

Date: _____

Acct # _____

Patient Information

Name _____
First _____ Middle Initial _____ Last _____ Chosen/Called Name _____

Address: _____
Street _____ City _____ State _____ Zip _____

Phone Number: () _____ () _____ () _____
Home _____ Work _____ Mobile _____

Preferred Contact # **Home/Work/Cell** **Email Address:** _____

Emergency Contact _____
Name _____ Contact number _____ Relationship _____

Gender on file with insurance: M / F **Marital Status:** M / P / S / D / W **Children:** Y / N

Birthdate: _____ **Pronouns:** _____

Work Status: Employed Full Time / Employed Part Time / Retired / Student / Other

Medications: **Allergies:**

1. _____ mg 1. _____

2. _____ mg 2. _____

3. _____ mg 3. _____

4. _____ mg 4. _____

5. _____ mg

Did someone refer you to our office? Y / N _____

Have you ever had chiropractic care before? Y / N _____

Primary Care Doctor : _____

Name _____

Contact number _____

Primary Care Doctor Location/Address _____

Other Information: _____

Consent to Chiropractic Services

PAYMENT AND INSURANCE

Pt. Initials _____

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

CONSENT TO TREATMENT OF A MINOR CHILD

Pt. Initials _____

I authorize the licensed doctor to administer chiropractic care as deemed necessary to my
(Relationship) _____ Name _____

PREGNANCY

Pt. Initials _____

This is to certify that to the best of my knowledge I am not pregnant and that Brueggeman Chiropractic Center has my permission to request or take x-rays.

Beginning date of your last menstrual period: _____

I am currently pregnant. My due date is: _____

Pt. Initials _____

CONSENT TO RELEASE INFORMATION TO MEDICAL DOCTOR

Pt. Initials _____

I authorize the release of any pertinent examination or diagnostic testing findings to my medical doctor. I understand communication of important health information between my physicians is necessary to provide me with the most comprehensive care possible.

CONSENT TO CHIROPRACTIC SERVICES

Pt. Initials _____

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physical therapy, diagnostic x-rays, and/or tests by Brueggeman Chiropractic Center and their staff who now or in the future will treat me while employed by this office. I have had an opportunity to discuss with the physician and/or with other clinic personnel the nature and purpose of treatment indicated. I understand that results are not guaranteed and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had an opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for the future conditions for which I seek treatment by this clinic and/or employed staff.

SIGNED _____

Date _____

Briefly describe your problem: _____

When did it start? _____

Does anything make it feel better? _____

Does anything make it feel worse? _____

How would you describe the pain? (i.e. burning, aching etc.) _____

Does the pain shoot/radiate into other areas of your body? _____

Is the pain worse or better at certain times of the day or after certain activities? _____

Have you ever had this problem before? _____

Mark the areas on this body where you feel the described sensations.

Use the appropriate symbols. Mark areas of radiation.

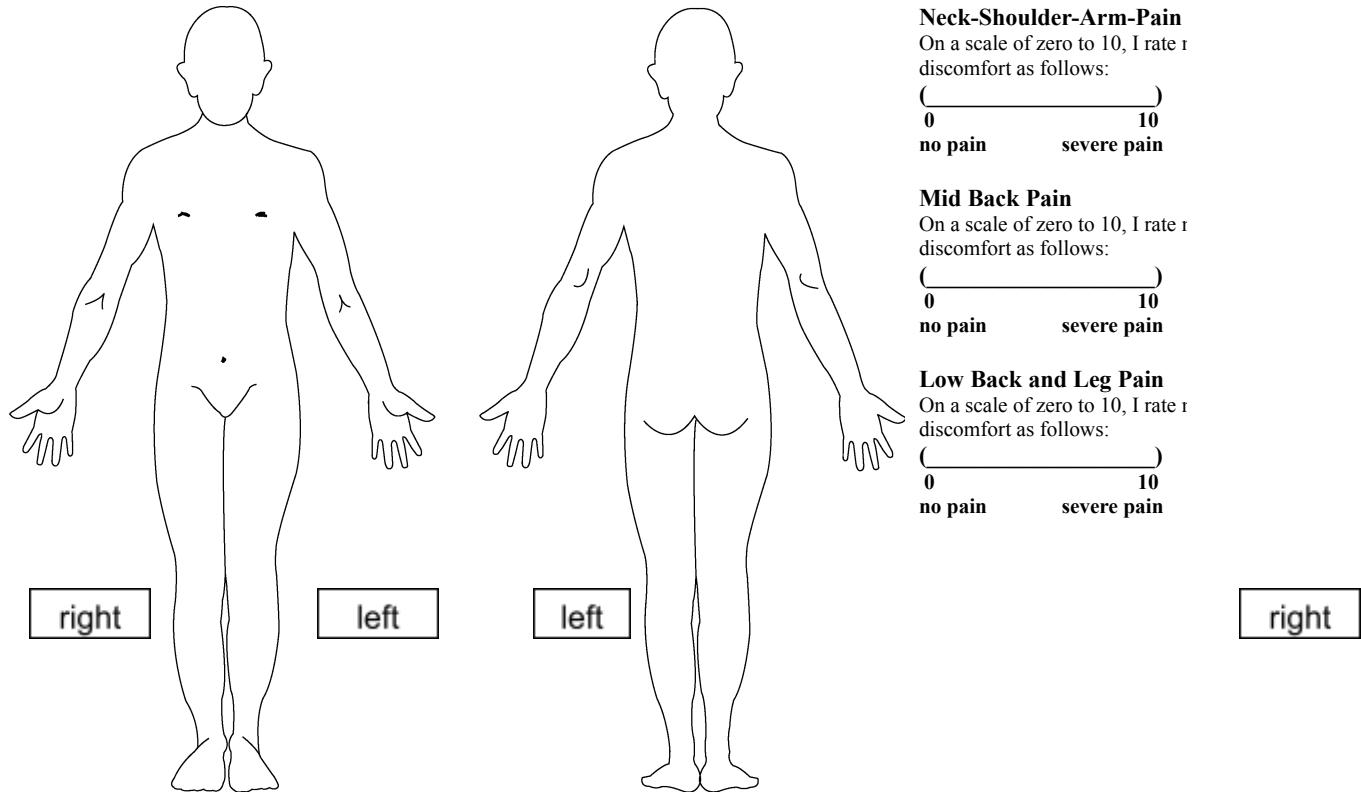
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXX	*****	
-----	00000	XXXXX	*****	
-----	00000	XXXXX	*****	

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.

10 being the worst pain you have felt with this condition.

Pain Chart



Date: _____

Signature: _____

Patient Name: _____

Date: _____

Symptom Survey

The symptoms listed below may be related to your current condition. To insure we have a correct picture of your health please complete this survey. In the space in front of each item enter (Y) if you are currently experiencing a symptom or you have had a significant problem with the symptom in the past.

General

- 1. Fever
- 2. Chills
- 3. Night Sweats
- 4. Loss of Sleep
- 5. Fatigue
- 6. Nervousness
- 7. Weight Loss or Gain
- 8. Allergies
- 9. Bleeding Problems
- 10. Anemia
- 11. Diabetes
- 12. Cancer
- 13. Thyroid Disease/Goiter
- 14. Alcoholism
- 15. Drug Abuse

Ear, Eye, Nose, Throat

- 16. Poor Vision
- 17. Pain in Eyes
- 18. Deafness/Difficulty Hearing
- 19. Nosebleeds
- 20. Nose Problems
- 21. Sinus Trouble
- 22. Dental Problems
- 23. Hoarseness
- 24. Tonsillectomy

Gastrointestinal

- 25. Poor Appetite
- 26. Poor Digestion
- 27. Difficulty Swallowing
- 28. Belching or Gas
- 29. Frequent Nausea
- 30. Vomiting
- 31. Vomiting Blood
- 32. Pain over Abdomen
- 33. Ulcer
- 34. Black or Bloody Stools
- 35. Liver Problems
- 36. Gall Bladder Problems
- 37. Jaundice
- 38. Hernia
- 39. Diarrhea
- 40. Constipation

41. Hemorrhoids

42. Appendicitis

75. Breast Lump or Pain

76. Sexual Difficulties

Men Only

43. Testicular Swelling/Pain

44. Prostate Problems

Women Only

45. Painful Periods

46. Excessive Flow

47. Irregular Cycles

48. Vaginal Burning/Itching

49. Hot Flashes

50. Date last period began

51. Date of last Pap smear

Cardiovascular

52. Irregular Heartbeat

53. High Blood Pressure

54. Pain over Heart

55. Previous Heart Trouble

56. Ankle Swelling

57. Varicose Veins

58. Rheumatic Fever

59. Stroke

Respiratory

60. Difficulty Breathing

61. Chronic Cough

62. Spitting Phlegm

63. Spitting Blood

64. Wheezing/Asthma

65. Pneumonia

66. Tuberculosis

Genitourinary

67. Frequent Urination

68. Painful Urination

69. Blood in Urine

70. Kidney Disease

71. Urinary Infection

72. Inability to Control

Urination

73. Difficulty Starting Urine

Flow

74. Get up at night to urinate

Skin

77. Itching

78. Bruising

79. Change in Moles

80. Skin Cancer

Neurologic

81. Weakness

82. Twitching

83. Tremors

84. Headache

85. Fainting

86. Dizziness

87. Convulsions

88. Epilepsy/Seizures

89. Numbing/Tingling

90. Arm/Leg Pain

91. Mental Disorder

Musculoskeletal

92. Neck Stiffness/Pain

93. Pain between Shoulders

94. Low Back Pain

95. Swollen Joints

96. Painful Joints

97. Muscle Aches/Soreness

98. Spinal Curves

99. Arthritis

Brueggeman Chiropractic Center, LLC

108 Magnolia Dr., STE A

Glen Carbon, IL 62034

Ph: 618-692-0000

Fax: 618-655-1550

Financial Policy

Welcome to Brueggeman Chiropractic Center LLC. Our goal is to provide our patients with the best possible care and to maintain a good physician-patient relationship. We believe that these objectives are best achieved when our patients are clearly informed of our financial policy. Please review this policy carefully. We encourage patients to freely communicate with our office and to review any questions with our staff.

Fees for Our Most Common Services

New patient exam fees: \$84 - \$99

Existing patient exam fees: \$59 - \$84

Chiropractic Adjustments: \$50 - \$55

Hot/Cold Packs: \$10

Muscle Stimulation: \$25

Ultrasound: \$20

Acupuncture: \$50

Rehabilitative Exercise Training: \$50

No Show/Late Cancellation Fee: \$40

Insurance Coverage

By receiving services from this office, you have created a legal obligation between you and this office, and you are agreeing to pay for our services. This legal obligation exists independently and regardless of insurance or health benefits you may have. Your insurance policy or health plan is an agreement between you and your insurer, not between your insurer and this clinic, even if this office is a participating provider in your insurance network, and even if we agree to bill your plan. You agree that you intend, to the full extent allowed by law, for the legal obligation between you and this office to take priority over any agreement between you and your insurer or health plan, or any agreement between your insurer or health plan and this office. In the event discrepancies exist in the agreements between and among you, this office and your health insurer or health plan, you intend for this Financial Policy to control. Therefore, you acknowledge your obligation to pay this office for any and all services rendered, regardless of whether insurance coverage is denied at any time and **for any reason**, including but not limited to the insurer's or plan's determination that a procedure is not medically necessary or is experimental and/or investigational.

Insurance coverage for the services we provide varies from insurer to insurer and plan to plan. Our clinic will contact your insurer or health plan to inquire about your benefits. However, most insurers and health plans provide that an initial "verification" of coverage is not a guarantee of payment. We are not responsible for your insurer's or health plan's final benefit determinations, and you are responsible to pay for any care that is determined to be non-covered, even after an initial verification of coverage.

Patients and/or this clinic may obtain information indicating that a contemplated service or services will not be covered by insurance or the health plan. Additionally, some plans require pre-authorization as a condition of payment for certain services, after which the plan may deny or limit authorization of the services requested. In any case in which a patient and/or this clinic know that contemplated services will not be covered by a patient's insurance, this office will ask the patient prior to service to sign a form acknowledging that the services will not be covered and that the patient will be personally responsible for payment.

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Most insurance policies and health plans require the beneficiary to pay co-insurance, co-payment and/or a deductible. Our clinic requires the payment of these fees on the date of your visit. This office does NOT routinely waive co-insurance, co-payments or deductibles.

If your insurance or health plan requires you to obtain a written referral from your primary care provider as a condition to your receiving services from our clinic, it is your responsibility to obtain and present the referral prior to or at the time of your visit to our clinic. If you need assistance in obtaining the referral, our clinic will provide assistance at your request. If your plan requires our office to complete a referral for services outside of our office, we require 3 business days to complete the forms, except in emergencies. Please plan your visits accordingly.

Billing and Payment

This office accepts cash, checks, and the following credit cards: Visa, Mastercard, and Discover.

Our office will submit bills to your insurance if you are covered by a plan in which we participate. You will be required to sign an Assignment of Benefits as a condition to our billing your insurance. However, the Assignment of Benefits does not cancel your financial obligation to this office. Full payment is due at the time of service for uninsured patients; for patients who are covered by a plan in which our office participates but services are not covered; or for patients who are insured by a plan in which this office does not participate.

All remaining balances are due upon receipt of the billing statement. We will impose a \$25 fee for returned checks. Any accounts not paid within 30 days of the statement date will begin to accrue interest at 9% per annum and will be turned over for collection.

In cases of separation, divorce and/or shared custody, any adult accompanying a minor child to an appointment is responsible for payment, regardless of the terms of the separation or divorce. It is the responsibility of family members, not this office, to resolve legal disputes, and terms of a divorce do not supersede the legal obligation for the accompanying parent to pay for our services. However, we understand that temporary financial issues may affect timely payment, and we encourage patients to contact our staff regarding payment arrangements in such situations.

Missed, Late and Canceled Appointments

This office reserves the right to assess a \$40 fee for "no-shows." Due to scheduling and staffing requirements, we must ask that cancellations be made more than 24 hours prior to your appointment. We recognize that occasionally circumstances may not permit you to provide 24 hours' notice, and we will consider these situations on a case by case basis.

For patients who arrive to appointments 20 minutes or longer after the scheduled time, we will attempt, but cannot guarantee, that the patient can be seen. In these cases, we reserve the right to charge the above-mentioned missed visit fee if the lateness becomes a chronic issue.

Medical Records Copying and Transferring

Medical records will be released within 20 days of request pursuant to your request, in accordance with the rules for the Health Insurance Portability and Accountability Act (HIPAA), CURES, Illinois law, or under other circumstances required by law. We will not charge copying fees when the medical records are requested by the

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patient. Requests made by 3rd parties, such as attorneys, may be charged a fee in accordance with rules for HIPAA, Illinois Law, or other regulations.

Medical Forms, Reports, Testimony and Miscellaneous Fees

This office will fill out routine forms at no charge. However, we reserve the right to determine which forms are routine in nature. Our physicians may provide additional services, such as expert review and consultation, narrative reports, testimony at depositions and trials, or family conferences, at an hourly rate. Should you need these services, please see our staff for further details.

I understand and agree to all terms and conditions of this Financial Policy, including the provision that all health services rendered to me and charged to me are my personal financial responsibility.

Please initial each page and sign below.

Signature of Patient or Responsible Party

Date

Printed Name of Patient or Responsible Party

Assignment of Benefits (must be completed for our office to bill your insurance for services rendered)

I authorize the release of any medical or other information necessary to process my insurance claims to any authorized representative of my insurance carrier. I also request payment of government benefits or private insurance benefits to:

Brueggeman Chiropractic Center, LLC
108 Magnolia Dr., Suite A Glen Carbon, IL 62034
Ph: 618-692-0000 Fax: 618-655-1550

Who accepts assignment for these claims.

A photocopy of this shall be considered as valid as the original document.

Patient/Claimant Signature _____

Printed Name of Patient or Responsible party _____

Date _____

(9-2025)

Patient Initials _____

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Brueggeman Chiropractic Center's *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name (print)

Patient's Date of Birth

Patient Signature

Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____
(Print) _____ Date _____

Signature of Personal Representative: _____

Relationship to Patient: _____ Drivers License Number: _____ State _____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the *Notice of Privacy Practices*:

Attempt 1: _____ Date _____ Staff: _____

Attempt 2: _____ Date _____ Staff: _____

PHI Use and Disclosure Authorization

I grant Brueggeman Chiropractic Center permission to (required, please check all that apply):

- Leave messages on the phone number provided as my preferred contact number.
- Send text reminders to my mobile phone number.
- Email me information regarding appointment scheduling.
- Email me receipts with all FSA/HSA required information.

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize Brueggeman Chiropractic Center disclosure of my individually identifiable health information to the authorized individuals listed (optional):

1. Authorized Individual _____ Relationship to Patient _____

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and future Appointments
- Receive phone messages and/or email regarding appointments or test results
- Other _____

2. Authorized Individual _____ Relationship to Patient _____

Authorization to:

- Disclose treatment plans and test results
- Billing information including statement balances
- Past and Future Appointments
- Receive Phone Messages or email regarding appointments or test results
- Other _____

This authorization is effective through (required, check one):

_____ / _____ / _____

NO EXPIRATION unless revoked or terminated by the patient or the patient's personal representative

I understand that I may revoke this authorization to disclose information at any time by notifying Brueggeman Chiropractic Center in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Brueggeman Chiropractic Center until the termination request is received in writing and processed.

Authorization to Disclose:

Patient Name (print) _____

Patient's Date of Birth _____

Patient Signature _____

Date _____

For Minors and Medical POA

Patient Name (print) _____

Signature of Personal Representative (If Patient is a minor) _____

Date _____

Relationship to Patient: _____ Drivers License Number: _____ State _____