Albany County Chiropractic Center

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

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

Address: _______________________________ City: ___________________ State: _____ Zip: ___________

Social Security #: _______________________ Email Address: _____________________________________

Home Phone: _________________________ Cell Phone: __________________________

Occupation: ___________________ Work Phone: ________________ Work Address: __________________

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: ___________________

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being rendered.

Check box if Yes

☐ 1. Have you ever experienced a professional massage or bodywork session?
How recently and how often: ____
☐ 2. Do you have tension or soreness in a specific area?
Please specify: ____
☐ 3. Do you frequently suffer from stress?
☐ 4. Do you have diabetes?
☐ 5. Do you experience frequent headaches?
☐ 6. Are you Pregnant?
If yes, how far along are you: ____
☐ 7. Do you suffer from arthritis?
☐ 8. Are you wearing contact lenses or dentures?
☐ 9. Do you have high blood pressure?
Medications: ____
☐ 10. Do you suffer from epilepsy or seizures?
☐ 11. Do you suffer from joint swelling?
☐ 12. Have you had any joint dislocations?
If yes, where: ____
☐ 13. Do you have varicose veins?
☐ 14. Do you have any contagious disease?
If yes, what disease: ____

☐ 15. Do you have osteoporosis?
☐ 16. Do you have any allergies?
If yes, what: ____
☐ 17. Do you bruise easily?
☐ 18. Are you very sensitive to touch or pressure in any area?
If yes, where: ____
☐ 19. Have you been in an accident or suffered any injuries or broken bones in the past 2 years?
If yes, please explain: ____
☐ 20. Do you have any cardiac or circulatory problems?
☐ 21. Do you have respiratory problems
If yes, what: ____
☐ 22. Do you have stomach or intestinal problems?
☐ 23. Do you have any kidney problems?
☐ 24. Have you ever been diagnosed with cancer?
☐ 25. Do you have numbness or stabbing pains anywhere?
If yes, where: ____
☐ 26. Do you suffer from back pain?
☐ 27. Do you have athlete's foot or other skin rashes?
If yes, what: ____
☐ 28. Have you ever had surgery?
Please explain: ____

☐ 29. Do you have any other medical condition(s)? ____

____

Comments: ____

____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. **If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort**.

I further understand that massage/body work should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician or another qualified medical specialist for any mental or physical ailment that I am aware of. Nothing said in the course of the session should be construed as a skeletal adjustment, diagnosis, prescription, or treatment of any physical or mental illness. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there should be no liability on the practitioner's part should I fail to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

I understand that I am financially responsible for the services that I receive. I authorize the massage therapist to render massage to me (or my dependent/minor child).

Client signature: ____ Date: __________________
(If Minor, Client's parent/Guardian)

Massage Therapist signature: ______________________________ Date: __________________

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

PAYMENT AND CANCELLATION POLICY

- **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 and hot packs.
  - No discount can be applied if sent to **Health Insurance**, **Work Comp**, **Car Insurance**, **Aflac or Medicare**.
  - **Medicare patients** please be aware that Medicare does not cover hot packs, therapies and the initial patient fee and you will be responsible for payment. If you have a secondary insurance they may cover these fees but please know you will be responsible for payment if they are not.
  - 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.
  - No date of service cash discount will 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 schedule.

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, 2015

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 any remaining balance patients, will receive the first and second office billing with no additional charge; thereafter a **$4.00 billing fee** will be added to any additional billing statements. The full amount must be paid within 90 days of the visit**. Bills not paid in full by 90 days from service date will be subject to collection proceedings**.

Collections: Accounts turned over to a collection agency for non-payment on balance due, an administrative fee of 20% of the balance will be added at time rendered to ACSI Collection Agency.

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 90 days from the billing date will be subject to collection proceedings.

Workers' Compensation: The patient must provide this office 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 you may have accumulated. Balances that are your responsibility need to be paid in full within 90 days from the initial billing date.

Motor Vehicle Accidents: The patient must provide this office 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 by the car insurance company, you are then responsible for any unpaid balance you may have accumulated. Balances that are your responsibility need to be paid in full within 90 days from the initial billing date.

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: ___________________