"Science in Motion"

1526 Rose St. La Crosse WI 54603 (608) 781.9880

Name:____ **Date:**_______________
First **M.** **Last**

Address:____

City:______________________________________ **State:**______
Zip:_________________________

Home Phone: (_____)_____________________ **Work Phone:** (_____)_________________

Cell Phone: (_____)______________ **Can you receive and send text messages?** Yes No

Email Address: ____

Best way to get ahold of you: ( ) Text Message ( ) Email ( ) Cell Phone ( ) Home Phone ( ) Other Please Specify ____

Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Spouse's Name: ____

Referred By: ____

Occupation: ______________________________ **Employer:** _______________________

Emergency Contact: ________________________ **Phone #:** (_____) ________________

Primary Insurance: _____________________ **Secondary Insurance:** ________________

Is this visit due to an auto accident or a work related injury? _______________________

Who is responsible for this account? ____
Name **Relationship**

Insured Patients

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Breidenbach Family & Sports Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to BFSC will be credited to my account upon receipt. However, I clearly understand that even though all services rendered to me are charged directly to my insurance company, that I am personally responsible for the payment of any unpaid balance or non-covered services. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered to me will be immediately due and payable.

*__Our Collection Policy:__ For any patient responsibility you will be sent one statement. If payment is not received within 30 days you will receive one reminder call. If balance is not paid, you will be sent a final notice.

Signature ____ **Date** ______________________

Assignment and Instructions for Direct Payment to Doctor

I hereby instruct and direct my insurance company to pay by check made out to Breidenbach Family & Sports Chiropractic.

A photo copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. Adjustor and attorney involved in the case.

Signature ____ **Date** ______________________

Time-Of-Service/Cash Patients

I understand and agree that I am directly responsible for payment of all services rendered on the same day of service. I agree to pay the total balance of my account unless BFSC has approved other payment arrangements.

Signature ____ **Date** ______________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that Breidenbach Family & Sports Chiropractic has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us. This includes the situation where your first date of serviced occurred electronically.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received Breidenbach Family & Sports Chiropractic's Privacy Notice.

______________________________	______________________________
Print Name	**Unique Identifier**
______________________________	______________________________
Patient's Signature	**Date**

For Office use only:
Patient Name: ___________________________________
Medical Record #: ________________________________
Date of Admissions: _______________________________
File completed form to patient's chart ___ Yes ___ No

Breidenbach Family & Sports Chiropractic staff should complete of Acknowledgement Form is not signed.

1. Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No
2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and Breidenbach Family & Sports Chiropractic's efforts in trying to obtain the patient's signature (check all that apply):

[ ] Patient Unable to Comprehend [ ] Patient/Legal Representative Left before Signature Obtained
[ ] Patient Communication Barrier [ ] Emergency Admission/Patient Not Present for Registration
[ ] Legal Representative not Available [ ] Patient bypassed Registration – Not Available
[ ] Other: ____

3. Completed by:

______________________________	____________________	____________________
Workforce Member Signature	**Title**	**Date**

INFORMED CONSENT FOR DIGITAL MOTION X-RAY

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold your consent to the procedure.

If you are pregnant or think that you may be pregnant, please inform your doctor or the front desk personnel.

Your doctor has requested that we perform a DMX to obtain additional information. DMX produces images of the internal body parts being examined. DMX is painless, however, radiation is emitted. Therefore, it is critical for you to inform your doctor or the front desk personnel if there is any possibility you could be pregnant. Because the DMX is a diagnostic procedure, it provides information that may aid your doctor in diagnosing and treating your medical condition. Without the DMX, accurate diagnosis and proper treatment may be delayed.

There may be other imaging alternatives; however, your doctor believes the DMX to be the best diagnostic test for you, considering your symptoms and conditions. The benefit of this exam is to assist your doctor with a diagnosis.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (ME) HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS. I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF TREATMENT, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED AND I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

____

Printed Name

______________________________________ ______________________

Patient/Parent/Legal Guardian Signature Date