NAME: _____ **BIRTH DATE:** _____ **SEX:** M / F

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

TELEPHONE: (H) _____ **CELL:** _____ **WORK:** _____

OCCUPATION: _____ **EMPLOYER:** _____

E-MAIL*: _____ **HOW DID YOU HEAR ABOUT US?** _____

*NOTE: EMAIL ADDRESSES WILL ONLY BE USED FOR OFFICE PUPROSES AND WILL BE KEPT PRIVATE.

CIRCLE ONE:

SINGLE MARRIED DIVORCED WIDOWED

NAME IN CASE OF EMERGENCY: _____ **PHONE NUMBER:** _____ **RELATIONSHIP:** _____

PRIMARY PHYSICIAN:_____ _____**CITY:**_____**PHONE NUMBER:**_____

OTHER PHYSICIANS: _____**CITY:**_____ **PHONE NUMBER:**_____

_____**CITY:**_____ **PHONE NUMBER:**_____

_____**CITY:**_____ **PHONE NUMBER:**_____

WHAT IS CURRENTLY YOUR MAIN HEALTH CONCERN?

_____

_____

DATE PROBLEM/PAIN BEGAN?

_____

IF YOU HAVE PAIN, PLEASE RATE YOUR PAIN ON THE SCALE BELOW:

---

0 1 2 3 4 5 6 7 8 9 10

Past Medical History: (Please circle "Yes" or "No")

Yes/No History of recent infection
Yes/No Diabetes
Yes/No Birth control pills
Yes/No Stroke
Yes/No Numbness in groin/buttocks
Yes/No Aortic aneurysm
Yes/No Osteoporosis
Yes/No Frequent urination
Yes/No Abnormal weight gain/loss
Yes/No Visual disturbances
Yes/No Arthritis
Yes/No Surgeries/Medications*: (see below)
Yes/No Family history of cancer
Yes/No Family history of diabetes

Yes/No Recent fever
Yes/No Corticosteriod use
Yes/No High blood pressure
Yes/No Dizziness/fainting
Yes/No Urinary retention
Yes/No Cancer/tumor
Yes/No Recent trauma
Yes/No Pregnancy, # births_____
Yes/No Epilepsy/seizures
Yes/No History of back/neck pain
Yes/No History of alcohol/tobacco use
Yes/No Family history of high blood pressure
Yes/No Family history of cardiovascular problems

If 'Yes' to Surgeries/Medications

Surgeries:

_____

_____

Your height: _____Your Weight:_____

Medications:

_____

_____

_____

**I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. IF MY INSURANCE INFORMATION IS NOT ACCURATE, OR IF IT DOES NOT COVER CHIROPRACTIC CARE, I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS (SIGNATURE ON FILE). I HAVE READ AND UNDERSTAND THE PATIENT PRIVACY NOTICE.

Patient Signature: _____ Date: _____

FINANCIAL AGREEMENT and INFORMED CONSENT

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage
Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner as a courtesy to you.

Payment Arrangements
We require that you pay your portion at each visit. If we are unable to verify your insurance, we will ask that you pay an estimated portion until we can accurately verify your coverage. This may be up to $50. If you overpay, we will refund your money as soon as the insurance is called. If you underpay, you will be notified on your next visit. If we bill you via standard mail, past due balances may have an interest charge of 18% applied per month, starting after 90 days.

Assignment of Benefits
Attached is an "Assignment of Benefits" form which you will need to sign. This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

Release of Information
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Informed Consent

All procedures in health care carry material risks and it is unavoidable to avoid all risks. The material risks inherent in chiropractic are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, burns, strokes from certain types of cervical manipulations, stiffness/soreness following treatment. We make every reasonable effort during the examination to screen for contraindications to care; however if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us. The probability of risk with chiropractic is very small in comparison to more aggressive medical procedures. You must allow us to properly screen you for risk factors which may include x-rays for underlying weakness of bone that may lead to fracture. You must allow us to take your history including medications and take your vitals/blood pressure to assess for stroke risk. Some complications may occur despite pre-screening procedures. You are free to consult any and all doctors concerning your condition and this may include: OTC medications, prescription medications, hospitalizations and surgery. If you choose these treatments, you must sign an informed consent for those procedures with the doctor that performs them. This informed consent does not cover you for other doctors' procedures and surgeries. The risks and dangers of remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Late Fees

If you do not call us then we are left with a significant time block that was put aside for you. There is a $25 missed appointment fee for visits that are missed without calling us in advance. For bounced checks we charge a $15.00 Non-Sufficient Funds fee and for all payments not paid within 30 days of receipt there is 26% A.P.R added to your initial bill. If the late payment is still not satisfied after 60 days the interest will continue.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

I have read and agree to the above. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Signature **Date**

_____

Print name

Medicare

Dear Medicare patient:

The initial visit is **$50,** and remaining visits are typically **$48**.

Medicare requires that you pay a yearly deductible of $135 towards your medical expenses before they begin paying. Other doctor visits as well as ours go towards this deductible.

Medicare has a policy that the ONLY service that is MEDICALLY NECESSARY is a spinal adjustment. Under your insurance, this means that **the only thing Medicare will pay for is to adjust your spine**. They will pay 80%.

If you have secondary insurance, that insurance company will only pay for the services that Medicare pays for. That means they will pay 20% for a spinal adjustment. Each policy is different. Many policies have limits. If your policy does not cover the 20%, then you are responsible to pay (it's usually between $5-8, very reasonable).

…But only if it's medically necessary.

This means that:

- Nutritional advice
- Exercise therapy
- Soft tissue therapy
- Laser therapy
- Stretching

Are all NOT medically necessary.

Therefore, Medicare won't pay for it, nor will the secondary insurance.

In order to help seniors, we offer these services. We understand that most people are on a fixed income so we charge $48 for any and all of the services that are not spinal adjustments.

It's not $48 for each item; it's $48 for anything that needs to be done.

We're letting you know this in advance to avoid confusion. We understand that insurance companies' policies are very confusing.

_____ _____

Patient Signature Date

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. ☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**. ☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	**J. Date:**

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.