Services Agreement

I, ____, being a patient of Anderson Bauman Chiropractic located at 733 North Pine St, Burlington, WI, acknowledge that it has been explained to me that the following **services may not be covered or are not covered** by the benefits available to me under the terms of my Health Plan or insurance policy:

- Exams
- Spinal Manipulations
- Massages
- Extremity Manipulations
- Hot/Cold packs
- Interferential
- X-Rays
- Therapeutic activities/exercises
- Manual Therapy Techniques
- Orthotics
- Traction
- Ultrasound
- Supplies/Supports

The reason for this is that:

- This service is excluded from my plan coverage or
- This service has not been authorized by my health plan or
- This service or services may be determined to be a maintenance, preventive, or wellness care

I agree to pay for these services myself and to make financial arrangements, if needed, with Anderson Bauman Chiropractic.

Patient/Guardian
signature:____ Date:_____________

Informed Consent to Chiropractic Treatment at Anderson Bauman Chiropractic

The Nature of Chiropractic Examination and Treatment: The doctor will perform a physical examination. X-rays may be taken to evaluate your condition. The doctor will use his/her hands in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used. Exercise and massage therapy may be recommended.

Benefits of Chiropractic Treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible Risks: As with any health care procedure, complications are possible following chiropractic treatment. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. X-rays produce ionizing radiation. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of a stroke. The possibility of such injuries occurring in associated with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare".

Other Treatment Options which could be considered include the following:

1. *Over-the-counter analgesics*. The risks of these medications include irritation to the stomach, liver, and kidneys, increased cardiovascular risk, and other side effects in a significant number of cases.
2. *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these prescription drugs include all side effects as above, plus patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds additional risk of exposure to medical error, infection and other complications in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

________ Patient or Parent/Legal Guardian Initials

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. This informed consent will remain in effect unless there are significant changes in my diagnosis. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

____

Printed Name | Patient or Parent/Legal Guardian Signature | Date

Anderson Bauman Chiropractic

Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, WI 53105
www.notjustbackpain.com

Authorization for Verbal Communication And/ or To Leave Voice Mail Messages

This Does not authorize release of copies of medical records

____
Date (MM/DD/YYYY)

______________________ ______________ ______________________
Patient Last Name | Patient Middle Initial | Patient First Name

____
Patient DOB (MM/DD/YYYY)

Information to be disclosed: Verbal Communication Only Re: Patient care and Scheduling

Communication Between: ____

____

Can we leave a voicemail or send a text to all people named above? ◯ Yes ◯ No

Information to be disclosed: Verbal communication only Re: patient account and billing

Communication Between: ____

Can we leave a voicemail or send a text to all people named above? ◯ Yes ◯ No

(List Names of Health care facilities, Schools, Work, medical transportation, assisted living, and family with their phone numbers)

This authorization will expire:

◯ **Indefinite** ◯ **One year from signed date**

In accordance with the conditions listed above, I authorize the use and/or disclosure of the medical information. This authorization incudes disclosure of information regarding all aspects of my medical health. If you choose indefinite, you can let us know at any time if you need to change the information above and we can fill out a new paper,

Signature of Patient/ Parent or Guardian: ______________________ **Date:** ______________

Anderson Bauman Chiropractic Financial Policy

We strive to provide the highest quality health care, all the while maintaining affordability for you, the patient. We understand that even with insurance, most patients will experience at least some out of pocket expense.

Participating Insurance

Our office will accept your insurance on assignment and do participate as preferred providers for many insurance plans. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. If you have a question or concern with your reimbursement, you will need to contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery. We cannot be certain if your insurance covers chiropractic care, although most policies do provide coverage. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is our policy and agreed that any services rendered are charged to you directly and you are responsible for payment of any non-covered services, deductibles or copays.

You are also responsible for updating health insurance information with the front desk any time it changes, terminates, or new coverage begins. Our office is subject to a "timely filing period" which means that if you do not supply us with health insurance information in a timely fashion, the claim may be denied and you agree to pay for these services.

High Deductible Insurance Plans

We will gladly bill your insurance company for you, and will call to determine your chiropractic benefits. We do require patients with high deductible plans to make a weekly payment on their account during active care. The amount to be paid will be discussed and agreed upon by you and the front desk staff.

Patients without Insurance or Self-Pay Patients

We require that you pay at the time of service unless other arrangements have been made (ie. a monthly payment plan or CAP agreement). Patients that are put on a CAP agreement (discussed & decided between the patient and the doctor) will be required to make their agreed upon monthly payments. If the monthly payments are not made, a 1.5% interest charge will be applied. You will continue to receive a statement in the mail until the CAP amount is fully paid. Once the CAP amount has been paid in full, your remaining balance will be written off. We are happy to accept cash, check, Mastercard, Visa, and HSA cards. No insurance will be billed.

Medicare Patients

Our office accepts assignment from Medicare. Reimbursement is sent directly to our office in payment for chiropractic services that Medicare will cover. Medicare will **ONLY** cover manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining fees for services Medicare does not reimburse. These non-covered services include, but are not limited to, x-rays, examinations, therapies, orthotics, supplies/supports, massages, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary or supplemental insurance may or may not pay for these non-covered services.

Secondary/Supplemental Insurance

Please inform us of any secondary or supplemental insurance you may have. We will file and collect from your secondary insurance for services covered by the secondary payer.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account, or a 'flex spending plan'. We will be happy to provide you with a statement of your charges for reimbursement.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment in our office, we will verify your policy benefits. However, phone or fax verification of coverage is never a guarantee of payment.
2. Returned checks will be subject to an additional fee.
3. You will be charged a 1.5% interest rate on any payment plans that aren't kept current.
4. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis and it takes 3-4 weeks to hear back on said claims from insurance.
5. You will be responsible for your full deductible and co-payment or co-insurance. Payment is due when services are rendered (unless other arrangements have been made). If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial (we sent out denial letters as we receive them and patient statements once per month).

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me/or my child at Anderson Bauman Chiropractic and agree to the above terms.

Patient Name (printed):

Guardian Name (printed):

Patient/Guardian Signature: Date:

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HEALTH INFORMATION

Anderson Bauman Chiropractic

Dr. Michael Anderson
Dr. Ryan Bauman
Dr. Susan Reinke
733 N Pine Street
Burlington, WI 53105
www.notjustbackpain.com

All information you supply is confidential. We comply with all federal privacy standards.
Please Print Clearly
(Pediatric paperwork 0-6 yrs. old)

Today's Date

Whom may we thank for referring you

Have you seen a Chiropractor before? Yes ◯ No ◯ When? If so, Whom?

Age

Gender Male ◯ Female ◯

Race ◯American Indian ◯ American Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian ◯Other Pacific Islander ◯ other ◯ White Decline to answer

Ethnicity

Birth Date (MM/DD/YYYY)

Patient Last Name | Patient Nickname | Mothers Name

Patient First Name | Patient Middle Name (or Initial) | Fathers Name

Address

Legal Guardian

City | State/Province | ZIP/Postal Code

Home Phone | Cell Phone

Email Address

Emergency Contact Name | Emergency Contact Phone Number

Primary Physician & Location

Please Check one:

◯ Insurance: If you wish to have your services Billed to Insurance, Please present your Insurance card to a staff member at this time
Are you the primary holder of this Insurance?
◯ Yes ◯No If No,

Name of Holder | Date of Birth of Holder

Relationship

◯ Non- Insurance: I agree to pay in full at the time of service

Current Health Conditions:

What health condition(s) bring your child to be evaluated by a chiropractor?

Have you received care for this problem before? ◯Yes ◯No

If Yes, please explain:

When did the condition(s) first begin?

What makes the problem better? | What makes the problem worse?

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Pregnancy & Labor History

Was the birth:	◯ Normal Vaginal	◯ Forceps
	◯ Cesarean	◯ Vacuum Extraction
	◯ Breech	◯ Home Birth
	◯ Birthing Center ____________	◯ Hospital ____________

Pregnancy Problems: ____________

Labor or Delivery Problems: ____________

Congenital Defects/Anomalies: ____________

Please Explain any other concerns or notable remarks about your child's conception or pregnancy: ____________

____

Growth & Development History:

Has your child had any of these problems with the following now or in the past? Check all that apply.

◯ Bed Wetting	◯ Colic	◯ Dizziness	◯ Chronic Earaches
◯ "Growing Pains"	◯ Diabetes	◯ Difficulty Sleeping	◯ Ear Infections
◯ Cold/ Flu	◯ Diarrhea	◯ Hear Trouble	◯ Ear Tubes
◯ Constipation	◯ Digestion Problems	◯ Joint Problems	◯ Poor Appetite
◯ Sinus Trouble	◯ Walking problems	◯ Headaches	

Is there anything else we should know about your child? ____________

____

Is/was your child Breastfed? ◯ Yes ◯ No If yes, How long? ____________

If no, Why not? ____________ Difficulty with breastfeeding? ◯ Yes ◯ No

Did they ever use Formula ◯ Yes ◯ No If yes, at what age? ________ If yes, What type? ____________

Lifestyle:

Please List any allergies your child may have: ____________

Please list any medications your child is taking. ____________

How many hours per day does your child typically spend on electronics (TV, Computer, Tablet, Phone)? ____________

On average how many hours a sleep does your child get? ____________

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Family History

Relative	Age (if living)	State of Health Good – Poor	Illnesses	Age of Death	Cause of death Natural- Illness
Mother	______	○ ○	______	______	○ ○
Father	______	○ ○	______	______	○ ○
Sister	______	○ ○	______	______	○ ○
Sister	______	○ ○	______	______	○ ○
Brother	______	○ ○	______	______	○ ○
Brother	______	○ ○	______	______	○ ○

Are there any other hereditary health issues that you know about? ______________________________

____

Acknowledgements:

To set clear expectations, improve and help you get the best results in the shortest amount of time, please read each statement and initial your agreement

Initials_____ I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractor care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art form medicine and does not proclaim to cure any named disease or entity.

Initials_____ I may request a copy of the privacy policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials_____ I grant permission to be called to confirm or reschedule an appointment and to be send occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials_____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

______________________________ ______________________________

Parent (Or Guardian's) Signature Date (MM/DD/YYYY)