# Bahnemann Family Chiropractic, PC: Registration and History

## 1 PATIENT INFORMATION

Date_____

Patient_____

Patient Social Security _____

Address_____

_____

City State Zip

Email_____

Would you like to receive correspondence via e-mail? Y/N

Sex: □ M □ F Age_____ Birth Date_____

□ Single □ Married □ Widowed □ Separated □ Divorced

Occupation_____

Employer_____

Spouse's name_____

Birthdate_____Occupation_____

Whom may we thank for referring you?_____

_____

## 2 PAYMENT INFORMATION

__ Auto Insurance Claim __Commercial Insurance
__Medicare
__Worker's Compensation __ ***No Insurance (Self Pay)***

Please fill out the following "Assignment and Release" and provide your health insurance card and photo ID to the receptionist so she can make a copy of the card. *We will file the insurance claim for you, although we may not be in network, and therefore may not be covered by your company. Verification of coverage is your responsibility.*

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____and assign directly to Bahnemann Family Chiropractic, PC all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance***. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

## 3 PHONE NUMBERS

Home_____ Work_____ Ext._____

Cell_____ Best number to reach you

May we remind you of your next appointment via e-mail? (Circle one) Yes/ No

If yes, specify info: _____

*IN CASE OF EMERGENCY, CONTACT*

Name_____Relationship_____

Phone_____ Alt Ph_____

## 4 ACCIDENT INFORMATION

Is condition due to an accident? __Y __N Date_____

Type of accident __Auto __Work __Home __Other

To whom have you made a report of your accident?

__Auto Ins __Employer __Work Comp. __Other

Information for Auto Claims Only:

Name of Auto Insurance:_____

Claim #_____Ph #_____

Adjuster's Name:_____

## 5 PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Mark an **X** on the picture for pain and mark **//** for numbness and/or tingling.

Please Rate the Severity of your pain on a scale from **1 (least pain) to 10 (severe pain)**

Pain Rating for Past 24 hrs: _____ Pain Rating for the Past Week: _____

Type of Pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting

□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other

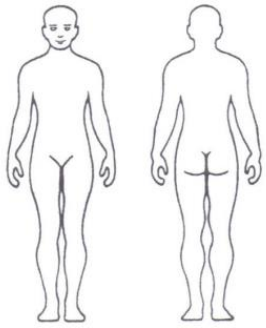
How often do you have this pain? □ Constant □ Frequently (50-75% of the day)

□ Occasionally (25-50% of the day) □ Intermittently (under 25% of the day)

Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation

Activities or movements that are painful to perform: _ Sitting _ Standing _ Walking _ Bending _ Lying Down

In general, would you say that your overall health is: _ Excellent _ Very Good _ Good _ Fair _ Poor



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# Health History

What treatment have you already received for your condition? □ Medications □ Surgery □ Physical Therapy
□ Chiropractic Services □ None □other_____
Name and address of others doctor(s) who have treated your condition_____

_____

**Date of last:** Physical Exam_____ Spinal X-Ray _____ Blood Test_____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

**Please place a mark to indicate if you have had any of the following:**

| | | | |
|---|---|---|---|
| □ AIDS/HIV | □ Emphysema | □ Migraine Headaches | □ Rheumatic Fever |
| □ Alcoholism | □ Epilepsy | □ Miscarriage | □ Scarlet Fever |
| □ Allergy Shots | □ Fractures | □ Mononucleosis | □ Stroke |
| □ Anemia | □ Glaucoma | □ Multiple Sclerosis | □ Suicide Attempt |
| □ Appendicitis | □ Goiter | □ Mumps | □ Thyroid Problem |
| □ Arthritis | □ Gout | □ Osteoporosis | □ Tonsillitis |
| □ Asthma | □ Heart Disease | □ Pacemaker | □ Tuberculosis |
| □ Bleeding Disorders | □ Hepatitis | □ Parkinson's Disease | □ Tumors/Growths |
| □ Breast Lump | □ Hernia | □ Pinched Nerve | □ Typhoid Fever |
| □ Bronchitis | □ Herniated Disk | □ Pneumonia | □ Ulcers |
| □ Cancer | □ High Cholesterol | □ Prostate Problem | □ Whooping Cough |
| □ Chemical Dependency | □ Kidney Disease | □ Prosthesis | Other_____ |
| □ Chicken Pox | □ Liver Disease | □ Psychiatric Care | _____ |
| □ Diabetes | □ Measles | □ Rheumatoid Arthritis | _____ |

| **EXERCISE** | **WORK ACTIVITY** | **HABITS** | |
|---|---|---|---|
| □ None | □ Sitting | □ Smoking | Packs/Day_____ |
| □ Moderate | □ Standing | □ Alcohol | Drinks/Week_____ |
| □ Daily | □ Light Labor | □ Coffee/Caffeine | Drinks/Week_____ |
| □ Heavy | □ Heavy Labor | □ High Stress Level | Reason_____ |

**Are you Pregnant?** □ Yes □No Due Date_____

**Injuries/Surgeries** you have had: Description _____ Date_____
Falls_____
Head Injuries_____
Broken Bones_____
Dislocations_____
Surgeries_____

| MEDICATIONS | ALLERGIES | VITAMINS/HERBS/MINERALS |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

FAMILY HISTORY: (type/relationship)
Cancer _____ Cardiovascular _____ Diabetes _____
_____ _____ _____
Thyroid _____ Arthritis / Bone disorders _____ Other: _____
_____ _____ _____

People choose chiropractic care for a number of reasons. How long you decide to benefit from chiropractic care is always up to you. Please check the type of care you desire so that we can meet your needs whenever possible.
___Relief Care ___Corrective Care ___Maintenance Care ___Check here if you'd like the Doctor to decide the best type for you

***I clearly understand and agree that I am personally responsible for payment of all services rendered to me.*** Further, in the event that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court cost incurred in collecting the balance. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

SIGNATURE_____ DATE_____

IF MINORS, PARENT/GUARDIAN SIGNATURE_____ DATE_____

**Bahnemann Family Chiropractic PC**
**CONSENT TO TREATMENT**

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.
There are some risks that may be associated with treatment, in particular you should note:

a. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. ***The possibility of such injuries resulting from cervical spine manipulation is extremely remote***

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms.

Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and

d. Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.
I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with
Kerri Bahnemann, DC and Bahnemann Family Chiropractic PC
(health care providers name).

Dated this_____day of_____ 20

_____ _____

***Print Patient Name*** ***Print Witness Name***

_____ _____

***Patient signature (or Legal guardian)*** ***Signature of Witness***

# Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

8. From time to time we may send you birthday cards or letters use your name on a birthday list or use your name on a referral board in our office. By your signature below you have given us permission to do so.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Name Date

_____

Patient Signature

*Bahnemann Family Chiropractic PC*

# 2024
# PATIENT FINANCIAL POLICY

BAHNEMANN FAMILY CHIROPRACTIC, PC

Patient Name / Family: _____

Date completed: _____

Thank you for choosing Bahnemann Family Chiropractic PC as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

**Co-pays**

The patient is expected to present an insurance card at their initial visit, and any time there are changes to their insurance company. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with us. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

**Insurance Claims**

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, ***it is the insurance company that makes the final determination of your eligibility and benefits***. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

**Participating Insurances**

- **Blue Shield Federal Plans**
- **Blue Shield of CO & PPO Plans**
- **Medicare Part B**
- **TriWest VA authorized beneficiaries**

**Non-Participating Medicare plans accepted**

- **Humana**
- **Aetna**
- **Cigna**
- **United Healthcare**

**Participating Insurances**

**If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your insurance claims. If you have out of network benefits, they may pay a portion of your billed charges; however, you are ultimately responsible for any charges you incur while under care in our office.**

**Referrals and Preauthorizations**

Certain health insurances (HMO,POS, etc.) require that you obtain a referral or prior authorization from you Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility.

**Self-pay Accounts**
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our practice does not participate, or patients without an insurance card on file with us. It is always the patients' responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Self-pay patients will be required to pay for their initial telemedicine history, in-office examination and treatment at the initial appointment. Payment arrangements are available if needed, and discounts are available ***when paid at time of service***. Please ask to speak with Dr. Bahnemann to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

**Motor Vehicle Accident (MVA) and Third Party Billing**

We will bill your automobile insurance company for bodily injury care. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to report your injury to your insurance to open a medical payment claim. They may send you an accident questionnaire form to be completed by you. If the questionnaire is not returned to your insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

**CANCELLATION OF APPOINTMENTS**

If it is necessary to cancel a scheduled appointment, we require at least 3 hours advance notice.

**Late Cancellations:** A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 3 hour advance notice.

**No-shows:** a no-show is when a patient misses an appointment with no notice ***or shows up too late to the appointment to be seen***.

A **$40.00 fee** will be billed to your account for late cancellations and for no-shows.

Repeatedly missing visits jeopardizes your care. For this reason ***after an ESTABLISHED patient has two (2) late cancellations and/or no-shows or a NEW PATIENT has one (1) cancellation or no-show, they will be discharged from the practice.***

***Extenuating circumstances will be considered in making this decision when clearly communicated to our office.***

***COMPLETION OF FORMS POLICY***

In order for us to better serve you, we request that you are aware of the following:

Your insurance company will not be billed as insurance companies do not reimburse for the time and judgment that are required to complete these forms. **Please allow 7 business days for completion of forms.**

***Payment is required prior to completion of all form(s)***

The fee for completion of forms varies from **$20 to $40** depending on time and complexity. This includes summary of care, FMLA paperwork, or disability determinations.

- **Returned Checks**
  The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash-only basis following any returned check.

  **Medical Record Copies**
  Patients or attorneys requesting copies of medical records will be charged:
  - $18.53 for the first ten pages (1-10)
  - $0.85 per page for the next 30 pages (11-40)
  - $0.57 per page for pages 41 and above (41+)
  - $10.00 additional fee for certification of medical records
  - Cost of portable media supplies, if applicable, i.e. CD or flash drive

**Minors**
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

**Outstanding Balance Policy**
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

*This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.*

*I understand the above-written financial policies and have had opportunity to discuss my concerns or questions, if I had any, to my satisfaction. Furthermore, I agree to abide by these financial policies for any services rendered to me at Bahnemann Family Chiropractic, PC.*

_____ _____
*Patient or legal guardian Signature* *Date*

email: _____ Cell/Home phone: _____

*BAHNEMANN FAMILY CHIROPRACTIC, PC RESERVES THE RIGHT TO CHANGE AND/OR MODIFY THE INFORMATION ON THIS AGREEMENT AT ANY TIME.*
*PATIENTS WILL BE LIABLE FOR THE TERMS OF THEIR MOST RECENTLY SIGNED AGREEMENT.*