THE WELLNESS CENTER OF BOISE

CONFIDENTIAL PATIENT INFORMATION

Name: _____
Main 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**?** _____
Occupation: _____
Are you typically at a desk or on your feet? _____

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

HEALTH INFORMATION:

Please circle if you are experiencing any of these:

PAIN TIGHTNESS DISCOMFORT TENSION STRESS POSTURAL CONCERNS OTHER

What area (s) are you experiencing these: _____
_____
Have you ever had this issue in the past? Yes No If yes, explain: _____
Which activities aggravate your condition? _____
Have you seen other doctors for this condition? Yes No
If yes, what is the name of the doctor and facility: _____

Have you had any surgeries that may pertain to the symptoms you're having? Yes No If yes, explain: _____
_____
Are you taking any medications for your condition? _____
How old is your mattress: _____ Is it comfortable: Yes No
What size pillow do you sleep on: _____
What type of shoes do you most often wear: _____
Have you ever been in an automobile accident? Yes No If yes, please summarize:_____
_____

Have you ever suffered from: ____Arthritis ____ Asthma ____ Back Pain ____Diabetes_____ Digestive Issues
_____Dizziness _____ Heart Trouble _____Headaches _____Hearing Loss _____Migraines _____Neck Pain
_____Numbness _____Nervousness _____Restless Leg Syndrome _____Ringing in Ears _____Sciatic
_____Sinus Issues _____Stroke _____Tuberculosis _____Trouble Sleeping

Other conditions you would like Dr. Collin to address today:
_____
_____
_____

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

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

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

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 understand that for the courtesy of all of our patients, it is important to contact The Wellness Center of Boise if I am going to miss an appointment.

_____ 4. I authorize The Wellness Center of Boise to release any information to my insurance company, adjuster, or attorney involved in this case.

_____ 5. I have received 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.

_____ 6. 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.

_____ 7. I authorize payment be made by my insurance company directly to Dr. Collin. If my current policy prohibits direct payment to Dr. Collin, I hereby instruct my insurance company to make out the check to me and mail it as follow to The Wellness Center of Boise, 1675 N. Maple Grove Rd., Boise, ID 83704

_____ 8. I authorize Dr. Collin to deposit checks received on my account for services rendered if they are made out in my name.

_____ 9. 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.

Patient Name: _____

Insurance: _____

I. Advanced Notice of Non-Covered Services

Notice of Non-Covered Services for Chiropractic Care:
This is to notify you that we will check with your insurance to assess your benefits, however, despite our efforts to verify the information, your insurance does not guarantee payment even if it is indicated on your benefits breakdown. Therefore, this is to inform you that your health plan **may not cover or completely cover** the following professional services, and often we must wait for the Explanation of Benefits to confirm patient responsibility:

1. Chiropractic adjustments **2. Chiropractic exams** **3. Chiropractic X-rays**

II. Notice of PT Services and MT Services

Notice of Physical Therapy and Massage Therapy Services:
This is to notify you that chiropractic and physical/massage therapy procedure codes are shared in the healthcare industry. As we recognize PT or MT codes as separate benefits, The Wellness Center of Boise does not utilize them or bill insurance for these services. PT and MT services in our clinic include icing and stabilization, manual traction, ultrasound, muscle stim, massage therapy, Rossiter and other modalities that Dr. Struble may recommend as part of your chiropractic care. These **services are charged at a small flat rate** and paid by the patient at time of service.

☐ **Yes - I acknowledge the above information and choose to receive these services.**

☐ **No - I acknowledge the above information and choose not to receive these services.**

Signed: _____ Date: _____

****

OPT OUT OF INSURANCE: (complete this section ONLY if you do NOT want us to bill insurance)
I am electing to **self-pay** for 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

Subjective:

What is the chief complaint?_____

What is the date or onset of this condition?_____

If the discomfort radiates where does it travel to?_____

On a scale from 1-10 (10 being most severe) what is your pain?

1 2 3 4 5 6 7 8 9 10

How did this injury occur?_____

What is the frequency of pain? Circle all that apply.

Constant (100% of the time) Frequent (75% of the time)

Occasional (50% of the time) Intermittent (less than 25% of the time)

Other:_____

Quality of discomfort? Circle all that apply.

Aching, annoying, burning, deep, diffuse, dull, heavy, intolerable, pulling, sharp, "shock like", stabbing, stiff, throbbing, tight, tingling, or other?_____

Symptom relieved by?_____

Symptom aggravated by?_____

Any past episodes of this complaint?_____

Any past care for this complaint?_____

Any recent diagnostic images or tests for this complaint?_____

_____