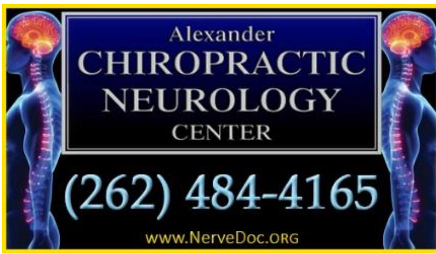

WELCOME to ACNC

Dr. Keith A. Alexander, DC, DCBCN SPECIALIZES IN ASSESSING THE JOINT, MUSCLE, NERVOUS SYSTEM LOOP AND INTERDEPENDENT BALANCE BETWEEN THEM. WE TAKE GREAT PRIDE IN BRINGING OUR PATIENTS BACK TO A FULLY FUNCTIONAL STATE OF HEALTH, AND WOULD BE HONORED TO SERVE YOU!

THANK YOU FOR YOUR TRUST!

PATIENT: ______________________ **TODAY'S DATE:** ____ / ____ / ____

(FIRST) (M.I.) (LAST) +(SR., JR., III) MONTH DAY YEAR

MAIDEN NAME: ______________________ CALLED / NICKNAME: ______________________

ADDRESS: ______________________ CITY, STATE, ZIP: ______________________

HOME PH: ( ) ______________________ WORK PH: ( ) ______________________ EXT.

HOME CELL: ( ) ______________________ WORK CELL: ( ) ______________________

EMAIL(S): ______________________ SEX: MALE- ☐ FEMALE- ☐

SPECIAL HISTORY:

BIRTHDAY: ____ / ____ / ____ ______

MONTH DAY YEAR AGE

SOCIAL SECURITY # ______ - ______ - ______

BIRTH PLACE: ______________ NATIONALITY: ______________ RELIGION: ______________

EDUCATION: HIGH SCHOOL- ☐ APPRENTICESHIP- ☐ TRADE SCHOOL- ☐ 2YR. COLLEGE- ☐ 4YR. COLLEGE- ☐ GRADUATE SCHOOL- ☐ DOCTORATE- ☐

FAVORITE HOBBIES / INTERESTS: ______________________

EMPLOYER: ______________________ OCCUPATION: ______________________

MARITAL STATUS: SINGLE- ☐ DIVORCED- ☐ WIDOWED- ☐ MARRIED- ☐ HOW MANY YEARS? ______

SPOUSE / SIGNIFICANT OTHER: ______________________ EMPLOYER: ______________________

EMERGENCY CONTACT: SAME- ☐ ______________________ PHONE: ( ) ______________________

CHILDREN'S NAME(S) & AGE(S):

1.) ______________________ AGE: ______ 4.) ______________________ AGE: ______

2.) ______________________ AGE: ______ 5.) ______________________ AGE: ______

3.) ______________________ AGE: ______ 6.) ______________________ AGE: ______

WHO MAY WE THANK FOR REFERRING YOU? ______________________

INSURANCE INFORMATION:

DO YOU HAVE ACTIVE HEALTH INSURANCE? YES- ☐ NO- ☐ ARE YOU THE HOLDER / MAIN NAME ON THE INSURANCE? YES- ☐ NO- ☐

SUBSCRIBER'S NAME: ______________________ RELATIONSHIP TO PATIENT: ______________________

BIRTHDAY: ____ / ____ / ____ ______

MONTH DAY YEAR AGE

SOCIAL SECURITY # ______ - ______ - ______

PRIMARY INSURANCE CO.: ______________ MEMBER ID#: ______________ GROUP #: ______________

SECONDARY INSURANCE CO.: ______________ MEMBER ID#: ______________ GROUP #: ______________

HEALTH ATTITUDE: (PLEASE CHECK ONE)

☐ TREATMENT ONLY — I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.

☐ MAINTAINING HEALTH — I'm conscious of my health, diet exercise, etc. & actively pursue these so I feel better, perform better and maximize my potential.

☐ PREVENTION — In addition to symptomatic treatment, I consult specialist's occasionally to prevent problems from reoccurring.

☐ FAMILY HEALTH — I actively in assist, inform & maintain the health of & with my family. I'm proactive with the long-term affects of good health.

***THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. ANY CHANGES TO THIS INFORMATION THE RESPONSIBILITY OF THE PATIENT TO NOTIFY OUR OFFICE SO THEIR RECORDS MAY BE UPDATED.

PATIENT / PARENT OR GUARDIAN'S SIGNATURE: ______________________ **DATE:** ____ / ____ / ____

IF PARENT OR GUARDIAN'S SIGNATURE PLEASE PROVIDE (TITLE). MONTH DAY YEAR

PAYMENTS, FEES & RECORDS REQUEST POLICY:

1.) All visit charges, supplements, supports and/or fees are payable as services are rendered and/or products received.
2.) The fee(s) paid for treatment x-rays is for analysis only. The film(s) themselves will remain the property of this this office. Once the films are used for treatment purposes they cannot be released. The x-rays are legal property and the responsibility of this office (Alexander Chiropractic Neurology Center LLC); however, copies can be made if necessary. Any and all fees incurred for copies will be the sole responsibility of the patient, guardian, attorney or requestor with a valid, current and signed release request and/or release consent.

COST OF RECORDS- PER WISCONSIN STATUTE 146.83(1B)-146.83(3F)(B):

- **(2a.)** For paper copies: $1 per page for the first 25 pages; 75 cents per page for pages 26 to 50; 50 cents per page for pages 51 to 100; and 30 cents per page for pages 101 and above.
- **(2b.)** For microfiche or microfilm copies, $1.50 per page.
- **(2c.)** For a print of an X-ray, $10 per image.
- **(2d.)** If the requester is not the patient or a person authorized by the patient, for certification of copies, a single $8 charge.
- **(2e.)** If the requester is not the patient or a person authorized by the patient, a single retrieval fee of $20 for all copies requested.
- **(2f.)** Actual shipping costs and any applicable taxes.

3.) I hereby authorize Dr. Keith A. Alexander, DC, DCBCN and whomever the doctor may authorize as qualified to take x-rays, notes and/or view personal or otherwise private/classified patient information as deemed necessary by the doctor.
4.) I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand Alexander Chiropractic Neurology Center, LLC will prepare any necessary reports and/or complete any forms approved by Dr. Keith A. Alexander, DC, DCBCN to assist me in making collections from the insurance company and that any amount(s) authorized to be paid directly to Alexander Chiropractic Neurology Center LLC. Will be credited to my account upon receipt; however I clearly understand and agree that I am personally responsible for payment in addition to any amount(s) for services rendered but not approved and/or paid for by my insurance.

PATIENT / PARENT OR GUARDIAN'S SIGNATURE: ______________________________ **DATE:** ____ / ____ / ____

IF PARENT OR GUARDIAN'S SIGNATURE PLEASE PROVIDE (TITLE). MONTH DAY YEAR

X-RAY CONSENT / PREGNANCY RELEASE:

I understand that despite the best research and training there is risk in all things leading to variable outcomes and that each patient and the results they experience may vary and that neither Alexander Chiropractic Neurology Center, LLC., Dr. Keith A. Alexander, DC, DCBCN or staff hereafter known as (they) can guarantee any single result. However, I also know that they have and will take every precaution and make every attempt to ensure my safety and provide me with the best possible outcome available. Knowing this and being in full mind and sole authority of myself I hereby release Alexander Chiropractic Neurology Center, LLC along with and including Dr. Keith A. Alexander, DC, DCBCN and staff of any and all liability.

PATIENT / PARENT OR GUARDIAN'S SIGNATURE: ______________________________ **DATE:** ____ / ____ / ____

IF PARENT OR GUARDIAN'S SIGNATURE PLEASE PROVIDE (TITLE). MONTH DAY YEAR

ASSIGNMENT AND RELEASE:

I certify that I and/or my dependent(s) have insurance coverage with ________________________________, and assign directly to Alexander Chiropractic Neurology Center, LLC. and Dr. Keith A. Alexander, DC, DCBCN all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges/fees whether or not paid by my insurance company. I authorize the use of my signature on all insurance submissions. The aforementioned doctor may use my healthcare information and may disclose such information to the aforementioned insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This consent will terminate at the conclusion of my current care.

PATIENT / PARENT OR GUARDIAN'S SIGNATURE: ______________________________ **DATE:** ____ / ____ / ____

IF PARENT OR GUARDIAN'S SIGNATURE PLEASE PROVIDE (TITLE). MONTH DAY YEAR