Back-In-Action
CHIROPRACTIC

Dear New Patient,

Welcome to **Back-In-Action Chiropractic.** Our mission is to provide high quality care that helps you prevent further injury and keeps you living the active life you enjoy. Along with traditional spinal adjustments our chiropractors have also have extensive training in extremity adjustments and sports therapy. We strive to make our office a positive, friendly, and fun place to be and we hope you enjoy your visit as much as we will enjoy meeting you!

This packet is prepared for your assistance and convenience. Please look it over *before* your visit in order to make your initial visit at Back-In-Action Chiropractic S.C. smooth and efficient.

PAPERWORK TO PREPARE BEFORE YOUR VISIT

A. New patient questionnaire
B. Financial policy
C. HIPAA Privacy Forms
D. Consent to Treat
E. Insurance benefit information (optional)
F. Release of Information (optional)
G. List of treating physicians (optional)

If you are unable to print a copy of this information to bring along to your appointment, we will be happy to provide them to you upon your arrival. In that case, please plan to arrive 15 minutes prior to your scheduled appointment time. If you are able to bring all completed paperwork to your appointment, please plan to arrive 5 minutes prior to your scheduled appointment time.

WHAT TO BRING TO YOUR APPOINTMENT

A. A photo ID
B. A complete list of your current medication(s)
C. Name, address, and phone numbers of other physicians to whom you wish a report sent
D. Completed paperwork
E. List of questions you may have for the chiropractor
F. Insurance cards if you would like us to submit claims

Should you have any questions or need assistance prior to your visit, please feel free to contact our office at 608-782-7738.

We look forward to meeting you!

Back-In-Action Chiropractic
300 2nd Street N Suite 220
La Crosse, WI 54601
608-782-7738
www.backinactionchiropractic.org

Patient Information

Today's Date:_______________________________

First Name:_______________________________ Middle Name:_______________________________

Last Name:_______________________________ Nick Name:_______________________________

Date of Birth:_______________________________ Gender: □ Male □ Female □ Unspecified

Marital Status: □ Single □ Married □ Other

Address:____

City:_______________________________ State & Zip Code:_______________________________

Home Phone:_______________________________ Work Phone:_______________________________

Mobile Phone:_______________________________ *Please provide at least one phone number.*

Email:____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Emergency Contact:_______________________________Phone Number:_______________________

How would you like to receive appointment reminders?

□ Text, circle mobile phone carrier:

AT&T	Boost Mobile	Cricket	Metro PCS	Nextel
Sprint	T-Mobile	US Cellular	Verizon	Virgin Mobile

□ Email

□ I prefer not to receive reminder calls

How early would you like to receive reminders: (only one please!)

□ 2 days □ 1 days □ 4 hours □ 2 hours

Briefly list allergies:____

Any medication allergies:____

List current medications (or bring a list) you are taking, including frequency and dosage if known.
If there are no current medications, check here: ❑

____

____

____

____

If you would like other persons to have access to your health or billing records or would like the chiropractor to update any of your healthcare team (Family Physician, Physical Therapist, etc.) please fill out the information disclosure and provider update forms.

Back-In-Action CHIROPRACTIC

ESTIMATES:
Your first visit will cost $148 and you should expect to be here an hour. This includes the new patient exam and treatment. Additional appointments range from $45 to $72 depending what is recommended. After your first visit, we will be happy to give you an estimate of your current treatment plan costs. Ask at the front desk and we'll get it ready for your next visit.

Please let us know which category you fit into:

_____**HEALTH INSURANCE**

If you would like us to file your claims for you, you must provide a current copy of your insurance card. As a courtesy we will file your claim(s) and when requested by your insurance company, we will supply them additional information, which may include medical records, to support a claim. We will verify your insurance, but also recommend that you contact your insurance for information on your **out of network** chiropractic coverage. If you have not met your deductible, we ask that you pay at your appointments until your deductible has been met.

Most policies will reimburse Back-In-Action and we will send you a statement for the remaining balance. If your insurance reimburses you directly, you are responsible for payment in full to us. If your insurance reimburses us for services you have already paid for, we will promptly issue a check reimbursing you for overpayment.

_____**SELF PAY: No Chiropractic Coverage or Self-Filing Claims**

We offer a day of service discount of 5% on our active plan services when the balance is *paid in full on the day of service*. For patients who would like to self-file with their insurance, we will supply a superbill upon request.

_____**MEDICARE**

Medicare will cover chiropractic spinal adjustments *that are considered medically necessary*. Medicare does not cover exams, extremity adjusting, or exercises. After Medicare sends us an explanation of benefits (EOB), they will forward the claim to your supplement insurance if applicable. After we receive your primary (and secondary) EOB you will receive a statement from us specifying the amount paid and any remainder that is your responsibility. Prompt payment is expected upon receipt of this statement.

_____**Work Compensation or PI Insurance (Auto Accident)**

In the case of work compensation we will need a claim number and a contact number for your supervisor or the insurance agency covering the case. In the case of on auto accident we will need a claim number, as well as a contact at your insurance company. Please ask at the front desk and they will get you the appropriate forms.

INITIAL:____________

CHECKS RETURNED FOR INSUFFICIENT FUNDS:
The processing charge for a returned check is $40, payable by cash or money order. If two occurrences of checks returned for non-sufficient funds are noted in your account, you will be placed on a cash only basis for future services.

PAYMENTS FOR DEPENDENTS:
The parent(s) or guardian(s) is responsible for full payment and will receive all billing statements. Signature of this document authorizes treatment and acceptance of this payment responsibility for dependents.

PATIENT BILLING STATEMENTS:
We will send monthly statements after receiving the explanation of benefits from your insurance company or as arranged ahead of time for patients on payment plans. If no payment has been made after two statements have been sent, payment in full must be made prior to future service. If no payment has been made after 3 statements have been sent your account will be sent to collections.

Please feel free to contact us for further information:
Back-In-Action Chiropractic
via email: ak@biachiropractic.com
or telephone: 608-782-7738

I have read and acknowledge this patient financial policy and agree to the terms as described.

Please Print Patient Name____

Name of Parent/Guardian if applicable:____

Signature____ **Date**_______________

Back-In-Action Chiropractic S.C.
300 2nd Street N, Suite 220
La Crosse, WI 54601
Phone: 608-782-7738

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:______________________________**Date of Birth:**________________________

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of Back-In-Action Chiropractic.

I understand that the Notice describes the uses and disclosures of my protected health information by Back-In-Action Chiropractic and informs me of my rights with respect to my protected health information.

____
Patients Signature or that of Legal Representative

____
Printed Name of Patient or that of Legal Representative

____
Today's Date

____
If Legal Representative, Indicate Relationship

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):____

____
Employee Name

____
Today's Date

Informed Consent for Examination/Treatment

Back-In-Action Chiropractic S.C.
300 2nd Street N, Suite 220
La Crosse, WI 54601
608-782-7738

Consent for Treatment

I hereby consent to the performance of examination and treatment on me by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and, am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. I also agree to notify the doctor at future visits if I become pregnant.

______________________ Patients Name (Printed)	______________________ Authorized Representative (**if applicable**)
______________________ Signature of Patient or Representative	______________________ Relationship of Authorized Representative
______________________ Date	______________________ Provider Representative

If patient is a minor:
As of this date, I have the legal right to select and authorize health care services for the minor child named above. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify Back-In-Action Chiropractic.

______________________ Signature	______________________ Date
______________________ Printed Name	______________________ Relationship to Patient