Tree of Life Chiropractic Wellness Center

Peter R. Raether, DC
Doctor of Chiropractic, LLC

3823 S. 108th Street
Greenfield, WI 53228
Office: 414-327-6400
Fax: 414-327-1215

Patient Registration Form

Date:______________

Name:_______________________________________ **Social Security #**:____________________________

Address:____________________________________ **City**:_________________ **State**:_____ **Zip**:_________

Home Phone:________________________ **Cell Phone**:__________________________

Email Address:____

Age:_________ **Birth Date**:______________________ **Race**:_____________ **Sex**: ☐M ☐F

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse:________________________ **How Many Children** _________

Children's name and age:____

Occupation:____________________ **Employer**:___________________ **Employer Phone**:______________

Emergency Contact Name:____________________ **Relationship**:_____________ **Phone**:______________

How were you referred to our office?:____

Family Medical Doctor:____
When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office?:________________

Name of Primary Insurance Company: ____
Name of Secondary Insurance Company (if any):____
Name of Insured:_______________________ **Relationship to Insured**:_____________ **DOB**:___________

Please check any and all insurance coverage that may be applicable in this case:
☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident
☐ Medical savings Account & Flex Plans ☐ Other

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

Patient's Signature:____ **Date**:__________________

Guardian's Signature Authorizing Care:____________________________ **Date**:__________________

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______ **INSURED PATIENTS**

Your insurance is an agreement between you and your insurance company, not between your insurance company and this clinic. It is policy of this office that all services rendered are charged directly to you, the patient, and that ultimately, it is the patient who is responsible for all the charges including those not reimbursed by a third party payer. All deductibles and co-payments are due at the time of service or at the end of that week. Patient's balances may not exceed $300.00 at any time. Since we do not own your insurance policy, we may at some point ask for assistance in dealing with your insurance carrier.

_______ **CASH PATIENTS**

It is the policy of this clinic that cash patients pay their balance at each visit or at the end of that week. There may be a $10.00 extra charge on some therapies.

_______ **MEDICAID PATIENTS**

Medicaid only covers an exam, x-rays if necessary and the adjustment, therefore there will be an additional charge of $5.00-$10.00 when therapies are added.

_______ **MEDICARE PATIENTS**

We do accept assignment from Medicare; therefore, we will receive the check from Medicare. We will then bill your secondary insurance if you have one. Wisconsin has a special mandate that requires supplemental insurance to pay for chiropractic services even if Medicare doesn't. (Two exceptions are if your place of employment is self-insured or if the policy is very old then the mandate may not apply). As of October 1, 2004 Medicare will no longer be covering maintenance care. However, once Medicare denies the claims we will submit these charges to your supplemental insurance. If only Medicare and no secondary, there will be an additional charge of $5.00-$10.00 when therapies are added.

_______ **PERSONAL INJURY (auto, etc.)**

We will be as helpful as we can in filing your claims ASAP, but to do so it is very important to receive your information right away. Some claims may take as long as 3-4 years to settle so we will be willing to make payment arrangements with you while we wait for the insurance company to pay.

_______ **WORKERS COMPENSATION**

We will be as helpful as we can in filing your work comp claim, however, if your employer does not accept liability, the charges will be your responsibility. We can then bill your regular insurance company but your help will be needed in keeping your balance low.

Please note that should your account go unpaid and into collections, you will be responsible for all costs incurred including, but not limited to, collection agency fees, attorney fees, and court fees. Please initial here to acknowledge your understanding. _________

Lastly, it is the goal of this office to provide you with the best quality care. Please, if you ever have any questions, don't hesitate to ask. Thank you for choosing our office.

I, the undersigned, have read and agree with the above policy.

SIGNED:____ DATE:______________

DOCTOR: Peter Raether, DC PATIENT____ Patient # _____________

DATE OF VISIT ___/___/20___ Birthdate _____________ Age ________ Insurance ___________________________

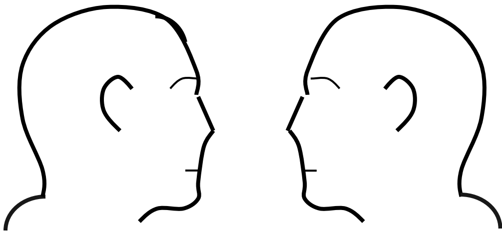
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms ______________________

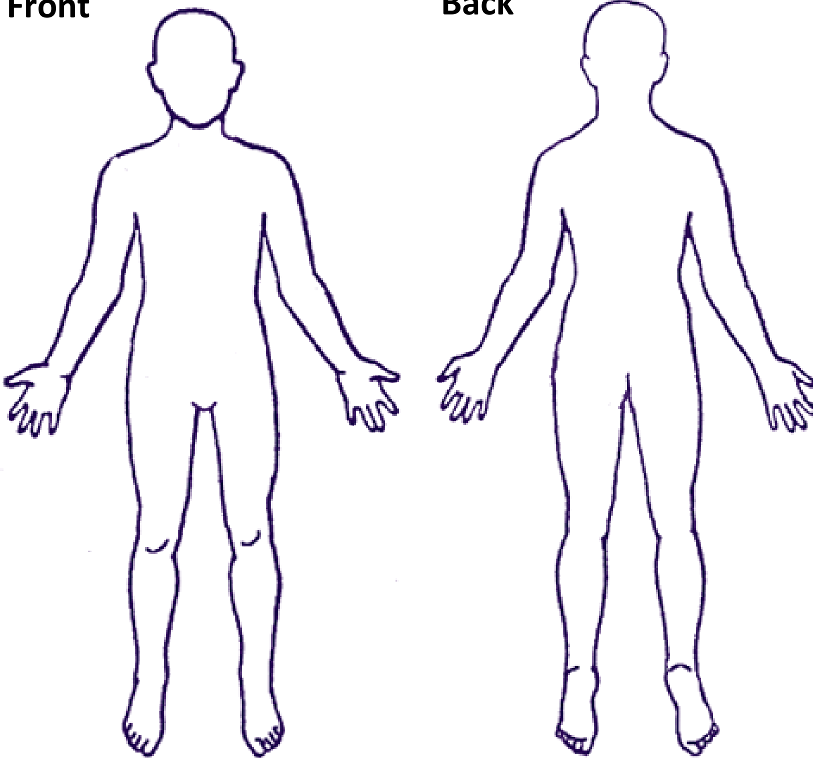
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? ________________________________

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

____ _________________

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Patient Health Information

Name:_______________________________________ Date:_______________

Height_____________ Weight______________

Right Handed _______ Left Handed _______ Ambidextrous_______

Smoking Status:
- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

Do you have any medication allergies?
- No known medication allergies
- Yes.
  What?____
  __

Are you currently taking any medications?
- Not currently prescribed any medications
- Yes…….

What?______________________________________ __________mg
What?______________________________________ __________mg
What?______________________________________ __________mg

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Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name:___________________________________ **Date**:____________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

The patient understands and agrees to allow this chiropractic office to use their Patient Heath Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

The following person(s) have my permission to receive my personal health information:

____

____

Dated this ___________ day of _____________________, 20____

By ______________________________________
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By ____
Signature of Parent/ Guardian (circle one)