# 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: ( )_____Email_____

Address: _____ City:_____ State:_____ Zip:_____)_____

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

**If patient is a minor:* Parent/Guardian Name: _____ Relationship: _____

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

Name:_____ Date of birth_____ Date: _____

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 vaccinated with COVID-19 vaccine? _____Brand:_____ Date:_____

List others : _____

Do you have **allergic reactions** to any medications? Indicate:

Medication: Reaction: 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 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 (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 based on 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.**
- Effective October 1, 2021 Bio Energy Medical Center will not participate or bill any commercial insurance plans. Our nurse practitioners will continue to participate with Original Medicare, and we will submit insurance claims for billing to them. Dr. Neuenschwander does not participate with ANY insurance plans including Medicare. Medicare patients will need to privately contract with him. All patients with commercial insurance plans will be given a detailed receipt they can submit for possible reimbursement upon request.
- 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.

Client/Guarantor: _____ Witness: _____ Date_____

**Statement of Patient Financial Responsibility-effective October 1, 2021**

**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. Our providers **will NOT participate with any commercial insurance plans effective October 1, 2021.** Our nurse practitioners will continue to participate with Original Medicare. If you have an insurance plan that provides out-of-network benefits, we will provide you a detailed receipt for you to submit for possible reimbursement. **Dr. Neuenschwander *does not* participate with Medicare.** Medicare patients must sign a private contract with Dr. Neuenschwander and agree to pay for his services **without** any reimbursement from Medicare.
Payment is expected at the time or service. 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**

For Dr. Neuenschwander, Jade Russell, and Maria Gahry two business days' notice is required or 100% of the fee for that appointment will be charged to reschedule. For our other providers, if an appointment is broken without at least one full business day, you will be charged 50% of the fee for that appointment. You will need to pay this fee before rescheduling. For IV therapy appointments, same day cancellations will be charged 100% of the 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 (greater than 10 minutes for a 30-minute visit and 20 minutes for 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.

**Patient/Guarantor Signature _____ Date _____**