Albany County Chiropractic Center

LARAMIE OFFICE
807 South Third Street · Laramie, WY 82070
(307)742-6840 Fax (307)745-3712

SARATOGA OFFICE
112 W. Bridge Street · Saratoga, WY 82331
(307)326-4000 Fax (307)326-5002

New Patient Intake Form

Bring completed form to your first appointment and lab work that has been completed over the past year, list of immunizations, current medications, vitamins, minerals, and/or herbal supplements, copies of MRI, X-ray, CT imaging and/or reports, and insurance card(s).

PLEASE NOTE THAT MISSING INFORMATION WILL DELAY YOUR CLAIM

Legal Name: ______________________________ Sex: _________ Date of Birth: _____ /_____ /_____
(Please Print)

Address: _____________________________ City: __________________ State: ____ Zip: __________

Social Security #: _______________________ Email Address: _________________________________

Home Phone: _________________________ Cell Phone: __________________________
(Please circle phone number desired for confirmation calls)

Occupation: ______________________________ Work Phone: _________________________

Work Address: ________________________________ Is Patient a Minor: Y / N

Emergency Contact: __________________________ Phone: _________________________

Relationship: _______________________ Referred By: ______________________________

Medical Insurance? Yes _____ No ______ If yes, Company: ________________________

ID #: _____________________________Group #: __________________________________

If you are not the policyholder for your insurance please provide the policyholder's information below

Print Name: ______________________________ Home: _________________ Cell: _________________

Address: ________________________________ City: ________________ State: _____ Zip: __________

Social Security #: _____________ Date of Birth: ___/___/___ Relationship: _________________________

Primary Care Physician: __________________________ Date of Last Visit: _____ /_____ /_____

What is your primary reason for seeking care at our office: ____

____

Have you seen another healthcare professional for this problem? Y / N (Describe): ______________________

____

Have you EVER had an MRI, X-ray, or other diagnostic imaging? Y / N (Describe): ______________________

____

HEIGHT__________ WEIGHT __________ BP __________ PULSE __________

What are your health goals: ____

____

Do you use tobacco? Y / N: Type: __________________ Do you drink alcohol? Y / N: Type: ______________

What are your hobbies: ____

Averaged over the week, how much time do you spend on moderate to vigorous exercise and/or physical activity: ____________ Describe: ____

Have you ever travelled outside the country? Y / N: List: ____

Please list all hospitalizations: ____

____

Please list all surgeries: ____

____

Please list all fractures: ____

____

Please list all accidents/injuries: ____

____

Date of last: Eye Exam: ____/____/____ Dental Exam: ____/____/____ Dermatologist: ____/____/____

Audiologist (hearing): ____/____/____ Colonoscopy: ____/____/____ Physical: ____/____/____

Female Only: Date of last Menstruation: ____/____/____ Regular / Irregular

Date of last: Pap___/___/___ Breast Exam: ___/___/___ Mammogram: ___/___/___ DEXA: ___/___/___

Are you pregnant? Y / N If yes, how many months: _______________

Family History: Please check the box if an immediate family member (parent, grandparent, or sibling) have previously or are currently receiving treatment for the CONDITIONS listed.

☐ Anemia ☐ Allergies ☐ Addiction ☐ Arthritis ☐ Cancer ☐ Lung Disease ☐ Heart Disease ☐ Hypertension ☐ Reproductive Problems	☐ Diabetes ☐ Ulcer ☐ Kidney/Urinary Disease ☐ Thyroid Disease ☐ Depression/Mental Illness ☐ Stroke/Seizure ☐ Digestive Disease ☐ Muscle, Bone, Nerve Disease ☐ Other __________________

List cause of death and age of deceased immediate family members ________________________________

____

____

Patient/Guardian Signature ____ **Date** __________________

Doctor Signature ____ **Date** __________________

Albany County Chiropractic Center

Signs/Symptoms

Please circle all that apply CURRENTLY OR PREVIOUSLY

1	**Abdominal pain or distention**	20	Irregular heartbeat
2	Acid Reflux/GERD	21	***Increased thirst or urination***
3	**Bloody cough**	22	**Joint or bone pain**
4	Bloody stool	23	Kidney stones
5	Bloody urine	24	Night sweats
6	Blurry vision	25	Nose bleeds
7	Breast lump or pain	26	Numbness
8	Chest pain	27	**Pelvic pain**
9	Concussion	28	**Poor memory**
10	**Cough-Persistent or Chronic**	29	Poor sleep
11	Dark stools	30	**Shortness of breath**
12	Depression	31	Sleep difficulty
13	**Difficult eating/swallowing**	32	Sudden energy drop
14	Dizziness/vertigo	33	Swollen glands
15	Easily bruising	34	Tinnitus
16	**Fatigue- Unchanged by rest**	35	Tremor
17	Frequent urination	36	**Unsteady gait**
18	Grinding teeth	37	Wake to urinate
19	Hair changes	38	**Weight loss/gain**

DOCTOR USE ONLY

Signature

Date

Health History

Please circle all that apply CURRENTLY OR PREVIOUSLY

1	Arthritis	14	Kidney Disease
2	Asthma	15	Mental Illness
3	Auto-immune Disease	16	Muscle Disease
4	Bone Disease	17	Nerve Disease
5	Cancer	18	Osteopenia/Osteoporosis
6	COPD/Emphesema, other lung disease	19	PCOS (Polycystic ovarian syndrome)
7	Diabetes	20	Prostate abnormalities
8	Food allergy	21	Seizure
9	Hay Fever (Seasonal Allergy)	22	STD
10	**Headache/Migraine**	23	Stroke/TIA
11	Heart disease	24	Thyroid Disease or Irregularity
12	High blood pressure	25	Tuberculosis
13	**High cholesterol/trigylcerides**		

DOCTOR USE ONLY

Signature

Date

Patient/Guardian Signature ____ **Date** ______________

Albany County Chiropractic Center

Medication/Supplement List

	Reason taking	Prescribing Doctor	Date prescribed
Prescription medicine			
NOTES *(Doctor use)*			

Over the Counter Medicine *(e.g. Tylenol, Benadryl)*			
NOTES *(Doctor use)*			

Herbal Supplements *(e.g. Ginseng, Gingko, Cinnamon)*			
NOTES *(Doctor use)*			

Vitamins/Minerals *(e.g. Calcium, Centrum Silver, Vitamin C)*			
NOTES *(Doctor use)*			

Supplements or medicaiton allergies

Patient/Guardian Signature ____ **Date** _______________

Albany County Chiropractic Center

Darren Bressler, D.C., P.C.
807 South Third • Laramie, WY 82070
(307) 742-6840 • fax (307) 745-3712

PAYMENT AND CANCELLATION POLICY

Effective January 1, 2018

- **Chiropractic Appointments**:
  - A date of service cash discount will be given if paid in full at time of service. Discount will be applied to spinal manipulation, therapies, hot packs and massages.
  - No discount can be applied if sent to **Health Insurance**, **Work Comp**, **Car Insurance, or Aflac.**
  - **Medicare patients** please be aware that Medicare does NOT cover hot packs, therapies and the initial consult fee.
  - Hot packs and therapies are an additional charge to the spinal manipulation.
- **Massage Appointments:**
  - A date of service cash discount will be given for massage appointments only if paid in full at time of service.
  - A date of service discount will NOT be offered for massage therapy appointments that are submitted to **Health Insurance**, **Work Comp**, and **Car Insurance**.
  - We request a **four-hour** notice for massage cancellations, if you fail to show without notification on **two** consecutive massage appointments, you will be charged **50%** of the price of the second missed scheduled massage.
  - We offer a $5.00 discount towards your massage for same day massage/chiropractic appointments. Not applicable for those submitted to Insurance, Car Insurance or Work Comp.
  - For our massage client, we would like you to receive the full benefit of your massage therapy. Therefore, we ask that you are in the lobby 10 minutes before your scheduled appointment. This insures that the therapist has the opportunity to assess your needs and medical history. Your promptness will insure you receive the full time allotted for your massage. Otherwise time may be deducted from your massage. This will be dependent upon your therapist's availability.

I, the patient (or Parent/Guardian, if Minor), have read and understand the above and agree to these terms.

Signed ___________________________________ Date _____________

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Albany County Chiropractic Center Financial Policy

Effective January 1, 2018

Albany County Chiropractic Center requires payment in full at the time of service for chiropractic care, massage therapy, and Ideal Protein Weight Loss program. Payment can be made with cash, check, Visa, Mastercard, or Discover. There will be a $25 service charge added to your account balance for all NSF checks. (**NOTE**: There will be a 3% fee for all credit card refunds)

For accounts with any remaining balance a **$4.00 billing fee** will be added to any additional billing statements after 60 days past due. **Bills not paid in full by 120 days from service date will be subject to collection proceedings**.

Collections: All outstanding balances at 120 days will incur a 20% interest per annum. Accounts turned over to a collection agency for non-payment may also incur reasonable attorney fees and court costs.

Health Insurance: Our office offers the service of direct claim submission to personal health insurance companies. By signing this you also give our office permission to release any information that may be requested by your insurance company. If your medical insurance deductible **HAS NOT** been met, please pay **AT THE TIME OF SERVICE**. Payments from your insurance company will be sent directly to Albany County Chiropractic Center. If, for any reason, an insurance payment is sent to you, it is your responsibility to bring that payment to our office as soon as it is received. Any remaining balance not covered by your insurance company is your responsibility and will be billed to you accordingly. The remaining balance must be paid within 30 days. Balances not paid in full within 120 days from the billing date will be subject to collection proceedings.

Workers' Compensation: The patient must provide Albany County Chiropractic Center with a copy of the worker's compensation claim that includes: the case number, employer, location, and the date of injury. The patient is not responsible for any charges until the doctor releases him/her from care. If for some reason your case is denied by workers' compensation, you are then responsible for any unpaid balance. Balances that are patient responsibility need to be paid in full within 60 days from the Work Comp denial date. Please note that collections proceedings may occur for any past due balances of 120 days.

Motor Vehicle Accidents: The patient must provide Albany County Chiropractic Center with a copy of the accident report along with personal auto insurance and the responsible party's insurance company and card. Car accident patients will be asked to sign a lien letter. The patient is not responsible for any charges until the doctor releases him/her from care. If for some reason your case is denied, you are then responsible for any unpaid balance. Balances that are patient responsibility need to be paid in full within 60 days from the Insurance denial date. Please note that collections proceedings may occur for any past due balances of 120 days.

I, the patient (or Parent/Guardian, if Minor), have read and understand the above and agree to these terms.

Signed ___________________________________ Date __________________

Signature below is acknowledgement that you have received and understand the HIPAA Compliance of our privacy practices:

Print Name: ________________________________

Signature: __________________________________ Date: ___________________