bend in the river ***chiropractic***

Marina Proudfoot, DC

2021 East Hennepin Avenue
Minneapolis, Minnesota 55413
info@bendintheriver.com
612-676-0438

Please read and sign below:

Cancellation Policy

Bend in the River Chiropractic's commitment is to offer quality chiropractic care. In order to do this, we allow substantial time with each client. This means we can only see a limited number of clients per day. Not showing up for your appointment means someone else could not get in for treatment. Therefore, we require a 24-hour notice of cancellation for any scheduled appointment. We plan to uniformly enforce this policy as follows:

1. Clients will be charged ($75 for a half-hour visit and $150 for an hour visit) for any appointment for which we do not receive a 24-hour notice of cancellation.

2. Unusual circumstances and extreme hardship will be considered but cannot be assumed by the client. Reasons such as illness, car trouble, work or day-care conflicts do not fall under this category.

3. If your care is being paid for by insurance, missed appointments cannot be billed to your insurance company. Therefore you will be responsible for the cost of the appointment yourself.

I have read and understand this policy and agree to pay for a missed treatment if I cancel my appointment less than 24 hours before its scheduled time or fail to show for a scheduled appointment.

Signature Date

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Patient Information

Please complete the following:

NAME | **DATE**

DATE OF BIRTH | AGE | SOC. SEC. #

ADDRESS | EMAIL

CITY | STATE | ZIP

PHONE — HOME | WORK | CELL

EMPLOYER NAME | OCCUPATION

ADDRESS | PHONE

CITY | STATE | ZIP

SPOUSE/PARTNER'S NAME

PHONE — HOME | WORK | CELL

EMERGENCY CONTACT NAME (person other than spouse/partner)

PHONE — HOME | WORK | CELL

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WHOM MAY WE THANK FOR REFERRING YOU TO US?

YOUR MEDICAL DOCTOR'S NAME | PHONE

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?

INSURANCE COMPANY NAME | PHONE

ADDRESS

CITY | STATE | ZIP

NAME OF INSURED

BIRTH DATE OF INSURED | RELATIONSHIP

ADDRESS

CITY | STATE | ZIP

GROUP # | I.D. # | CLAIM #

NAME OF SECONDARY INSURANCE

GROUP # | I.D. # | CLAIM #

IS YOUR INJURY/COMPLAINT RELATED TO: ☐ AUTOMOBILE ACCIDENT ☐ WORK INJURY ☐ OTHER

DATE OF INJURY/ACCIDENT

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS INJURY/COMPLAINT? ☐ YES ☐ NO

IF YES, DOCTOR's NAME | PHONE

ADDRESS

ATTORNEY'S NAME | PHONE

Please see the next page >>

Patient Information (page 2)

PLEASE DESCRIBE YOUR PRESENT COMPLAINT:

PLEASE DESCRIBE THE HISTORY OF YOUR CURRENT CONDITION:

HAVE YOU EVER HAD THIS CONDITION BEFORE? ☐ YES ☐ NO

IF YES, WHEN:

ARE YOU DOING ANY SELF CARE FOR THIS CONDITION? ☐ YES ☐ NO

IF YES, WHAT:

DO YOU HAVE ANY OTHER HEALTH PROBLEMS? ☐ YES ☐ NO

IF YES, PLEASE LIST:

PLEASE CHECK BOXES IF ANYONE IN YOUR FAMILY HAS ANY OF THESE CONDITIONS AND LIST FAMILY MEMBER(S):

STROKE ☐ FAMILY MEMBER:

CARDIOVASCULAR DISEASE ☐ FAMILY MEMBER:

ARTHRITIS ☐ FAMILY MEMBER:

DIABETES ☐ FAMILY MEMBER:

HIGH BLOOD PRESSURE ☐ FAMILY MEMBER:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST:

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Please read and sign all below:

Assignment of Insurance Proceeds

By agreeing to this assignment, you agree that we will direct your insurance company to make any payments for your chiropractic, physiotherapy, x-rays, diagnostic testing, or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to Bend in the River Chiropractic any insurance proceeds, including accident and health insurance, auto insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account.
In giving this assignment, I acknowledge that I will be responsible for the amount of any unpaid balance with interest as allowed by law.

Signature Date

Records Release Authorization

To: Bend in the River Chiropractic
You are authorized to release any information contained in my file to any insurance company, attorney or member of your office staff, including any contracted billing services representing the clinic, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed parties should phone contact be required for the purpose of obtaining payment for charges outstanding.

Signature Date

Cost of Collections

I understand that if I fail to pay my account as agreed, Bend in the River Chiropractic may, after reasonable attempts to obtain payment, place my account for collection. I understand that if my account is placed for collection with an agency or attorney, payments made after that collection agency placement result in an agency service fee of one-third to one-half of any amount paid. If my account is placed for collection, I agree to pay Bend in the River Chiropractic's costs of a collection agency up to one half of the amount recovered.

Signature Date