

# ***Bio Energy Medical Center***

**Please print clearly in blue or black ink.**

Please give this to the front desk receptionist when checking in for your visit

## **Patient's Information**

Patient's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_ / \_ / \_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

*\*If patient is a minor:* Parent/Guardian Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Parent/Guardian SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

How did you hear about BEMC? \_\_\_\_\_

How did you find our phone number? \_\_\_\_\_

## **Employer and Spouse Information**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Emergency Contact**

Emergency Contact Name and Relationship: \_\_\_\_\_

Emergency Contact: Phone Number: ( ) \_\_\_\_\_ Alternate: ( ) \_\_\_\_\_

## **Insurance Information (please give card/cards at front desk)**

Subscriber's Name: \_\_\_\_\_ Relation: *Self* [ ] *Spouse* [ ] *Child* [ ]

Insurance Company: \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_

Contract/ID Number \_\_\_\_\_ Policy/Group Number \_\_\_\_\_

# MEDICAL HISTORY

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Are you currently under the care of a physician? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Other Care Providers: \_\_\_\_\_

Are you currently being treated for any health problems? \_\_\_\_\_

Diagnosis and date: \_\_\_\_\_

What specific problem brought you to the center today? \_\_\_\_\_

Provide a brief description of symptoms, diagnoses received and current treatment methods:

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What do you think caused your health problems? \_\_\_\_\_

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Provide a brief description of childhood and adult illnesses and operations:

Operations:	Date/Age:	Type of Operation:	Reason:
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Childhood Illnesses:	Date/Age:	Diagnosis:	Recovery:
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Adult Illnesses:	Date/Age:	Diagnosis:	Recovery:
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Have you been immunized? \_\_\_\_\_ List immunizations: \_\_\_\_\_

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Do you have allergic reactions to any medications? Indicate:

Medication:	Reaction:
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## SYMPTOM SURVEY: COLON FUNCTION

How often do you have bowel movements? \_\_\_\_\_ Times per Day \_\_\_\_\_ Times per Week

Indicate what type of bowel movements you have and how often they occur:

TYPE	FREQUENTLY	OCCASIONALLY	NEVER
Diarrhea	[ ]	[ ]	[ ]
Constipation	[ ]	[ ]	[ ]
Mucous	[ ]	[ ]	[ ]
Undigested Food	[ ]	[ ]	[ ]
Gas/Flatulence	[ ]	[ ]	[ ]
Blood in B.M.	[ ]	[ ]	[ ]
Painful B.M.	[ ]	[ ]	[ ]

Do you have a medical history of colon problems?

[ ] Colitis	[ ] Diverticulosis	[ ] Appendicitis	[ ] Obstruction
[ ] I.B.S.	[ ] Cancer	[ ] Other:	

Have you ever had abdominal surgery?

Type:

Date:

Recovery:

\_\_\_\_\_

\_\_\_\_\_

Have you noticed any significant changes in your colon's bowel habits within the last?

[ ] 1-Month: \_\_\_\_\_ [ ] 2-months: \_\_\_\_\_ [ ] Other: \_\_\_\_\_

Do you use any laxatives? \_\_\_\_\_ Brand: \_\_\_\_\_ Frequency: \_\_\_\_\_

Do you give yourself enemas? \_\_\_\_\_ How often?: \_\_\_\_\_

Have you ever had colonics? \_\_\_\_\_ When? \_\_\_\_\_

Name of your colon therapist: \_\_\_\_\_

## **Informed Consent**

The purpose of this consent is to document an understanding between the Bio Energy medical Center and its clients. By signing this document, the client understands and accepts the following points:

- Although Dr. Neuenschwander is an Allopathic physician, his treatment protocols include the sciences of Acupuncture, Homeopathy, and Naturopathic Medicine and are not considered the standard of medical care. The client agrees to accept the attendant risks associated with an alternative approach. Most clients coming here are looking for an alternative or integrative approach to their healthcare needs. Standard Allopathic services can be provided at the client's request. It is the client/patient's responsibility to inform the staff if they would like a standard of care approach to be used.
- Dr. Neuenschwander is a medical doctor with substantial experience in alternative medicine and natural healing. While his recommendations are based upon the best of his knowledge, experience, and training as to safety and effectiveness, many of his recommendations have not been reviewed by the U.S. Food and Drug Administration. In addition, he uses approved treatments for "off label use" – uses for which they have not been approved. I understand that some of the treatments or recommendation may be considered unproven or experimental by third party payers.
- Patients are treated as individuals, not solely on the basis of their diagnostic grouping or by the "one size fits all" approach.
- Treatment at Bio Energy Medical Center involves a team approach; and the client understands that his/her case may be discussed at team meetings unless prior arrangements are made. As always, any information will be treated in a professional and confidential manner.
- To remain active and receive advice, lab interpretations, and/ or prescriptions, you must be seen in our office every six months.
- Bio Energy Medical Center will submit insurance billing. However, clients are ultimately responsible for any charges incurred. Unless other arrangements have been made, payment is expected at the time of service for the following: products, insurance co-pays and deductible payments, patients without insurance coverage, or insurance coverage that does not cover our services.
- Information requested from an insurance company that may be needed to result in payment will be released.
- The client understands that certain treatments may not be covered or considered billable under his/her insurance plan. In this case, the client is responsible for payment.

By signing this document, the client understands and agrees to its provisions.

Client: \_\_\_\_\_ Witness: \_\_\_\_\_ Date \_\_\_\_\_

## **HIPAA Consent**

I am aware that a document containing my privacy rights under the HIPAA laws is available in the Bio Energy Medical Center waiting room should I wish to review it. By signing this document, I am signifying that I understand and agree to its provisions.

Client: \_\_\_\_\_ Witness: \_\_\_\_\_ Date \_\_\_\_\_

**Bio Energy Medical Center, P.C.**

**Statement of Patient Financial Responsibility**

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Thank you for choosing Bio Energy Medical Center for your healthcare needs. The service/services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. For patients who have insurance, we gladly accept most insurance; but Dr. Neuenschwander **DOES NOT participate with any managed care programs such as PPO's or HMO plans.** Many of these insurances do provide out-of-network benefits. If your plan provides out-of-network benefits, as a courtesy, we will bill your insurance carrier on your behalf. However, *you are ultimately responsible for payment of your bill. Please take time to become familiar with your benefits, particularly your deductible and co-pay responsibilities.* It is the responsibility of the patient to ensure that the insurance information on file is current. Any changes must be brought to the attention of the clinic as soon as possible to ensure accurate billing.

**You are responsible for payment of any deductible and co-payment/co-insurance** as determined by your contract with your insurance carrier. **Deductibles and co-pays are due at the time of service.** Additional fees may be added to your account for generation of statements in which payment due at time of service is not paid. Most insurance companies *require* you pay the co-pays and/or deductibles at the time of service and may have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you. Non-covered services and patients without insurance coverage will require payment in full at the time services are provided.

I have read and understand the above Policy, and I agree to the terms describe: **Initials** \_\_\_\_\_

**Package Purchase Policy**

Many of our non-billable services are needed on a regular or frequent basis. In an effort to help decrease costs, we offer packages at a discount rate. These packages are **non-refundable** should I choose to purchase one.

I have read and understand the above Package purchase Policy, and I agree to the terms describe: **Initials** \_\_\_\_\_

**Cancellation / No Show / Late Arrival Policy**

We kindly ask that you let us know **24 hours** in advance if you are unable to keep your appointment. No-shows and same day cancellations will be **charged 100%** of the service/office fee. We respect your time and operate our business in a timely manner. We do not double book patients; and in consideration of other patients, we regret that late arrivals will not receive an extension of scheduled service time and will be responsible for full service/office fees. Some appointments may need to be cancelled due to late arrival.

I have read and understand the above Cancellation / No Show /Late Arrival Policy, and I agree to the terms described: **Initials** \_\_\_\_\_

**IV Policy**

Some patients require intravenous therapy as part of their treatment. Should you schedule an appointment for IV therapy, we require 24 hours notice to cancel. Same day cancellations and no-show appointments will be charged 100% of the fee if the IV has been prepared for their appointment.

I have read and understand the above IV Policy, and I agree to the terms described: **Initials** \_\_\_\_\_

I have read the above policies regarding my financial responsibility to Bio Energy Medical Center for the above named patient. I authorize my insurer to pay the full amount (less deductible and co-payment/co-insurance) of charges incurred by the above named patient directly to Bio Energy Medical Center.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_