WOLF RIVER CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION
(Please print legibly)

Date: _____

Name: _____

Address: _____

_____

*E-mail: _____
*Will not be given out, we will not e-mail you daily, e-mail is needed to contact you to change appointment times, communicate insurance issues, reschedule in bad weather, etc.

Sex: M F Age: _____ Birth Date: _____

Patient SS# : _____

Occupation: _____

Employer: _____

Employer Address: _____

_____

Employer Phone: _____

SPOUSE INFORMATION:

Spouse's Name: _____

Spouse Birth Date: _____

Spouse SS#: _____

Spouse Occupation: _____

Spouse's Employer: _____

Who can we thank for referring you?

_____

_____

PHONE NUMBERS:

Home: _____ Cell: _____

Work: _____ Extension: _____

*Cell Phone Carrier: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Phone: _____

Relationship: _____

ACCIDENT INFORMATION:

Is this condition due to an accident? Yes No

Date/Time of Accident: _____

Type of Accident: (Please Circle Below)

Auto Work Home Other: _____

To whom have you made a report of your accident?

Auto Insurance Employer Worker's Compensation

Other: _____

Attorney Name(if applicable): _____

CONSENT TO TREAT:

By signing below you state you are willing to undergo treatment including an examination, x-rays (if needed), adjustments & therapies (as needed) as outlined by the doctor of chiropractic.

Printed Name: _____

Date: _____ Signature: _____

Consent to Treat a Minor Child:

Signature: _____

Relationship: _____ Date: _____

PATIENT CONDITION:

Reason for visit: _____

_____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Rate the severity of your pain: Scale 0 (no pain) to 10 (extreme pain) _____

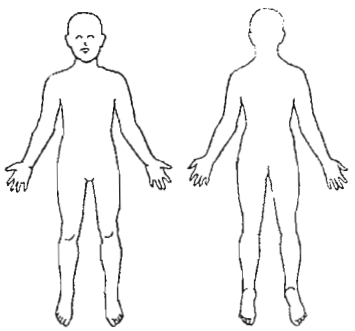
How often do you have this pain? _____

Does the pain interfere with any of the following: (Circle all that apply)

Work Sleep Daily Routine Recreation Family Activities Household Chores

Driving Sitting Walking Stairs Mood Personal Care Lifting Bending

Please circle where you have pain on the diagram below.



FEMALE ONLY:

Are you Pregnant? Yes No

Due Date: _____

Birth History

LABOR AND DELIVERY:

How long was the labor from the first regular contractions to the birth? _____ Hours

How long was the 2nd stage (the pushing phase) of the labor? _____ Hours

	Yes	No	
Hospital Birth	☐	☐	_____
Home Birth	☐	☐	_____
Midwife Assisted	☐	☐	_____
Vaginal Delivery	☐	☐	_____
Planned C-Section	☐	☐	_____
Emergency C-Section	☐	☐	_____
Was Birth Induced (Pitocin)	☐	☐	_____
Forceps Delivery	☐	☐	_____
Vacuum Extraction	☐	☐	_____
Anesthesia Administered	☐	☐	_____
Fetal Distress	☐	☐	_____
Meconium Staining	☐	☐	_____
Head Presentation	☐	☐	_____
Face Presentation	☐	☐	_____
Breech Presentation	☐	☐	_____

BABY'S CONDITION IMMEDIATELY AFTER BIRTH:

Apgar Scores: At 1 minute _____/10 At 5 minutes _____/10

Baby's Crying: Baby cried immediately After Birth ☐

Cried Strongly ☐ Weak Cry ☐ Did Not Cry for _____ minutes

Baby's Color: Pink All Over ☐ Blue Face ☐ Blue Hands/Feet ☐

Baby's Activity: Arms and Legs Actively Moving ☐ Floppy Baby ☐

Intensive Care: Was Required ☐ Days in Neonatal Intensive Care Unit _____

Medication Given at Birth? _____

Vaccines Administered: _____

Birth Weight: _____ lbs/kgs Birth Length: _____ ins/cms Baby Home On Day: _____

Pregnancy History

Date: _____

Child's Name: _____ Sex: M F DOB: _____ Age: _____

Mother's Name: _____ How many children do you have? _____

What was the term of your pregnancy? _____ Weeks

DURING YOUR PREGNANCY, DID YOU HAVE ANY OF THE FOLLOWING:

	Yes	No	
Falls	☐	☐	_____
Motor Vehicle Accidents	☐	☐	_____
Near-Miss MVA	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Anemia	☐	☐	_____
Morning Sickness	☐	☐	_____
Indigestion	☐	☐	_____
Seizures	☐	☐	_____
Swollen Ankles	☐	☐	_____
Thyroid Problems	☐	☐	_____
Heart Problems	☐	☐	_____
Back Pain	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Were you hospitalized?	☐	☐	_____
Any other illnesses?	☐	☐	_____

DURING YOUR PREGNANCY, DID YOU USE ANY OF THE FOLLOWING:

	Yes	No		
Tobacco	☐	☐	_____	
Alcohol	☐	☐	_____	
Herbal Supplements	☐	☐	_____	
Non-Prescribed Drugs	☐	☐	_____	
Prescription Medications	☐	☐	Medication _____	Reason _____
			Medication _____	Reason _____
Over-the-Counter Meds	☐	☐	Medication _____	Reason _____
			Medication _____	Reason _____

SCHOOL-AGE CHILD HISTORY

6 Years and Older

Today's Date: _____

Patient's Name: _____ Sex: M / F Date of Birth: _____ Age: _____

Reason for today's visit: _____

When did the problem first occur? _____

Yes No

☐ ☐ Has your child ever had this problem before? _____

Has your child previously been treated for this problem? ☐ Yes ☐ No

If yes, by whom? _____

☐ ☐ Has your child previously had chiropractic care? If yes, by whom? _____

HEALTH HISTORY

In the past year have you had any of the following:

Yes No

☐ ☐ Back or neck pain? _____

☐ ☐ Pain in the legs or arms? _____

☐ ☐ Headaches? _____

☐ ☐ Asthma? _____

☐ ☐ Allergies? _____

☐ ☐ Earaches? _____

☐ ☐ Falls from a bicycle, skateboard, scooter, roller blades or similar? _____

☐ ☐ Do you ever have a problem with bedwetting? _____

☐ ☐ Have you ever been in a motor vehicle collision? _____

☐ ☐ Have you ever had any broken bones? _____

☐ ☐ Have you ever had any surgeries? _____

☐ ☐ Are you presently taking any medications (prescribed or over-the-counter) or supplements?

List medications or supplements and dosages (if known) _____

_____

☐ ☐ Do you have any other concerns about your health you wish to discuss? _____

_____

ABOUT YOUR LIFESTYLE

What grade are you in at school? _____

How do you carry your school books? _____

How heavy is your school book bag? _____

What sports do you play? _____

What hobbies do you have? _____

How many hours each day do you watch TV? _____

How many hours each day do you spend using a computer? _____

How often do you play video games? _____

On average, how many hours sleep do you get each night? _____

Are there any smokers in your family? _____

Do you feel stressed out? _____

Do you have trouble reading the board in class? _____

Do you ever have blurred vision? _____

Do you wear glasses or contact lenses? _____

Do you sometimes get headaches when you read? _____

ABOUT YOUR DIET

What do you usually eat for breakfast? _____

_____

What do you usually eat for lunch? _____

_____

What do you usually eat for dinner? _____

_____

What snacks do you have after school? _____

_____

What is your favorite food? _____

How much water do you drink each day? _____

How many sodas or sweetened drinks do you have each day? _____

How often do you eat fast food items? _____

WOLF RIVER CHIROPRATIC APPOINTMENT POLICY

Office visits are scheduled accordingly to the severity of your condition and the program of chiropractic care that the doctor feels is best for you. Because your condition requires numerous appointments over the next few weeks or months, we have designed a multiple appointment program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine. The frequency of your visitation schedule is of paramount importance to your results so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results.

Our Goal is to provide quality individualized chiropractic care in a timely manner to patients. "No shows" and late cancellations inconvenience the practice and those needing to get in for care. These policies enable us to better utilize available appointments for our patients in need of chiropractic care.

Regardless of how many appointments are scheduled for you in each week, please note that it is the frequency of visits that count, not the days on which you receive the service. If, for any reason, you are unable to keep an appointment, we require that you telephone immediately (920)240-4441 to reschedule the visit. When at all possible it is the patient's obligation to **make up a missed appointment within 7 days of any cancellation.** Our staff will try to re-schedule you the same day or within 24 hours to make-up any missed appointments.

Unless canceled in advance, our policy is to **charge for missed appointments** at the rate of a normal office visit. This charge will be your responsibility and **CANNOT** be billed to your insurance company. The courtesy of canceling in advance is appreciated by other patients in need of care.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no show". This includes arriving 15 minutes after your scheduled appointment.

Note that after the 3rd late cancellation or "no show" we reserve the right to discharge the patient from care in our office in addition to billing the patient for each missed office visit.

After normal office hours, weekends & holiday visits will include an extra $30 charge in addition to normal service charges.

When entering the office on any given visit, please go directly to the front desk and "sign-in" on the form located within your patient file. We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

Signature: _____

Print Name: _____ Date: _____

WOLF RIVER CHIROPRACTIC L.L.C. FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your health. Please understand that payment of your bill is expected in exchange for the professional services we offer. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

PAYMENT IS DUE AT TIME OF SERVICE
We accept cash, checks, debit card, VISA, MASTERCARD, CARE CREDIT, and ChiroHealthUSA. We offer extended payment plans and cash discount plans for those who qualify. If payment is not made to our office in a timely manner you will be turned over to a collections agency for payment which will affect your credit rating. In the event your account is turned over to collections or a collection agency **an additional fee of 30%** of the total balance reported to collections will be added to any outstanding patient account balance. We reserve the right to charge interest at the rate of 12% as provided by state law.

RETURNED ITEM FEE: We reserve the right to charge a **Returned Item Fee of $30.00** for all checks returned to us by your financial institution for any reason (ex. NSF, Account Closed, Stop Payment, etc).

INSURANCE: Please give your insurance card to our front desk assistant. We will be happy to verify coverage for you, but ultimately you are expected to understand your plan coverage. We will bill your insurance company as a courtesy to you. Always inform us of any insurance changes. We accept assignment of most insurance benefits. However, we do require your portion of the bill to be paid at the time of service. **THE BALANCE IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE PAYS OR NOT**. Your insurance policy is a contract between you and your insurance company. If your insurance company has not honored their portion of payment within 60 days, the balance will be transferred to you. In some cases, part, and perhaps all, of the services provided may not be covered or considered "medically necessary" by Medicare, Medical Assistance and/ or other insurance plans. Our practice is committed to delivering the best care for our patients, and we will provide whatever treatment is necessary regardless of any insurance company's arbitrary determinations. We will do our best to assist you if any disputes arise with an insurance company.

MEDICARE: We will submit assigned claims to Medicare on your behalf for covered services. If services are approved, Medicare will pay 80% of Medicare's allowable charges for the service. The remaining 20% will be submitted to you or your secondary insurance (if applicable). You will be responsible for any allowed amounts not paid by insurance. If services are not approved or are not covered, you will be responsible for payment in full. **Please understand Medicare DOES NOT cover any examinations, x-rays, extremity adjustments, therapies, or maintenance care.**

MEDICAL ASSISTANCE: We will submit claims to Medical Assistance for all covered services. You will be responsible for payment of all non-covered services and your co-payment at the time of service per the coverage of your plan.

DISCOUNTS: We offer a discount for payment made at the time of service (cash discounts), financial arrangement plans, and offer discounts to military members, in addition to our in-network insurance contracts with carriers.

MINOR PATIENTS: The parent or guardian accompanying a minor is responsible for full payment of the account. **** Please be aware, children less than 12 years of age possibly may not be covered by insurance benefits for chiropractic care. ****

MISSED APPOINTMENTS: Please make every effort to maintain your appointments and your schedule of care. Our staff will try to re-schedule you the same day or within 24 hours to make up any missed appointments. Unless canceled in advance, our policy is to charge for missed appointments at the rate of a normal office visit. This charge will be your responsibility and **CANNOT** be billed to your insurance company. The courtesy of canceling in advance is appreciated by all and shows respect for our time.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy outlined by Wolf River Chiropractic L.L.C., and I understand and agree to this policy.

Signature: _____ **Date:** _____

Printed Name: _____

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Wolf River Chiropractic L.L.C.
N5644 State Highway 76
Shiocton, WI 54170-8612

ABOUT MEDICARE CHIROPRACTIC COVERAGE

Your Medicare coverage of chiropractic care is limited. They will only pay for the chiropractic adjustment (manipulative treatment) when it meets Medicare's rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or counsel.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

Non-covered items will appear on your insurance claim form. They will show as a Medicare Non-covered service like this: "72010–GY". The "72010" code is for an x-ray. The "-GY" means that it is not-covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract.

ALWAYS-COVERED SERVICES

A typical example of a Medicare COVERED service is when you are injured or you are in much pain due to a bad spinal condition. You should expect Medicare to pay for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your chiropractic adjustment, we will discuss this matter with you. We will also give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

MY FINANCIAL RESPONSIBILITY

I have received the above information, "About Medicare Chiropractic Coverage." I understand that I am personally **financially responsible** for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

MY AUTHORIZATION

I authorize the **release** of any medical or other information necessary to process my claims. I also **request** payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

x _____ _____

Signature of patient or person acting on patient's behalf — Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

ADVANCE PATIENT NOTIFICATION

We provide excellent services to our patients in good faith and expect compensation accordingly. It is your duty as a patient to know and understand your insurance plan which is subject to your plan provisions. Health insurance is a contract between you and your Health Insurance Company or carrier, not our office.

Should your insurance company determine services provided in our office are not medically necessary, deny payment or coverage we reserve the right to transfer any balance owed to you.

I understand that the normal fee for the treatment I will be receiving is: Initial Examination $50-$195; Re-examinations $40-$150; X-rays $80-$120 per area; Spinal adjustments $45-$90; Nutritional Counseling $180 (3 sessions), Neuromuscular re-education $20-$30; Additional Therapies $20-$35 each; Custom Foot Orthotics $350-$550; Body Composition Analysis $25, ALCAT Food Sensitivity Testing $1,200 plus a $50 mobile lab fee.

*Note if our office is in-network with your health insurance carrier the rates may fluctuate. I understand the expected value of care is estimated at the full prices listed below:

1 Examination ($95) , X-rays ($280)(Full Spine Sectional with Cervical Flexion/Extension Views) , 8 Adjustments ($65.00each)= $520 , 8 Therapies (1 per visit)($30 each)=$240, Custom Foot Orthotics ($467), Heel Lift ($10 + tax), Nutritional Counseling $180 (3 sessions at $60 each). Total estimated cost =$1,792.50. Additionally, ALCAT Testing can be performed at the cost up to $1,200.00 + $50.00 mobile lab fee. Cold Laser/Light Therapy ($20 per session). Other: _____

*** We reserve the right to send radiologic examinations to a radiologist to be read (per the chiropractor's discretion). There is a $20 reading fee for this service, which cannot be submitted to insurance for reimbursement. You will be financially responsible for this fee.**

All nutritional supplementation and supplies **MUST** be paid for prior to leaving our office. There are absolutely **NO RETURNS FOR ANY NUTRITIONAL SUPPLEMENTATION this includes UNOPENED/ OPENED/USED SUPPLIES.**

**** This is NOT a guarantee you will be billed this amount, but is an advance notification of office charges that can accrue during the course of treatment. ****

I understand my health care provider will make recommendations based upon medical necessity for my condition but cannot guarantee insurance reimbursement. This is only an estimate and my treatment plan will be determined by my health care provider based upon my unique needs and response to care.

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* This notification applies from this date forward and is good for all patient cases and conditions.

_____ _____

Signature of Patient or Guardian Date

_____ Staff Initials _____

Effective Date

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If your Health Insurance Company is, or could possibly change to WEA Trust / Magellan Healthcare / HSM Physical Health Inc, or your insurance contracts with them as a 3rd party, we can reasonably assume they will **NOT** cover or will deny as **NOT** medically necessary the following:

- Any spinal imaging/X-Rays ($50-$120 per area) within the first 30 days of care.
- CPT Codes 97012 - Mechanical Traction ($30), 97140 - Trigger Point Therapy/Graston Technique ($30)
- CPT Codes 98940 ($50) and 98941 ($65) - Spinal Adjustments, or 98943 - Extremity Adjustments ($45) after 30 days of care, or the denial will arise if there is no evidence of functional impairment or improvement in your activities of daily living enough for them to determine Medical Necessity of care.

We anticipate they will not cover care beginning _____ (date).

All services will be performed at :
Wolf River Chiropractic L.L.C.
N5644 State Highway 76
Shiocton, WI 54170

* Our office staff has met with, and explained to the patient that these service(s) provided for their condition may be considered experimental, investigational, or not medically necessary by the patient's health insurance policy or benefits.

_____ Staff Initials

** We can reasonably anticipate you will receive a letter from these insurance companies or 3rd party contractors stating your care is "not medically necessary". Please call the office at 920-240-4441 if you receive this letter. We will discuss with you how to move forward with your care utilizing the affordable options we offer here at Wolf River Chiropractic LLC.

We offer options such as Cash At Time of Service (CATS) discounts, Care Credit, and ChiroHealthUSA to make your care more affordable.

If you wish to proceed with chiropractic treatment at this time, you understand that you will be financially responsible for costs not covered by your insurance company.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Guardian

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, trigger point therapy, cold laser, or manual/mechanical traction may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare", statistically less often than complications from taking a single aspirin tablet..

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Chiropractic is a system of health care delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, condition, or disease as a result of treatment in this office.

Unusual Risks: I have had the following unusual risks of my case explained to me:

Consent to evaluate and adjust a minor child:

I, _____, being the parent or legal guardian of _____, have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

I have read this Informed Consent form in its entirety. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo chiropractic care, and hereby give my full consent to treatment.

_____	_____	_____
Printed Name	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that *Wolf River Chiropractic L.L.C.* has provided you a copy of its Notice of Privacy Practices, which explains how your health information will be handled in various situations. We will try to have you sign this form on your first date of service with us. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I acknowledge that I have received and had the opportunity to review the
Notice of Privacy Practices of Wolf River Chiropractic.

Print Name	**Printed Name of Legal Representative**
Patient's Signature	**Signature of Legal Representative**
Date	**Date**

For Office Use Only:

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, however it could not be obtained because:

Please explain why the patient did not sign an acknowledgement form and Wolf River Chiropractic's efforts in trying to obtain the patient's signature (check all that apply)

- ☐ Patient refused to sign
- ☐ Patient unable to comprehend
- ☐ Patient communication barrier
- ☐ Legal Representative not available
- ☐ Patient/Legal Representative left before signature obtained
- ☐ Emergency Admission/Patient not present for registration
- ☐ Patient bypassed registration – not available
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ Other: _____

Completed by:

Wolf River Chiropractic Staff Member	Date

AUTHORIZATION TO ALLOW VERBAL COMMUNICATION AND/OR LEAVE DETAILED MESSAGES

Patient Information

Name – Last, First, MI			
Street Address	City	State	Zip
Date of Birth (MM/DD/YYYY)	Phone Number		

Information to be disclosed:

I hereby authorize Wolf River Chiropractic to engage in verbal communication or to leave a detailed message with the individual(s) or organization(s) identified below for the following purposes:

- ☐ All aspects of my care, treatment, and payment, including insurance, benefits, and claims
- ☐ All clinical care, including test results and visit documentation
- ☐ All billing and insurance information
- ☐ Schedule, cancel, reschedule, or obtain information about my appointments
- ☐ Text Message Reminders: Cell Phone #: _____ Cell Carrier: _____
- ☐ Email Message Reminders and newsletters: email address: _____
- ☐ Other (Describe): _____

Restrictions: _____

Verbal Communication Between:

Name/Relationship: _____ and Name/Relationship: _____

(List the name of the healthcare facility or specific Healthcare provider/staff member. Listing "WRC" Will cover all Wolf River Chiropractic locations.)

(List the name of the healthcare facility or specific Healthcare provider/staff member. Listing "WRC" Will cover all Wolf River Chiropractic locations.)

Additional authorized individual(s) or organization(s):

Name/Relationship: _____ and Name/Relationship: _____

Leave Detailed Message with:

Myself:

Phone #1: _____ and/or Phone #2: _____

Authorized individual(s) or organization(s):

Individual #1: _____ Relationship: _____ Phone #: _____

Individual #2: _____ Relationship: _____ Phone #: _____

Conditions of Authorization:

1. I understand that this authorization does not include obtaining copies of electronic or paper medical records.
2. I understand that if I agree to sign this authorization, I may request a signed copy of the form.
3. I understand that interaction with another individual may be denied if determined to be in my best interest.
4. I understand that detailed messages may not be left with me or another individual if determined to be in my best interest.
5. I understand that this authorization references all aspects of my healthcare at Wolf River Chiropractic, unless I have indicated any restrictions on this form.
6. I understand that I am fully responsible for reporting changes to data or named individuals.
7. I understand that this authorication references all aspects of my healthcare at Wolf River Chiropractic at (920) 240-4441.
8. Authorizations are executed in compliance with federal and state laws governing this action.
9. I understand that this authorization is executed in compliance with federal and state laws.
10. This authorization is effective on the date of signature and will remain in effect until Wolf River Chiropractic has been notified of changes in writing.

Signature of Patient or legal Representative: _____ **Date:** _____

Relationship: _____ Legal Authority: ☐ Legal Guardian ☐ Spouse of Deceased

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased ☐ Health Care Agent ☐ Personal Representative

☐ Other: _____