

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: _____

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. (____) _____ - _____ , (____) _____ - _____ .