Demographic Information

Amery Chiropractic LLC

408 Keller Ave South • Amery, WI 54001
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Dr. Cory Gosso
Dr. Kelsey Faschingbauer
Dr. Jennifer Waidelich

All information witll be kept confidential. We acomplay with all federal privacy standards.
Please let our staff take a copy of your insurance card (if you are wanting to use it).
Please print your answers clearly for our staff.

Personal Information

Today's Date:_____

Patients Name:_____ Nickname:_____
First MI Last

Address:_____
Street City State Zip

Date of Birth:_____/_____/_____ SSN:_____-_____-_____ Drivers#:_____

Gender: **Male** **Female** **Other**

Phone Number:_____ Work Number:_____

Email:_____

Employer:_____ City/State:_____

Emergency Information

Contact Name:_____

Phone Number:_____

Relationship:_____

Injury & insurance Information

My injury is related to: **NECK** **UPPER BACK** **MID BACK** **LOW BACK** **OTHER**

Result of an accident: **YES** or **NO** If Yes: **AUTO** or **WORK**

Are you using health insurance: **YES** or **NO**

Primary holder of my insurance is:_____ Birthday:_____

Relationship:_____

Referral

How did you find out about our office?

Yellow pages **Insurance Company** **Newspaper** **Website** **Facebook**

Other:_____

Thank you

Waiver and release of liability

In consideration of the risk of injury while participating in chiropractic and as consideration for the right to participate in chiropractic, I hereby, for myself, my heirs, executors, administrators, assigns, or personal representatives, knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in this Activity, and do hereby release and forever discharge Amery Chiropractic LLC, located at 408 Keller Avenue South, Amery, Wisconsin 54001, their affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors and assigns, for any physical or psychological injury, including but not limited to illness, paralysis, death, damages, economical or emotional loss, that I may suffer as a direct result of my participation in the aforementioned Activity, including traveling to and from an event related to this Activity.

I AM VOLUNTARILY PARTICIPATING IN THE AFOREMENTIONED ACTIVITY AND I AM PARTICIPATING IN THE ACTIVITY ENTIRELY AT MY OWN RISK. I AM AWARE OF THE RISKS ASSOCIATED WITH TRAVELING TO AND FROM AS WELL AS PARTICIPATING IN THIS ACTIVITY, WHICH MY INCLUDE, BUT ARE NOT LIMITED TO, PHYSICAL OR PSYCHOLOGICAL INJURY, PAIN, SUFFERING, ILLNESS, DISFIGUREMENT, TEMPORARY OR PERMANENT DISABILITY (INCLUDING PARALYSIS), ECONOMIC OR EMOTIONAL LOSS, AND DEATH. I UNDERSTAND THAT THESE INJURIES OR OUTCOMES MAY ARISE FROM MY OWN OR OTHERS' NEGLIGENCE, CONDITIONS RELATED TO TRAVEL, OR THE CONDITIONS OF THE ACTIVITY LOCATION(S). NONETHELESS, I ASSUME ALL RALATED RISKS, BOTH KNOWN AND UNKNOWN TO ME, OF MY PARTICIPATION IN THIS ACTICITY, INCLUDING TRAVEL TO, FROM AND DURING THIS ACTIVITY.

I agree to indemnify and hold harmless Amery Chiropractic LLC against any and all claims, suits or actions of any kind whatsoever for liability, damages, compensation or otherwise brought by me or anyone on my behalf, including attorney's fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf. If Amery Chiropractic LLC incurs any of these types of expenses, I agree to reimburse Amery Chiropractic LLC.

I acknowledge that Amery Chiropractic LLC and their directors, officers, volunteers, and representatives and agents are not responsible for errors, omissions, acts or failures to act of any party or entity conducting a specific event or activity on behalf of Amery Chiropractic LLC.

I ACKNOWLEDGE THAT THIS ACTIVITY MAY INVOLVE A TEST OF A PERSON'S PHYSICAL AND MENTAL LIMITS AND MAY CARRY WITH IT THE POTENTIAL FOR DEATH, SERIOUS INJURY, AND PROPERTY LOSS. The risks may include, but are not limited to, those caused by terrain, facilities, temperature, weather, lack of hydration, condition of participants, equipment, vehicular traffic and event officials and event monitors, and/or producers of the event.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS "WAIVER AND RELEASE" AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY. I EXPRESSLY AGREE TO RELEASE AND DISCHARGE Amery Chiropractic LLC AND ALL OF ITS AFFILIATES, MANAGERS, MEMEBERS, AGENTS, ATTORNEYS, STAFF, VOLUNTEERS, HEIRS, REPRESENTATIVES, PREDECESSORS, SUCCESSORS AND ASSIGNS, FORM ANY AND ALL CLAIMS OR CAUSES OF ACTION AND I AGREE TO VOLUNTARILY GIVE UP OR WAIVE ANY RIGHT THAT I OTHERWISE HAVE TO BRING A LEGAL ACTION AGAINST Amery Chiropractic LLC FOR PERSONAL INJURY OR PROPERTY DAMAGE.

To the extent that statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of Amery Chiropractic LLC, its agents, and employees.

In the event that I should require medical care or treatment, I agree to be financially responsible for any costs incurred as a result of such treatment. I am aware and understand that I should carry my own health insurance.

In the event that any damage to equipment or facilities occurs as a result of my or my family's willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

This Agreement was entered into at arm's length, without duress or coercion, and is to be interpreted as an agreement between two parties of equal bargaining strength. Both the Participants agree that this Agreement is clear and unambiguous as to its terms, and that no other evidence will be used or admitted to alter or explain the terms of this Agreement, but that it will be interpreted based on the language in accordance with the purposes for which it is entered into.

In the event that any provision contained within this Release of Liability shall be deemed to be severable or invalid, or if any term, condition, phrase or portion of this agreement shall be determined to be unlawful or otherwise unenforceable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

I, the undersigned participant, affirm that I am of the age of 18 years or older, and that I am freely signing this agreement. I certify that I have read this agreement, that I fully understand its content and that his release cannot be modified orally, I am aware that this is a release of liability and contract and that I am signing it of my own free will.

Patient's name	Patient's Signature	Date

Financial Responsibility Acknowledgment

We are sincerely pleased that you have chosen us to help you maintain your health and for the evaluation and treatment of your spinal/muscular problems.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communication. The following information is designed to provide you with detailed information about our financial policies to allow better understanding of your financial liabilities for our professional services.

Payments for services are due at the time service are rendered. We accept checks, cash, and for your convenience, MasterCard, Visa, and Discover. If our practice is a PREFERRED PROVIDER with your insurance company, we will submit the claim to your insurance company. If your insurance coverage or company changes, it is your responsibility to notify our office immediately for proper claims submission and processing.

Please read the following. If you have any questions please contact our staff for assistance.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you not your insurance company. Please also understand that when a doctor "accepts assignment" it simply means that your Insurance Company will send the payment directly to the doctor. This in no way relieves the patient of their deductible, co-pays, or fees for uncovered services.
2. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of services, please inquire with your insurance company or staff prior to treatment. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan, what services are or are not covered. Fees for the services, along with any unpaid deductible and co-payments are due at the time of treatment. You are responsible for these amounts.
3. Should you receive payment from your insurance company, or any lien, for services provided by this facility and have not turned said moneys over to this facility within 30 days, or should you fail to perform your obligation to pay these fees, then the entire amount of the chiropractic's billing shall bear interest at the highest rate permitted by law from the date chiropractic services were first rendered. **AND YOUR ACCOUNT WILL THEN BE PLACED FOR COLLECTIONS.**
4. **You are responsible for knowing your insurance benefits.** Does your insurance require a referral for chiropractic services? Which facilities/doctors participate in your plan? If we can be of assistance in your retrieval of this information, please let us know.
5. We will send you a statement monthly to keep you informed on the status of your account until it has been paid in full or placed for collections.
6. We will bill the insurance information that you have provided, but you are still ultimately responsible for payment of any services you receive. We will also follow up on your claim by checking with your insurance carrier once verbally and once in writing. **If your insurance does not respond to us within 60 days of claim submission, the amount will become your responsibility.**
7. Returned checks are subject to a $25.00 returned check fee in addition to the amount the check was written.
8. We do not submit any vitamins, supplements, neck and back supports, pillows, and supplies to any insurance companies. They are the patient's responsibility, if you want to submit your receipt for such products you are to do so on your own. Please consult with a staff member regarding products and prices.

We do understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____	_____	_____
Name	Signature of Patient	Date

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

Printed Patient's Name	Printed Office Staff Name
Signature of Patient	Signature of Office Staff
Date	Date