BEND WHOLE HEALTH

354 NE NORTON AVE, STE #100
BEND, OREGON 97701
FAX: (541) 389-1972

1 PATIENT INFORMATION

Date _____

SS# _____

PATIENT NAME _____
Last Name

_____
First Name M.I.

Address _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____

Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Divorced

Patient Employer/School _____

Occupation _____

Employer Address _____

Employer Phone ( ) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co _____

ID# _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Secondary Insurance Co. _____

ID# _____

3 ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp

❑ Other

Attorney Name (If applicable) _____

4 PHONE NUMBERS

Email _____

Cell Phone _____

Cell Phone Carrier _____

(For cell phone appointment text reminders, please list your cell phone carrier)

Home Phone _____

Family Physician _____

Physician Phone _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Phone Number(s) _____

Referred by: _____

FOR OFFICE USE ONLY

COPY OF DRIVER'S LICENSE ❑

COPY OF INSURANCE CARD ❑

INFORMED CONSENT TO CHIROPRACTIC CARE

Daniel J. Bourque, D.C.
354 NE Norton Avenue #100
Bend, Oregon 97701

Telephone (541) 389-1191

Patient Name_____ Birthdate_____

Please discuss any questions or concerns with the Doctor before signing this consent.

I hearby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or with other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below. Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains.

I understand that I will be receiving the following treatment:

EXAM PROCEDURES
CHIROPRACTIC ADJUSTMENTS
PHYSIOTHERAPIES
PRESCRIBED EXERCISE
NUTRITIONAL RECOMMENDATIONS

I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

WITNESS SIGNATURE & DATE_____

DOCTOR'S SIGNATURE & DATE _____

ACKNOWLEDGMENT AND CONSENT

I understand that Dr. Daniel J. Bourque of Bend Whole Health PC,

(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

BEND WHOLE HEALTH
FAMILY CHIROPRACTIC

FINANCIAL POLICY

This is an agreement between Dr. Daniel J. Bourque and you, the patient.
By executing this agreement, you are agreeing to pay for all services rendered.

Payment Information

Payment for services is expected at the time of service unless we approve other arrangements in writing prior to your treatment. Accounts are considered past due if not paid by the last day of each month.

Payment Options

If you have insurance Payment for services is expected at the time of service unless we approve other arrangements in writing prior to your treatment. Accounts are considered past due if not paid by the last day of each month.

If you have no insurance Payment for services is expected at the time of service unless we approve other arrangements in writing prior to your treatment. Accounts are considered past due if not paid by the last day of each month.

Insurance Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your insurance company as a courtesy to you, or if you decide to bill your insurance company we will provide you with a form (superbill) to give to your insurance company. Although we will estimate what your insurance company may pay, it is the insurance company who makes the final decision of your eligibility. You agree and understand that you are responsible for benefits, payments, or any claim inquiries.

Monthly Statements If you have a balance on your account, we will send you a monthly statement. It will show your previous balance and any new charges to your account and if any payments, credits or write offs have been applied to your account during the month(s).

Finance Charge A finance charge may be imposesd on your account which has not been paid within thirty (30) days of the date of receiving your statement. The finance charge will be computed at the rate of (2%) per month, or an Annual Percentage Rate of (18%). The minimum finance fee is $.50 cents.

Late Fee A late fee of $25 may be assessed on all charges that are not paid in full by the end of each billing cycle.

Returned Checks There is a $25.00 fee for any checks returned by the bank.

Missed Appointment Fee We require 24-hour notice in order to change any appointments. There is a $25 fee for all appointments that are missed or cancelled less than 24 hours in advance.

Past Due Accounts If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which may incur. If we have to refer collection to a lawyer, you agree to pay all lawyer's fees which we incur, as well as court costs. In case of suit, the venue will be in the Deschutes County.

Effective Date ***Once you have signed this document, you agree to all of the terms and conditions contained herein. This is a legally binding agreement and will be in full effect.***

ASSIGNMENT OF BENEFITS

I hereby assign all chiropractic benefits, including alternative care health coverage to which I am entitled, to Daniel J. Bourque, DC., for services rendered and charges appropriated. If any claims are denied or unpaid due to lapse in coverage, lack of chiropractic coverage, unmet deductible, maximized benefits, or for any other reason, I am fully responsible for any outstanding balance.

By: _____
PATIENT **DATE**

OR

By: _____
PATIENT REPRESENTATIVE **DATE**