WELCOME

ABOUT YOU

Today's Date: _____/_____/______

Patient Name: ______________________________________
Last First MI

What You Prefer to be called: _______________ __Male __Female

Date of Birth:___/___/___ Age: _____ SS#: __________

Mailing Address: ____________________________________

City State Zip

Home Phone#: (_____) ______________________________

Cell Phone #: (_____) _____________Carrier__________

Work Phone # (_____) ______________________________

Email Address: ______________________________________

Preferred Method of Contact:(Circle one) Phone, Text, Email, Paper

Referred By: ____

Employer: ___________________________ How Long? ______

Employer's Address: __________________________________

City State Zip

Occupation: ____

Status: __Minor __Single __Married __Divorced __Separated __Widowed

Spouse's Name: ______________________________________

Do You have Children? __Yes __No How Many? __________

ACCOUNT INFORMATION

Person Ultimately Responsible For Account

Name: ____

Relation: ____

Billing Address: _____________________________________

City State Zip

SS#: ____

Drivers' License #: ____________________________________

Work Phone#: ____

Payment Method: ___Cash ___Check ___Credit Card ___AutoPay

____

Credit Card – Enter card # above (If accepted)

_________ I hereby authorize assignment of my insurance rights and benefits
Initials directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company (if offered at this office).

INSURANCE INFORMATION

Primary Insurance

Co. Name: ____

Address: ____

City State Zip

Phone#: ____

Insured's ID#: _______________________________________

Group # (Plan, Local, or Policy#) _____________________________

Insured's Name: _____________________________________

Relation: ____________ Date of Birth: ___/___/___

SS#: ____

Insured's Employer: ___________________________________

Secondary Insurance

Co. Name: ____

Address: ____

City State Zip

Phone#: ____

Insured's ID#: _______________________________________

Group # (Plan, Local, or Policy#) _____________________________

Insured's Name: _____________________________________

Relation: ____________ Date of Birth: ___/___/___

SS#: ____

Insured's Employer: ___________________________________

IN THE EVENT OF EMERGENCY

Whom should we contact: ____________________________

Relation: ____

Home Phone#: (_____) __________________________________

Cell Phone #: (_____) __________________________________

Work Phone # (_____) __________________________________

Who is your Medical Doctor? ____________________________

Medical Doctor's Phone#: _______________________________

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid with 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency or attorney fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I hereby appoint Jenny L. Wiemann, D.C., P.C. including its authorized agents as my attorney in fact to collect any and all data required to satisfy my financial obligations to this office. I hereby give and grant to my said attorney full power and authority to do and perform all and every act and thing whatsoever necessary to be done, in order to fully carry out and effectuate the authority herein granted, as fully to all intents and purposes as I might or could do if personally present and personally acting, and I hereby ratify and confirm all that my said attorney may do pursuant to this power.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____ **Date** _____/______/______

___Adult Patient ___Parent/Guardian ___Spouse

Informed Consent & X-ray Permission Form

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Jenny L. Crosby and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the Dr. Jenny Crosby and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

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, disc injuries, strokes, dislocations and sprains. Serious complications after manipulation of the cervical spine are estimated to be 1 in 4 million manipulations or fewer.[1] In comparison, there is a 3-4% rate of complications for cervical spinal surgery, and 4,000-10,000 deaths per million neck surgeries.[2] In fact, Ibuprofen (Advil, and Motrin) send 200,000 Americans th the hospital each year and account for an estimated 16,000 deaths. Acetominophen (Tylenol) sends 56,000 people to the emergency room and accounts for 100 deaths a year.3

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I understand and agree that I am responsible for full payment for the chiropractic services provided by Crosby Chiropractic to the extent that such sums are not paid by the insurance company and/or the attorney. I understand that these fees are not negotiable since they are not payable at the time of service, but held as a courtesy.

I further understand and agree that if I file a claim against my personal health insurance plan for the physicians medical services for injuries arising out of an automobile accident, and my insurance plan discounts the physicians regular fee and will only pay the discounted fee, I will allow the physician to bill me for the difference between the physicians regular fee and the discounted fee, or the fee allowed by the insurance carrier. This sum, will be remitted from the monies recovered by settlement, judgment or verdict.

I authorize the performance of x-rays for me and that to the best of my knowledge that I am not pregnant. I have been advised that x-rays can be hazardous to an unborn child.

I authorize the performance of x-rays of my minor child ______________________________________.

I authorize Crosby Chiropractic Centre to release to the following people any access to my health and financial records: ____.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Signature________________________________ Date ____________________

Witness Signature ________________________________ Date____________________

1)Lauretti W "What are the risk of chiropractic neck treatments?" retrieved online 08 028 2006 from www.chiro.org
2)*The cervical spine research society editorial committee*. The Cervical Spine, Second edition. Philadelphia: J.B Lippincott Company 1990: 834.
3)USA Today citing the FDA in an article dated 12/19/06

Consent for use and/or disclosure of protected health information to carry out treatment, payment and/or health care operations.

Through the use of the consent form, Crosby Chiropractic Centre (referred to as the or this "office") is notifying you and you agree that:

1. Protected health information may be used and/or disclosed in order to carry out treatment, payment or health care operations.

2. If you do not consent to the above use/or disclosure, then this office will not treat you.

3. A notice containing the office's privacy practice, including a more complete description of uses and/or disclosures necessary to carry out treatment, payment and/or health care operations, is available for you to read, and you are hereby encouraged to do so prior to signing this consent form.

4. This office reserves the right to change its privacy practices that are described in the above-referenced notice, in accordance with applicable law, and will make available to all patients any and all revised and current notices.

5. You have a right to request that this office restrict how protected health information is used and/or disclosed to carry out treatment and/or health care operations.

6. This office is not required to agree to any restrictions that you have requested.

7. If this office agrees to a requested restriction, then the restriction is binding on the office.

8. You have the right to revoke this consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that this office has already taken action in reliance on this consent.

9. Should you revoke this consent at any time, the office retains its right to refuse treatment based upon the revocation and future lack of such consent.

10. You will sign and date all consents requested to which you agree.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____________________ ____________________
Name of Patient (Printed) Signature of Individual

____________________ ____________________
Signature of Legal Representative Relationship
(e.g. Attorney in Fact, Guardian, Parent if a minor)

Date Signed _____/_____/_____ ____________________
Witness

☐ NEW PATIENT ☐ FOLLOW UP VISIT - PRIOR DATE: ________ ☐ THIS IS AN UPDATE OF PATIENT INFORMATION

PATIENT NAME		
STREET		
CITY		
STATE & ZIP		
TELEPHONE		
SOC. SEC #		
DATE OF BIRTH		
AGE AND SEX		

PRE-PAY OPTION (Enclose one fee per date of films.)

MEDICARE MUST PRE-PAY

☐ CASH

☐ CHECK CK# ________

☐ CREDIT CARD HOLDER: ________________

CC #: ________________

EXP DATE: ________________

INSURANCE PATIENTS - PLEASE INCLUDE -or- ATTACH ALL INFO TO BILL

SEND BILL TO: ☐ GROUP INSURANCE ☐ ATTY ONLY ☐ ATTY + INSUR ☐ AUTO INSUR ☐ WORKERS COMP

CONDITION IS RELATED TO: ☐ AUTO ACCIDENT ☐ EMPLOYMENT ☐ OTHER ACCIDENT DATE OF LOSS: ________

INSURANCE COMPANY INFO		SECONDARY INFO	ATTORNEY NAME	EMPOLYER NAME
NAME				
STREET				
CITY				
STATE & ZIP				
PHONE				
POLICY #				
GROUP #				
ID #			Date of Accident:	Date of Accident:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT.

AUTHORIZATION TO PAY BENEFITS
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF MEDICAL BENEFITS THAT WOULD NORMALLY BE DUE ME. I HEREBY AUTHORIZE MY ATTORNEY TO PAY DIRECTLY TO THE PROVIDER SUCH SUMS WHICH MAY BE DUE AS A RESULT OF THIS ACCIDENT AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT AS MAY BE NECESSARY TO ADEQUATELY PROTECT SAID DOCTOR.

AGREEMENT TO PAYMENT TERMS
THERE WILL BE A FEE CHARGED FOR X-RAY INTERPRETATION. THIS WILL BE BILLED FROM RADIOLOGY CONSTULTANTS/MIDWEST. I AGREE TO REMIT IN FULL ANY BALANCE WHICH IS NOT COVERED OR PAID IN FULL BY ANY INSURANCE CARRIERS OR OTHER PARTIES THAT MAY HAVE RESPONSIBILITY OR LIABILITY FOR THE SERVICES RENDERED. MEDICARE REGULATIONS DO NOT ALLOW PAYMENT FOR THESE SERVICES.

________________ ________________ ________
PATIENT SIGNATURE PARENT/GUARDIAN DATE

CLINIC: ________________

DOCTOR: ________________

DOCTOR COMMENT or QUESTION:

OFFICE USE ONLY

C/S 2 3 5 7 B ______ ______

T/S 1 2 ______ ______

L/S 2 3 4 5 B ______ ______

PELVIS ______ ______

F/S 1 2 ______ ______

______ ______ ______

______ ______ ______

RADIOLOGIST 1 2 3

RADIOLOGY CONSTULTANTS/MIDWEST (636)256-7779
201 ENCHANTED PARKWAY (636)227-0624 FAX
BALLWIN, MO 63021 FED ID # 43-1912520

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney and any & all third party payer to pay directly to the applicable provider being **Dr Jenny L. Crosby-Wiemann d/b/a Crosby Chiropractic Centre, 331 Jungermann Rd, St. Peters, MO 63376** do hereby assign and convey all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any disability benefits, including but not limited to foundation grants, governmental or agency benefits, and or any other insurance or third party benefits obligated to reimburse the undersigned or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignee.

The parties further agree that, in the event my insurance company and /or attorney obligated to make payment to me upon the charges made by this office & assignee for its services(s) refuses to make such payment, this agreement is to act as an assignment of the undersigned rights and benefits to the extent of the office(s) services provided, therefore, I hereby assign and transfer to this office & assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office & assignee to prosecute said cause of action either in my name or in the assignee's name and further I authorize this office assignee to comprise, settle or otherwise resolve said claim or cause or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby further agree to give a full lien to said office against any & all insurance benefits named herein any and all proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by said office & assignee. The undersigned patient and/or assignee further agree that the assignees' right for payment from the undersigned patient shall be tolled by any statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and the undersigned patient are resolve. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or the rights of this office to recover & agree to be held fully responsible for all debts I incur by this office.

It is further agreed that the undersigned patient shall remain personally responsible for the total amount due this office & assignee for its services. The undersigned further understand & agree that this Assignment, Authorization & Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment for me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due & owing in full within 10 days of demand. I further understand that a monthly service charge is computed by a 'periodic rate' of 1.5% per month which is an annual percentage rate of 18% which is applied to the previous balance after deducting current payments and that the service charge may change without notice. It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30 service charge for which I agree to be held responsible for. I understand that all money due to this office will be paid in a timely manner with no amount of money due past 90 days from date service was incurred and that I am responsible for payment of all outstanding balances at that time, regardless of any attorney liens, representation of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance to the 90 day limit. Parties further agree & understand that if need arises accounts delinquent by 90 days may be placed to a legal collection agency/attorney for which I am fully responsible for and in full all court costs, filing fees, attorney costs & all associated collection costs.

I further understand and agree that as necessary this office and its staff my submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that the above mentioned office is given full power of attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee. I understand that this office, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However, as with any doctors treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur, but that I am still fully obligated to all charges for all services rendered to me.

SIGNATURE ______________________________ DATE ______________