede the legal obligation for the accompanying parent to pay for our services. However, we understand that temporary financial issues may affect timely payment, and we encourage patients to contact our staff regarding payment arrangements in such situations.

Missed, Late and Canceled Appointments

This office reserves the right to assess a $30 fee for "no-shows." Due to scheduling and staffing requirements, we must ask that cancellations be made more than 24 hours prior to your appointment. We recognize that occasionally circumstances may not permit you to provide 24 hours' notice, and we will consider these situations on a case by case basis.

For patients who arrive to appointments 20 minutes or longer after the scheduled time, we will attempt, but cannot guarantee, that the patient can be seen. In these cases, we reserve the right to charge the above-mentioned missed visit fee if the lateness becomes a chronic issue.

Medical Records Copying and Transferring

Medical records will be released within 20 days of request pursuant to your request, in accordance with the rules for the Health Insurance Portability and Accountability Act (HIPAA), CURES, Illinois law, or under other circumstances required by law. We will not charge copying fees when the medical records are

requested by the patient. Requests made by 3rd parties, such as attorneys, may be charged a fee in accordance with rules for HIPAA, Illinois Law, or other regulations.

Medical Forms, Reports, Testimony and Miscellaneous Fees

This office will fill out routine forms at no charge. However, we reserve the right to determine which forms are routine in nature. Our physicians may provide additional services, such as expert review and consultation, narrative reports, testimony at depositions and trials, or family conferences, at an hourly rate. Should you need these services, please see our staff for further details.

I understand and agree to all terms and conditions of this Financial Policy, including the provision that all health services rendered to me and charged to me are my personal financial responsibility.

Please initial each page and sign below.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name of Patient or Responsible Party

Assignment of Benefits

I authorize the release of any medical or other information necessary to process my insurance claims to any authorized representative of my insurance carrier. I also request payment of government benefits or private insurance benefits to:

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Who accepts assignment for these claims.

A photocopy of this shall be considered as valid as the original document.

Patient/Claimant Signature _____

Insurance Company & ID _____

Policy Holder's Signature _____ Date_____

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Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Brueggeman Chiropractic Center's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Drivers License Number: _____State____

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____Date _____ Staff: _____

Attempt 2: _____Date _____ Staff: _____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

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PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below.
I hereby authorize Brueggeman Chiropractic Center disclosure of my individually identifiable health information to the authorized individuals listed:

1. Authorized Individual _____ Relationship to Patient _____
   Authorization to:
   - ❑ Disclose treatment plans and test results
   - ❑ Billing information including statement balances
   - ❑ Past and future Appointments
   - ❑ Receive phone messages and/or email regarding appointments or test results
   - ❑ Other _____
2. Authorized Individual _____ Relationship to Patient _____
   Authorization to:
   - ❑ Disclose treatment plans and test results
   - ❑ Billing information including statement balances
   - ❑ Past and Future Appointments
   - ❑ Receive Phone Messages or email regarding appointments or test results
   - ❑ Other _____

We have permission to (please check all that apply):
- ❑ Leave messages on home phone or with household members
- ❑ Leave messages on work phone
- ❑ Leave messages on cell phone

We have permission to email the following information to my email address _____
- ❑ Information regarding appointment scheduling
- ❑ Patient receipts with all FSA/HSA required information

This authorization is effective through (check one):
- ❑ ____ /____ /____
- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Brueggeman Chiropractic Center in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Brueggeman Chiropractic Center until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative (If Patient is a minor) Date

Relationship to Patient: _____Drivers License Number: _____State____