

# 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.

**Personal Injury:** The following information is necessary to initiate your claim and treatment

Please be sure to provide the date of injury, insurance company name, address, telephone number, claim number and the name of the adjuster handling your claim.

If you have health insurance, we will require a copy of your insurance card, completion of Section One of the "Health Benefit Affidavit" along with verification of chiropractic benefits & eligibility (please confirm with your health insurance carrier that we are an in-network provider). In the event that your claim is denied, exhausted, or terminated through an Independent Medical Exam (IME) we will submit all bills to your health insurance carrier. Your co-payment/co-insurance/deductible will be due at the time of service. If you do not have health insurance, please complete Section Two of the "Health Benefit Affidavit".

We also require the name, address and telephone number of your attorney. Please sign and date a physician's lien (given at time of initial appointment), which will be sent to your attorney. If you do not have an attorney at this time, we still require your signature on the lien in the event that you do retain legal services.

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. If you any questions, please do not hesitate to ask.

Sincerely,

Carey Chiropractic & Rehabilitation Center

## ***Important Information for Patients Receiving Personal Injury Protection [PIP] Benefits***

### **You've been injured in a car accident...now what happens?**

Who is responsible for payment of your healthcare services? Trust us, the process can be complicated. As a courtesy to our patients, we will submit claims to the appropriate insurance carriers, provided we receive all necessary insurance information, signed releases, a copy of your health insurance card and a signed "Physician's Lien". We process claims directly through the insurance carrier and not through a third party [e.g., an attorney].

If you have health insurance that pays for chiropractic services, healthcare services claims are processed through your private health insurance. We will then submit any balances remaining from the medical claims [i.e., co-payments and deductibles] to the PIP carrier for payment. However, pursuant to our contractual agreements with health insurance companies, we must collect all deductibles, coinsurance and co-payments from you at the time of service. Upon payment from your PIP carrier, we will promptly reimburse you.

### **What if you have an attorney?**

If you have retained an attorney, we will gladly send him/her copies of your Chiropractic bills and notes, but we do not process claims solely through your attorney. When your claim is settled, we do not negotiate balances for our services.

### **Independent Medical Evaluations**

The PIP insurance company may schedule you to undergo an Independent Medical Examination [IME]. Please inform us so that we may forward information to the examining physician that will assist in your evaluation. This examination is performed by a physician who will attempt to assess your injuries, review your treatment and determine your response to therapy. If you fail to attend the IME, or if the IME physician determines that you have reached a "maximum therapeutic benefit" from treatment, your healthcare service benefits will be terminated and the PIP carrier will discontinue paying for your healthcare services.

### **What happens if your PIP benefits are terminated?**

If your PIP benefits are terminated, we may require payment for chiropractic services at the time rendered. We accept cash, checks, MasterCard and Visa and do not allow personal balances to exceed \$200.00.

### **What happens if all of your PIP benefits are exhausted?**

If your PIP benefits are exhausted, we require payment for all subsequent balances incurred. We will not finance care and wait for a law suit settlement for payment. We accept cash, checks, MasterCard and Visa and do not allow personal balances to exceed \$200.00.

### **About Missed Appointments**

There is a \$30.00 fee for missed appointments without 24-hour notice that must be paid before scheduling another appointment. If 3 appointments are missed without notice, you will be administratively discharged from care. A copy of your records will be forwarded to the physician of your choice to allow for continuation of care.

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

# 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
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Social Security No.	Home Phone No. ( )	Cell Phone No. ( )	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address	City	State	ZIP Code	Email Address
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Occupation	Employer	Employer Phone No. ( ) Ext _____
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Employer Address	City	State	ZIP Code
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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. ( )
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## 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.
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Claim No.	Injury reported? <input type="checkbox"/> Yes <input type="checkbox"/> No	( )
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Attorney Name	Attorney Address	Attorney Phone No. ( )
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## 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 \$
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Patient's Relationship to Subscriber  Self  Spouse  Child  Other \_\_\_\_\_

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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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. ( )
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X

\_\_\_\_\_  
PATIENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Acts of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, Health Insurance, etc.) available to you before your claim can be processed for Personal Injury Protection Benefits (PIP).

Any medical expense in excess of \$2,000.00 will not be paid under PIP if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, Medicare, Health Insurance, etc.). Bills submitted to the PIP carrier over the \$2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment.

If you have health insurance benefits available to you, please complete **SECTION ONE** (do not write in your automobile insurance information).

If you do not have any health insurance benefits available through your own policy or that of a household member, please sign and date **SECTION TWO**.

### SECTION ONE: BENEFITS INFORMATION

Your name: \_\_\_\_\_

Name of your Health Insurance Company: \_\_\_\_\_

Address of your Health Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### SECTION TWO: NO HEALTH BENEFITS

I hereby certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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 have made in completion of this form.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

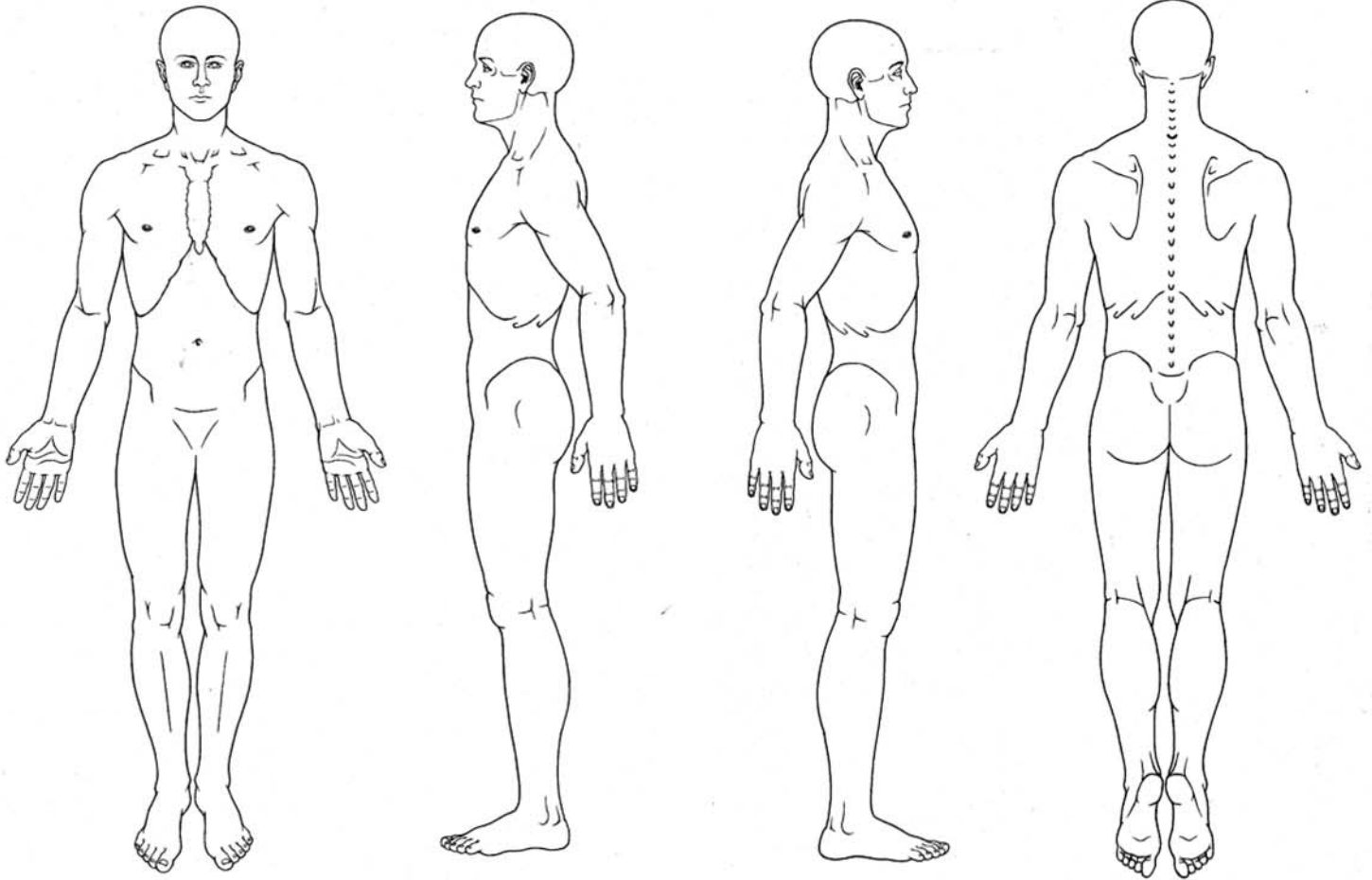
Date: \_\_\_\_\_

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 Carey Chiropractic & Rehabilitation Center 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)*

## Patient's Guide to Insurance Verification

We encourage you to verify your insurance benefits and have developed the following guide to assist with the process. Please record all relevant information to cross-check with our verification process.

You will find a customer service number on your insurance card. Please contact a service representative and ask the following questions about each recommended service.

It is always recommended that you record the name of the person with whom you discussed your coverage.

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

We have recommended the following treatments:

Procedure	Procedure Code	
Examination	99211-99215	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal manipulation	98940	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ultrasound	97035	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electrical muscle stimulation	97014	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exercises and stretches	97110	<input type="checkbox"/> Yes <input type="checkbox"/> No
Massage	97140	<input type="checkbox"/> Yes <input type="checkbox"/> No

*Please ask the following questions.*

Are the recommended treatments covered?  Yes  No

Is my provider covered / part of your network?  Yes  No If no, ask next question

Is there an out of network benefit?  Yes  No Details: \_\_\_\_\_

Do I need a primary care physician referral?  Yes  No

Is there a deductible?  Yes  No Amount: \_\_\_\_\_

Has it been met this year? \_\_\_Yes \_\_\_No

How many treatments may I receive? \_\_\_\_\_

Is there a maximum allowable payment for each service? \_\_\_\_\_ Amount: \_\_\_\_\_

Can you send me confirmation of this conversation?  Yes  No Confirmation #: \_\_\_\_\_