SWISS SPINE CLINIC

Confidential Patient Information

PATIENT INFORMATION Date:____________________

Name:____ Date of Birth:__________________________

Address: ______________________________________ City:_________________ State:______ Zip:________

Home Phone: __________________________________ Work Phone: ________________________________

Cell Phone: ____________________________________ E-mail address: ______________________________

Social Security #: _______________________________ Gender: ☐ Male ☐ Female

Occupation:____________________________________ Employer: __________________________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Primary Care Physician:____

Emergency Contact Name: ___________________________ Phone Number: __________________________

Who referred you to our office? ____

Is your visit today regarding a Work Injury or Car Accident? ☐ Yes ☐ No

Payment for services will be paid for by: ☐ Cash ☐ Check ☐ Credit Card (Visa/MC) ☐ Insurance

INSURANCE INFORMATION

Name of Insurance Co: ___________________________ Primary Insured Name: ________________________

Primary Insured Employer: ________________________ Primary Insured Date of Birth: __________________

Are you covered by more than one insurance company? ☐ Yes ☐ No Name: _________________________

SWISS SPINE CLINIC

This form is designed to inform you in advance of our policies for payments, insurance claims, and third party payment responsibilities. Please refer any questions that you may have to the front desk receptionist. Please read, initial, and sign below.

Initial

________ Payment for co-pays, co-insurance and deductibles is expected at the time of service. We accept cash, check, Mastercard, Visa, and Discover. A $35.00 service charge will be applied to all returned checks.

________ Insurance is a contract between you and your insurance company. As a courtesy to you, we will bill your health insurance carrier. You are responsible for any and all co-pays, co-insurance, non-covered services and deductibles.

________ A charge will be made to you for all broken appointments unless a 24-hour notice is given. There are no health insurance policies that cover fees for missed appointments or “No-Show” appointments.

________ We are happy to provide treatment for accident victims and those who are involved in liability cases. All information must be given to our office immediately following the accident. You must provide us with any and all attorney, liability, med-pay, and health insurance information.

________ In the case of minors, it is the responsibility of the accompanying legal guardian to approve in advance and pay for treatments. The guardian is also responsible for making sure the patient account is kept current.

________ I acknowledge that Swiss Spine Clinic "Notice of Privacy Practices" has been provided to me. I understand I have a right to review the notice prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Swiss Spine Clinic. This Notice of Privacy Practice also describes my rights and Swiss Spine Clinic’s duties with respect to my protected health information. The 4 page version of the Notice of Privacy Practices is provided upon request at the main administration desk of this practice. Swiss Spine Clinic reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment. I also have the right to revoke this consent, in writing, except to the extent that Swiss Spine Clinic has taken action in reliance on this consent.

I have read and understand the above information. By signing below I consent to treatment and agree to the terms listed above.

Patient/Guardian Signature:____________________________________ Date:___________________

Witness:____ Date:___________________

SWISS SPINE CLINIC

Dr Thomas H. Gugerli, DC FASBE

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible: ________________________) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by the Physician of Chiropractic named here, Dr. Thomas Gugerli, D.C. and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Thomas Gugerli, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient:	To be completed by the patient's representative, if necessary, (e.g. if the patient is a minor or is physically or mentally incapacitated)
______________________________ Print Patient's Name	______________________________ Print Name of Patient
	______________________________ Print Name of Representative
______________________________ Signature of Patient	______________________________ Signature of Representative