

Carey Chiropractic & Rehabilitation Center

7955 State Route 7/P.O. Box 489

Proctorville, OH 45669

Phone: (740) 886-7878

Welcome to Carey Chiropractic & Rehabilitation Center

In order to best meet your chiropractic needs, please complete the attached forms.

Medicare: The following information is necessary to initiate your claim.

We will require a copy of your Medicare card. If you have supplement health insurance, we will require a copy of your card.

We ask that you sign the attached Medicare Advance Beneficiary Notice (ABN) because Medicare pays for only a portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services and goods that may be necessary during care.

Medicare will deny payment for your initial examination and consultation. If you are an established patient presenting with a new problem or you have not been seen in the last six months, Medicare will deny payment for a reexamination.

Please fill out the Release of Records with the name and address of any specific physician or other person you would like to receive a copy of your evaluation.

We thank you for your cooperation and if you have any questions, please do not hesitate to ask.

Sincerely,

Carey Chiropractic & Rehabilitation Center

Patient's Name: _____ Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably WILL NOT pay for –**

Items or Services:

Initial examination or reexamination. Other diagnostic or therapeutic service furnished by a chiropractor or under his/her order is covered other than what is listed below. The number of visits approved by Medicare is based on the diagnosis. The patient is responsible for services rendered after number of visits exceeded.

Because:

Chiropractic service, which is eligible for reimbursement, is specifically limited by Medicare to the manual manipulation (i.e., by use of hands) of the SPINE for the purpose of correcting subluxation (Acute, Chronic, Acute and Chronic).

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$ _____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

Option 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2. NO. I have decided not to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date

Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

(office use only) Location: B H W Chart No. _____

PATIENT INFORMATION

| | | | | | |
|---------------------|-------|--------|---|---|---|
| Patient's Last Name | First | Middle | <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. | Marital Status (Circle One) Single / Mar / Div / Sep / Wid |
|---------------------|-------|--------|---|---|---|

| | | | | | |
|---------------------|-----------------------|-----------------------|-------------------|-----|--|
| Social Security No. | Home Phone No. () | Cell Phone No. () | Birth Date / / | Age | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
|---------------------|-----------------------|-----------------------|-------------------|-----|--|

| | | | | |
|----------------|------|-------|----------|---------------|
| Street Address | City | State | ZIP Code | Email Address |
|----------------|------|-------|----------|---------------|

| | | |
|------------|----------|-------------------------------------|
| Occupation | Employer | Employer Phone No. () Ext _____ |
|------------|----------|-------------------------------------|

| | | | |
|------------------|------|-------|----------|
| Employer Address | City | State | ZIP Code |
|------------------|------|-------|----------|

Who may we thank for referring you? Patient _____ Dr. _____ Insurance Plan Hospital
 Family Friend Close to Home/Work Yellow Pages Other _____

| | | |
|------------------------------|--------------------|----------------------|
| Primary Care Physician (PCP) | PCP Street Address | PCP Phone No. () |
|------------------------------|--------------------|----------------------|

WORK OR AUTO ACCIDENT INFORMATION (PLEASE FILL OUT ALL INFORMATION REQUESTED IF APPLICABLE)

| | | | |
|---|-----------------------|--|------------------------------|
| Is Injury Work or Auto related? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Injury / / | Name/Address of Insurance Carrier (For Claims) | Adjusters Name and Phone No. |
|---|-----------------------|--|------------------------------|

| | | |
|-----------|--|-----|
| Claim No. | Injury reported? <input type="checkbox"/> Yes <input type="checkbox"/> No | () |
|-----------|--|-----|

| | | |
|---------------|------------------|---------------------------|
| Attorney Name | Attorney Address | Attorney Phone No. () |
|---------------|------------------|---------------------------|

COMMERCIAL INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)

Is patient covered by insurance? Yes No Primary Insurance Type HMO PPO Indemnity Other _____
Please indicate primary insurance MEDICARE MASSHEALTH BCBS TUFTS HARVARD
 CIGNA UNITED HEALTHCARE GIC HCVM Other _____

| | | | | | |
|-------------------|---------------------|-------------------|---------|----------|------------------|
| Subscriber's Name | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment \$ |
|-------------------|---------------------|-------------------|---------|----------|------------------|

Patient's Relationship to Subscriber Self Spouse Child Other _____

| | | | |
|---|-------------------|---------|----------|
| Name of Secondary Insurance (if applicable) | Subscriber's Name | Group # | Policy # |
|---|-------------------|---------|----------|

Patient's Relationship to Subscriber Self Spouse Child Other _____

IN CASE OF EMERGENCY

| | | | |
|----------------------------------|-------------------------|-----------------------|-----------------------|
| Name of Local Friend or Relative | Relationship to Patient | Home Phone No. () | Work Phone No. () |
|----------------------------------|-------------------------|-----------------------|-----------------------|

X _____
PATIENT/GUARDIAN SIGNATURE DATE

Date: ____/____/____

File #: _____

HEALTH HISTORY

Name:
(Last, First, M.I.)

M
 F

DOB ____/____/____

What is the reason for your visit?

What do you think caused this problem?

PERSONAL HEALTH HISTORY

Please list any current medical conditions or symptoms you are currently experiencing, or have experienced during the past year:

Please tell us about any hospitalizations, serious illnesses or surgeries:

| Year | Reason | Hospital | Outcome |
|------|--------|----------|---------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

| Name | Dosage | Frequency Used |
|------|--------|----------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Please provide details of any known allergies. (e.g., latex, medications, foods)

| Allergen | Reaction |
|----------|----------|
| | |
| | |
| | |
| | |

HEALTH HABITS

Exercise: Sedentary (No exercise) Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
 Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.)
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet: Are you dieting? Yes No
 If yes, are you on a physician prescribed medical diet? Yes No
 # of meals you eat in an average day? _____
 Please rate the quality of your diet: *Perfect* 1 2 3 4 5 6 7 8 9 10 *Terrible*

Caffeine: None Coffee Tea Cola # of Cups/Cans Per Day? _____

Alcohol: How many alcohol containing beverages do you consume: daily _____ weekly _____

Tobacco: Do you use tobacco? Yes No
 Cigarettes - Pks/day # of Years _____ or Year Quit _____

Sleep: Does your complaint disrupt your sleep? Yes No
 How do you rate the quality of your sleep? *Perfect* 1 2 3 4 5 6 7 8 9 10 *Terrible*

Stress: Please rate your stress management strategies: *Perfect* 1 2 3 4 5 6 7 8 9 10 *Terrible*
 Please rate your daily stress level: None 1 2 3 4 5 6 7 8 9 10 *Terrible*

Pregnancy / Children: # pregnancies _____ # Birth children _____

FAMILY HEALTH HISTORY

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

| Condition / Body System | Self | Grandparent | Parent | Sibling | Child |
|---|------|-------------|--------|---------|-------|
| Aids / HIV | | | | | |
| Arthritis | | | | | |
| Bleeding disorders | | | | | |
| Cancer | | | | | |
| Endocrine / glandular (diabetes, thyroid) | | | | | |
| Hepatitis | | | | | |
| Immune | | | | | |
| Stroke / TIA | | | | | |
| Circulatory Problems (blood vessels, heart) | | | | | |
| Ear, Nose, Throat | | | | | |
| Heart Problems | | | | | |
| High blood pressure | | | | | |
| Neurological (brain, nerves) | | | | | |
| Gastrointestinal (stomach, intestines) | | | | | |
| Muscle / Joint / Bone | | | | | |
| Genitourinary (urinary, kidney, prostate) | | | | | |
| Psychological | | | | | |
| Respiratory (lung, breathing) | | | | | |
| Skin | | | | | |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Patient Signature

Date

Name: _____

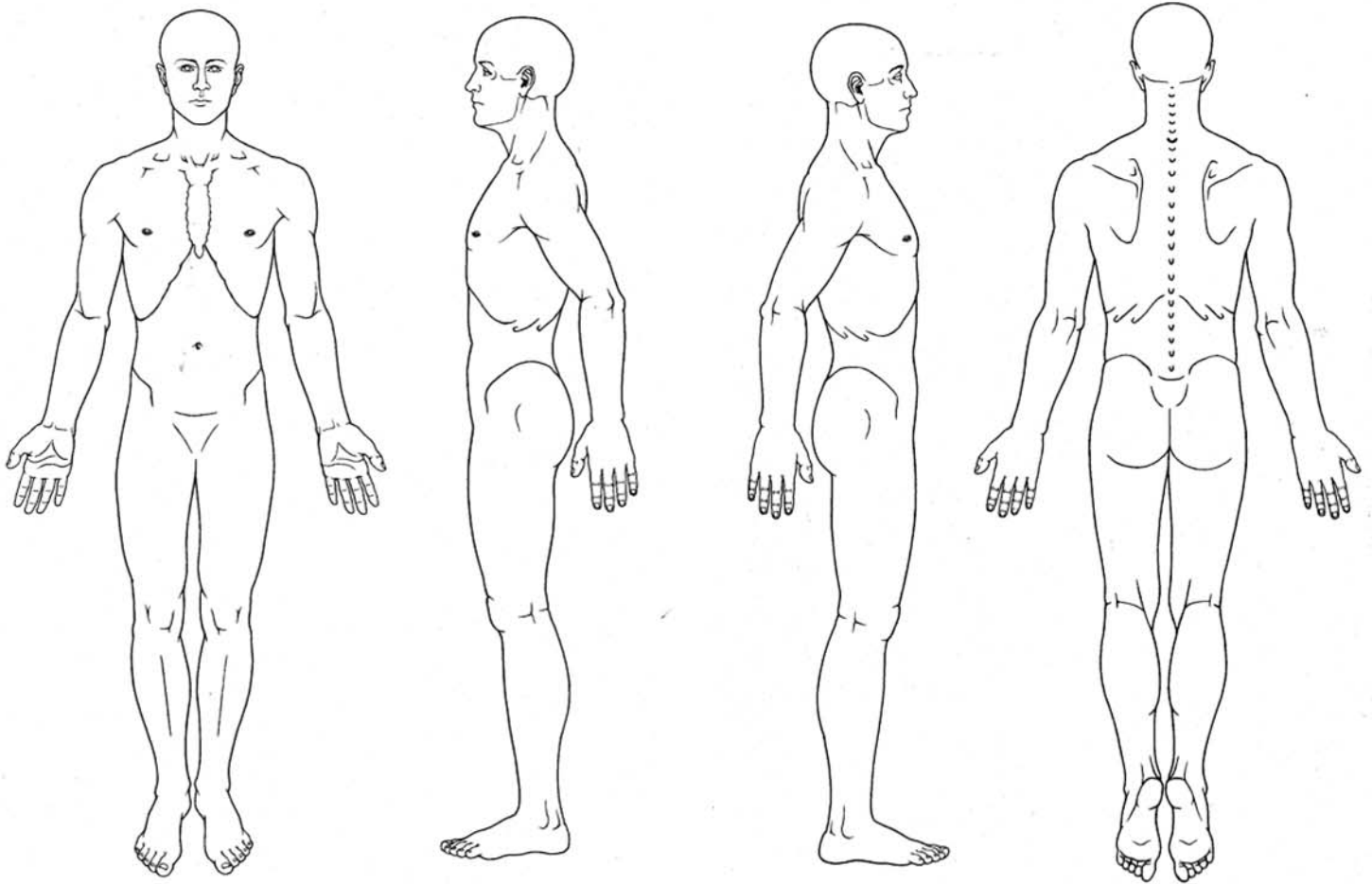
Date: _____

File: _____

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas. DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

Numbness - - - - Pins & Needles oooo Burning xxxx Aching **** Stabbing ////



Please place a vertical mark on the line below to indicate the severity of your complaint.

| | | | |
|---------------|---------|-------|--------------------------|
| Neck Pain | No Pain | _____ | Worse Pain Imaginable |
| Low Back Pain | No Pain | _____ | Worse Pain Imaginable |
| Other _____ | No Pain | _____ | Worse Pain Imaginable |

Credit / Financial Policy

Restoring your health is our foremost objective. Our treatment will always be rendered solely on the base of need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangements have been previously made. Our fees comply with the "usual and customary" rates for this region. We accept cash, checks and some credit cards. For patients who are unable to pay at the time of service, special arrangements are available upon request.

REGARDING ALL INSURANCE We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We will submit bills to your insurance carrier, but will not become involved in disputes between the insured and the insurance company. This courtesy will commence as soon as we are able to confirm coverage for chiropractic services and have the proper, signed insurance forms. Payment of non-covered and services balances, co-payments and deductibles is expected at the time of services. We strongly urge you to contact the insurance company to verify your benefits; sometimes incorrect information is provided to us.

If an insurance company fails to pay for services within ninety days, the undersigned is responsible for payment. Ultimately, you are responsible for all outstanding balances. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three days.

MEDICARE: Medicare pays for only a portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services and goods that may be necessary during care. Please be advised of the following Medicare restrictions and regulations.

- Medicare will pay for a maximum number of treatments per calendar year, based on your diagnosis. When the maximum number of treatments has been rendered, payment is expected at the time of service.
- Medicare will not pay for an initial examination. This fee is the patient's responsibility and will not apply to the patient's deductible.

PERSONAL INJURY, WORKER'S COMPENSATION AND/OR LITIGATION: If your complaint is the result of an occupational or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within fourteen days, all services must be paid for by the patient at the time rendered. It is our policy to bill the insurance company directly and will provide the attorney with a monthly statement.

Instances will arise when we exhaust all reasonable efforts to secure payment from your insurance company, but the insurance company refuses payment. We will do our best to assist you in securing payment, but all balances are ultimately your responsibility.

MISSED APPOINTMENTS: There is a \$30.00 charge for missed appointments without a 24 hour notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointments. We may request a deposit for future appointments. If more than three appointments are missed without notification, we will recommend that you seek treatment at another facility, or schedule care when you are able to commit to the recommended treatment program.

In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

I have read this policy and understand that I am financially responsible for all unpaid balances for my care.

Patient Signature: _____

Date: _____

Reviewed by: _____

Date: _____

RELEASE OF RECORDS

Date: _____

Patient Name: _____ Date of Birth: _____

I request and authorize New England Spine Institute, PC to release my chiropractic records to the organization, agency, or individuals named below.

I certify that this request has been made voluntary and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above-authorized information may not be accomplished without further written consent. Without my expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or, not later than _____.

Please release my records to:

Primary Care Physician:

Other Physicians:

Attorney:

Myself / Other:

(Signature of patient or person authorized to sign for patient)

(Relationship to patient of person authorized to consent)

I decline your offer to send records to any of the above and will advise you in writing if I wish you to do so in the future. _____

(Signature of patient or person authorized to sign for patient)