THE WELLNESS CENTER OF BOISE

CONFIDENTIAL PATIENT INFORMATION

Name: _____
Phone # :_____ Email: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Social Security: _____
Age: _____ Gender: M☐F☐ Marital Status: M☐S☐D☐W☐ Are you Pregnant: Yes☐ No☐
Emergency Contact: _____ Phone: _____

How did you hear about us**?** _____

INSURANCE INFORMATION:
Primary Insurance carrier: _____Secondary:_____
Subscriber Name: _____ Subscriber DOB:_____

Is your visit with us today due to injuries resulting from an auto accident? Yes☐No☐
If yes, do you have a claim in process with your insurance? _____

If not, have you ever been in an automobile accident? Yes☐No☐If yes, please summarize the incident:
_____

WORK OR DAILY ROUTINE INFORMATION:
What is your occupation? _____
Are you typically at a desk or on your feet? _____
What repetitive tasks do you do? _____

HEALTH INFORMATION:
What are the main symptoms that brought you in to see us today? _____
(Note: you'll have a chance to describe these symptoms in more detail on the last page of our paperwork)

Have you had any surgeries that may pertain to the symptoms that you're having? Yes☐No☐
If yes, explain: _____

Are you taking any medications for your condition? _____

Have you ever suffered from: (check all that apply)
_☐_Arthritis _☐_ Asthma _☐_ Back Pain _☐_Diabetes_☐_ Digestive Issues
_☐_Dizziness _☐_ Heart Trouble _☐_Headaches _☐_Hearing Loss _☐_Migraines _☐_Neck Pain
_☐_Numbness _☐_Nervousness _☐_Restless Leg Syndrome _☐_Ringing in Ears _☐_Sciatica
_☐_Sinus Issues _☐_Stroke _☐_Tuberculosis _☐_Trouble Sleeping

How old is your mattress: _____ Is it comfortable: Yes☐No☐
Do you like your pillow? _____What kind of pillow do you sleep on:_____

What type of shoes do you most often wear: _____

THE WELLNESS CENTER OF BOISE

PAYMENT

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature Date

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to various modes of physical therapy, rehabilitation procedures and future diagnosis studies including x-rays by Chiropractic providers and staff employed for The Wellness Center of Boise.

I understand 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, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. **The Wellness Center of Boise will not be responsible for any pre-existing medically diagnosed conditions.**

I have read, or have read to me, the above. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I'm welcome and encouraged to express all concerns arising out of the financial aspects of my medical care.

_____ _____ _____

Patient Name (Printed) Signature Date

_____ _____ _____

Parent or Guardian (Printed) Parent or Guardian Signature Date

FOR MINORS:
INFORMED CONSENT TO TREAT MINOR

I hereby authorize the doctors at The Wellness Center of Boise and whomever they designate as their assistants to administer treatment as they so deem necessary to _____.
(Name of Minor)

_____/_____ _____

Parent or Guardian Name and Signature Date

OFFICE FINANCIAL POLICY AND SERVICE CONTRACT
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY

_____ 1. I understand that The Wellness Center of Boise will bill my insurance as a courtesy, but my patient portion (copays for the office visits, deductible, and coinsurance for procedures) is my responsibility and due at time of service. If your staff is unable to determine what my responsibility will be, I will be billed and my payment is due upon receipt of the first invoice.

_____ 2. I understand that if The Wellness Center of Boise is contracted with my insurance company, you will apply the contracted adjustment to my claim, reducing my cost. If I have Medicare, you will file my secondary insurance. For both Medicare and other major insurance, I understand your staff will notify me of any services recommended for me that my insurance may not cover. I understand that these non-covered services that may be considered not medically necessary by my insurance are my responsibility and the contracted rate adjustment will not apply.

_____ 3. I authorize The Wellness Center of Boise to release any information to my insurance company, adjuster, or attorney involved in this case.

_____ 4. I am aware that I may have a copy of the notice informing me of my HIPAA privacy rights and understand that my health information will be used for treatment, billing, and office operation.

_____ 5. If my insurance fails to pay my claim in a timely manner, I authorize The Wellness Center of Boise to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ 6. I authorize payment to be made by my insurance company directly to our doctors. If my current policy prohibits direct payment to our doctors, I hereby instruct my insurance company to make out the check to me and mail it as follows to Struble Chiropractic DBA The Wellness Center of Boise, 1675 N. Maple Grove Rd., Boise, ID 83704

_____ 7. I authorize The Wellness Center of Boise to deposit checks received on my account for services rendered if they are made out in my name.

_____ 8. My primary insurance company _____, is responsible for this bill. I may have secondary benefits with another insurance company, but primary responsibility for my claim is with _____ insurance company.

*_____ 9. **Chiropractic Appointment Cancellations, Reschedules and No Shows -** 24-hour advance notice is required when canceling a chiropractic appointment. We feel that this is a courtesy for all of our patients so that appointments are available when needed. You may cancel or reschedule your chiropractic appointment without charge by contacting us no less than 24-hours in advance of your appointment. We regret that we will have to charge a **$25 fee for same-day cancellations/reschedules and no call-no shows**.

*_____10. **Report of Findings - There is a $75 fee for cancellations, reschedules and no show/no calls for this special appointment.** This is Part II of your initial visit. The Doctor will allocate a full one hour for this second appointment which is called your Report of Findings. These Reports are at no charge to you as the Doctor feels that they are a one time golden opportunity to thoroughly educate you on his findings and to make a plan for working together to get you out of pain. You won't want to miss it.

Please take note of the Courtesy Cancellation, Reschedule, No show/No call policy as asterisked above.

ABN - ADVANCED NOTICE Regarding Non-Covered Services:

A. Non-Coverage of Chiropractic Services:

- This is to notify you that we will check with your insurance to assess your benefits, however, despite our best efforts to verify the information, your insurance **does not guarantee payment** even if it is indicated on your benefits breakdown.
- This is to inform you that we will submit these services to your health insurance, however your health plan **may not cover or completely cover** the following professional services. Often, we must wait for the Explanation of Benefits (EOB) to confirm patient responsibility:

1. *Chiropractic adjustments $50-$70*
2. *Chiropractic exams $35-$65*
3. *Chiropractic X-rays $110-$250*

B. Non-Coverage of Therapeutic Services:

- We have found that most insurance plans do not cover therapeutic procedures, therefore, The Wellness Center of Boise **DOES NOT bill insurance for these services.**
- To make them affordable for you, these services are charged at a small flat rate and paid by the patient at time of service.

1. *Massage Therapy $70*
2. *Class IV Laser Treatments $39-$59*
3. *Manual Traction Table $10*
4. *Ultrasound therapy $35*
5. *Muscle Stim $25*
6. *Rest and Stabilization Table $5*
7. *Therapeutic Devices (vary)*

_____**Yes** - I acknowledge the above information regarding non-covered services, and choose to receive these services if the Doctor recommends them as part of my treatment.

_____**No** - I acknowledge the above information regarding non-covered services, and choose not to receive these services, even if the Doctor recommends them as part of my treatment.

Printed name: _____ Signature: _____

****

OPT OUT OF INSURANCE: (complete this section ONLY if you do NOT want us to bill insurance)

I am electing to **SELF PAY** for all of the services that I receive at The Wellness Center of Boise. Despite that I may be covered by a health insurance plan, I do not wish The Wellness Center of Boise to submit a claim to my insurance company for these services, and understand that none of the cost of services will be applied to my insurance deductible.

Signed: _____ Date: _____

THE WELLNESS CENTER OF BOISE

Name: _____ Date: _____

Your Subjective Assessment: (tell us about your pain or discomfort)

What are your chief complaints? _____

What is the approximate date or onset of these conditions? _____

Does the discomfort radiate to anywhere else in your body? _____

On a scale from 1-10 (10 being most severe) please rate your pain?

Is the pain or discomfort the result of an injury or auto accident? _____

What is the frequency of pain?

Constant (100% of the time) in the _____ areas of the body.

Frequent (75% of the time) in the _____ areas of the body.

Occasional (50% of the time) in the _____areas of the body.

Intermittent (less than 25% of the time) in the _____ areas of the body.

What is the quality of discomfort? (Circle all that apply)

ACHING☐ANNOYING☐BURNING☐DEEP☐DULL☐HEAVY☐INTOLERABLE☐PULLING☐SHARP SHOCK-LIKE☐
STABBING☐STIFF☐THROBBING☐TIGHT☐TINGLING☐NUMBING☐PINCHING☐Other: _____

This symptom is relieved by: _____

This symptom is aggravated by: _____

Past episodes of this complaint: _____

Past care or medication for this complaint: _____

Recent diagnostic images or tests for this complaint: _____