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)

Employer: _____ 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, 2019

- **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 _____

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

Albany County Chiropractic Center Financial Policy

Effective January 1, 2019

Albany County Chiropractic Center requires payment in full at the time of service for chiropractic care, physical therapy, orthotics, retail items, 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 _____

_____ *(Patients Initials)* I acknowledge that I have received and understand your practices HIPPA Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information.

_____ *(Patients Initials)* Albany County Chiropractic may leave a detailed phone message at the following listed numbers regarding my medical or billing information. (_____) _____-_____ , (_____) _____-_____ .