Bio Energy Medical Center PC

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:

_____

_____

_____

What do you think caused your health problems? _____

_____

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

Operations: Date/Age: Type of Operation: Reason:

_____

_____

_____

Childhood Illnesses: Date/Age: Diagnosis: Recovery:

_____

_____

_____

Adult Illnesses: Date/Age: Diagnosis: Recovery:

_____

_____

_____

Have you been immunized?_____ List immunizations: _____

_____

Do you have allergic reactions to any medications? Indicate:

Medication: Reaction:

_____ _____

_____ _____

_____ _____

Informed Consent

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

- Although Dr. Neuenschwander and Dr. Reese are Allopathic physician's, their 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 (medical director) 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 recommendations may be considered unproven or experimental by third party payers or other health care providers.
- 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 at least once every six months.**
- Bio Energy Medical Center will submit insurance billing for some services and some providers. 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. Dr. Neuenschwander and Dr. Reese do not participate with any insurance plans. Medicare patients will need to privately contract with them and patients with commercial insurance plans will be given a detailed receipt they can submit for possible reimbursement.
- 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.
- We are not set up to provide primary care. We request you establish or maintain a relationship with a primary care provider. We are happy to send a copy of your visit note to your care provider at your request. Please let our staff know at the time of your visit where you would like it sent.
- Dr. Neuenschwander may recommend and/or provide services for which he may not provide directly (IV therapy, supplement sales, products, etc.), other services provided at Bio Energy Medical Center by other providers, that he generates a profit from.

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

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_____

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____ Date: _____

Thank you for choosing Bio Energy Medical Center for your healthcare needs. The service/services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. For patients who have insurance, many of our providers accept most insurance; however, we **DO NOT participate with any HMO plans.** We currently participate with Medicare and Blue Cross/Blue Shield (except Dr. Neuenschwander, Dr. Reese, and Dr. Uma). If your plan provides out-of-network benefits, as a courtesy, we will bill your insurance carrier on your behalf for our nurse practitioner's services. 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.* **Dr. Neuenschwander and Dr. Reese *do not* participate with any insurance plans.** Medicare patients must sign a private contract with Dr. Neuenschwander or Dr. Reese and agree to pay for his services without any reimbursement from Medicare. Patients seeing Dr. Neuenschwander or Dr. Reese with other commercial insurance coverage will be provided a receipt to submit to their insurance company for possible reimbursement. It is the responsibility of the patient to ensure that the insurance information, current address and phone numbers on file are current.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier **which is due at the time of service**. 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. A **$35.00 fee** is charged for any checks returned from your banking institution.

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. Packages can be shared and are good for one year from the date of purchase.

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 for all appointments except those with Dr. Neuenschwander (which require **a two business days'** notice). No-shows and same day cancellations will be **charged 50% of the fee, with the *exception* of IV therapy appointments and appointments with Dr. Neuenschwander, which are charged at 100% of the fees.** 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 (greater than 10 minutes for a 30-minute visit and 20 minutes for a 60 minutes visit), will need to reschedule.

I have read and understand the above Policies, and I agree to the terms described: **Initials_____**

As a convenience to our patients, we offer for sale many of the most common supplements recommended. They are of high quality and offered at the standard retail price. We are not able to compete with large companies and websites who can buy in large bulk at deeper discounts. We encourage you to do your research on the quality of the products you purchase outside our recommendations. Supplements, with the exception of probiotics, may be returned within 10 days, after purchase. After this time they **are non-refundable**. Probiotics are **non-refundable** due to their fragile properties.

I have read and understand the above Supplement Return 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 _____