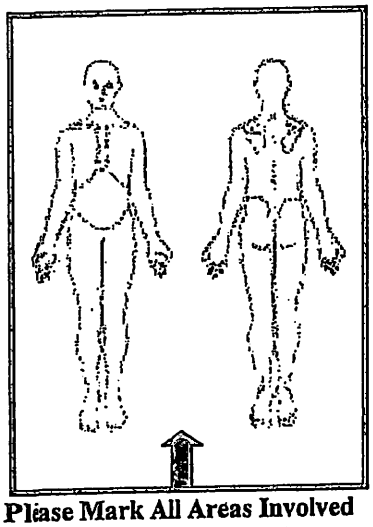
RIVER RIDGE

Spine and Rehabilitation Center
Welcome to our office!!

Patient Name: _____ ☐ Male ☐ Female Date: _____
Address: _____ Age: _____
City: _____ State: _____ Zip: _____ E-Mail: _____
Phone (H): _____ (W) _____ (Cell) _____ SS# _____
Date of Birth: _____ Marital Status: M S W D Spouses Name: _____
Occupation: _____ Employer: _____
How did you hear about us? _____
Emergency Contact: _____ Phone: _____
Person Responsible for Account Me Other _____
Will you be using insurance? __ Yes __ No Insurance Co. _____
Was this due to an Auto Accident? ☐ No If Yes, Auto Ins? _____ Is this a Work Related Injury? ☐ Yes ☐ No

Have you ever visited a Chiropractor? ☐ No If yes, whom? _____ Time under care: _____ Positive Experience? Y N
Reason for todays visit (List primary condition 1st and then any other conditions or concerns) 1) _____
_____ 2) _____ 3) _____
Please describe what happened: _____
When did condition begin? _____ Is it: ____ Constant? _____ Comes/Goes? _____ Getting Worse
What makes it worse? _____ Does anything make it feel better? _____
Is it ☐ Burning ☐ Aching ☐ Stabbing ☐ Dull ☐ Radiating, Where? _____ ☐ Other _____
Worse in: ____ Morning ____ During Work ____ Evening After Work ____ Middle Of Night ____ Other: _____
Have you had this before? ___ No If Yes, when? _____ Treatment then: _____
Have you had recent x-rays? ☐ Yes ☐ No **Are you pregnant?** ☐ Yes ☐ No ☐ Not Sure, Date of Last Menstrual Period _____



Please Mark All Areas Involved

Current Complaints
- __ Headaches
- __ Neck Pain
- __ Pain Down Arms
- __ Fatigue
- __ Dizziness
- __ Numbness
- __ Pins & Needles
- __ Sleeping Prob.
- __ Low Back Pain
- __ Pain Down Legs
- __ Freq. Urination
- __ Other _____

Health History (Past to Present) –Check all that apply

__ Heart Disease	__ Pacemaker	__ Depression
__ Stroke	__ Hepatitis	__ Asthma
__ Immune Disorder	__ Sinusitis	__ Fainting
__ High Blood Pressure	__ Arthritis	__ Ringing in Ears
__ Joint Replacement	__ Migraines	
__ Seizure/Epilepsy	__ Thyroid	
__ Kidney Disease	__ Loss of Weight	
__ Liver Disease	__ Loss of Sleep	
__ Diabetes	__ Urinary Problems	
__ Osteoporosis	__ Allergies _____	
__ Cancer _____	__ Other _____	

Past Surgeries/Hospitalizations: _____
Past Injuries (include auto, work, home, fractures, etc): _____
_____
Medications/Supplements (include prescription/non-prescription): _____
_____
Sleep: Average____ Hours/night Position ☐ Side ☐ Back ☐ Stomach Pillows Under Head ☐ 0 ☐ 1 ☐ 2
Exercise/Strenuous Hobbies: _____

I authorize release of any information concerning my (or my child's) health care, advice or treatment provided for the evaluation and administering claims for insurance benefits. I understand and agree that all services rendered to me (or my child) are charged directly to me and that I remain personally responsible for payment. I also hereby direct my insurance company to pay this clinic directly for services rendered in accordance with standard assignment of benefits.

_____ _____
Signature of Patient (or parent, if minor) Date

RIVER RIDGE FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your health care provider. The following is our financial policy. The complexity of today's medical billing and insurance reimbursement can often make receiving health care very confusing. It is important to us that you understand the process from the beginning of care. Therefore, it you have any questions or concerns about our payment policies, please do not hesitate to ask our office manager.

We do, in most instances, accept assignment of insurance benefits. However you must understand that.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party of that contract.

2. All charges are your responsibility whether your insurance company pays or not. Some insurance companies select certain services they will not cover. Fee for these services are your responsibility, however we will attempt to make you aware of these situations as soon as possible.

3. Co-payments and co-insurance are due at the time of service.

4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact that carrier to help speed things up.

5. If the insurance company does not pay in full within 45 days. We may ask that you pay the balance due with cash or check.

6. A charge of 1.5% may be assessed on all balances over 30days old.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Thank you again for choosing us. We appreciate your trust, and the opportunity to serve you.

Patients Signature_____ Date _____
(Parents signature if a minor)

CONSENT FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. _____ (and whomever he/she may designate as his/her assistant to administer treatment as necessary to myself or my _____ (indicate relationship of child). I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself not River Ridge. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse remittances for the conveyance of credit to my account. However I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patients Signature: _____ Date: _____
(Parents signature if minor)

RiverRidge
Spine & Rehabilitation Center
Your Wellness is Our Business

Appointment Policy

Our front desk staff will work with you to find a mutually agreeable time to accomplish your current treatment plan. You'll be offered an appointment card as a reminder of each scheduled appointment. Once your appointment(s) is/are booked, we reserve that time ***just for you*** and as such, we expect that you'll hold to that time commitment. The day before your appointment, you'll receive a text reminder of your upcoming appointment. It is your responsibility to not only keep your appointment but to arrive on time.

At the same time, we acknowledge that there are times when you are unable to keep set appointments due to emergencies or obligations to work and/or family. When this occurs, we require that you call our office to either reschedule or cancel your appointment **at least 24 hours in advance**. Doing so shows respect to the staff of the Clinic and it frees up much needed time in Dr. Van Riper's schedule to care for another patient.

In order to keep our Clinic schedule on time and respect everyone's time equally, River Ridge Spine & Rehabilitation has set forth the following policy as it relates to appointments:

- Late Arrival for Appointment
  - Arriving more than 5 minutes late for a scheduled appointment will likely lead to you being asked to reschedule your appointment.
- Cancellation of Appointments
  - Appointments may be cancelled by calling the office at (605) 334-7371 at anytime. If our office is closed or our staff is busy helping others, leave a voicemail with your cancellation notice and the reason.
- Failure to Cancel Appointment in a Timely Manner = "No Show" Appointment
  - Any cancellation made in under 1 business day of a scheduled appointment will be deemed a "no show" appointment.
    - *Example: if your appointment is scheduled for 3:00 p.m. Thursday, you'll have until 3:00 p.m. Wednesday to cancel or reschedule your appointment.*
- Failure to Keep Appointment = "No Show" Appointment
  - After one (1) "No Show" appointment, you'll receive a verbal reminder of this policy and/or a phone call notifying you of this occurrence. It will be noted in your file.
    - Your privileges to schedule future appointments will remain intact.

- Failure to Keep Appointment = "No Show" Appointment (continued)
  - After two (2) "No Show" appointments, you'll receive a call notifying you of this second occurrence. It will be noted in your file.
    - In addition, **you will be charged** an amount representative of your normal per visit charges, ranging from $25 - $75 depending on your current treatment plan. To restore your scheduling privileges, **you will be required to pay** the "no show" fees assessed to you prior to scheduling another appointment.
  - Should you choose to not pay the "No Show" fees or at the point where there are three (3) "No Show" appointments, you'll receive a **Release from Care** letter which will also provide you with names of chiropractors who can provide you care.
    - At this point, you will **no longer** be able to schedule appointments with Dr. Van Riper.

By signing this policy, you acknowledge that you understand the policy outlined above. You agree to pay any and all fees assessed as a result of implementing this policy towards your account.

_____ _____

Patient (or parent, if patient is minor) Signature Date Signed