# AMERY CHIROPRACTIC LLC

408 Keller Ave. So. • Amery, WI 54001
Phone 715-268-9146 • Fax 715-268-6907

Dr. Jennifer Waidelich
Dr. Cory Gosso
Dr. Kelsey Faschingbauer

Please take a moment to answer the following questions that are designed to maximize your child's health. Many types of stresses (physical, mental, chemical) can interfere with your child's growing spine and nervous system. Spinal health is an exciting new concept for many people, so please remember to ask questions.

Child's Name: _____ Birthday: _____Gender:_____

Parent's Name: _____Phone Number: _____

Address: _____
Street City State Zip

**Circle Appropriately:**

Does your child take vitamins or supplements? Yes No

Has your child been involved in a motor vehicle accident of any kind? Yes No

Has your child had surgery? Yes No If yes, for what? _____

Has your child been seen by either a doctor or hospital on an emergency basis? _____

_____

Does your child have any learning challenges? Yes No If yes, what are they? _____

_____

Which sports does your child participate in: Soccer Football Gymnastics Dance Karate Hockey

Baseball Basketball Other: _____

Does your child carry a backpack? Yes No

Circle any of the following your child has had in the past 12 months:

| | | | |
|---|---|---|---|
| Ear infection | Scoliosis | Seizures | Chronic cold |
| Asthma | Allergies | ADD | ADHD |
| Colic | Psoriasis | Diabetes | Headaches |
| Bed wetting | Back discomfort | Growing Pains | Digestive Problems |
| Recurring fevers | Temper Tantrums | Visual Impairment | Hearing difficulty |
| Eczema | Mood swings | | |

Approximately how many prescription and counter medications has your child taken?_____

Reason for prescriptions: _____

Is your child currently taking **any** medications? Yes No

If yes, what: _____

I authorize the doctors at Gosso-Waidelich Chiropractic to examine and care for my child.

Signed: _____ Date: _____
(Parent or Guardian)

# ***Waiver and release of liability***

**RELEASE FORM FOR MINORS (under the age of 18)**

**PARENTAL CONSENT REQUIRED**

I, _____, being the parent or legal guardian of _____ (the "Minor") hereby consent to and authorize the minor to be treated at Amery Chiropractic LLC located at 408 Keller Ave South Amery Wisconsin 54001. I acknowledge and agree that activities performed by the clinic.

On behalf of myself, the minor, and our respective heirs and personal representatives, I agree not to hold or attempt to hold Amery Chiropractic LLC, their population served, volunteers, or staff responsible for any injury or damage sustained or incurred by the minor, arising out of or in any way connected with the minor's activities. I hereby release and discharge Amery Chiropractic LLC, their doctors, employees, and their volunteers from any and all claims, demands, causes of action of any nature or cause, for any such injury or damage incurred or suffered by the minor.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Parent/Legal Guardian | Printed Name of Parent/Legal Guardian | Date |

_____

Phone Number(s) for Emergencies

# ***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.**

| Patient's Name | Signature of Parent | 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 Legal Guardian | Signature of Office Staff |
| _____ | _____ |
| Date | Date |