

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.

Worker Compensation: The following information is necessary to initiate your claim and treatment.

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

In the event that your workers compensation claim is denied we will submit all bills to your health insurance carrier and your co-payment/co-insurance/deductible will be due at the time of service. We will need a copy of your health insurance card along with verification of chiropractic benefits & eligibility (please confirm with your health insurance carrier that we are an in-network provider). If you have obtained an attorney we will need you to sign a physician's lien (given at time of initial appointment), which will be sent to your attorney.

After your initial visit, a treatment plan will be faxed to your insurance company's utilization review for pre-certification. We will schedule your treatment plan, however, no treatment may be provided without pre-certification from utilization review.

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 have any questions, please do not hesitate to ask.

Sincerely,

Carey Chiropractic & Rehabilitation Center

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

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: _____

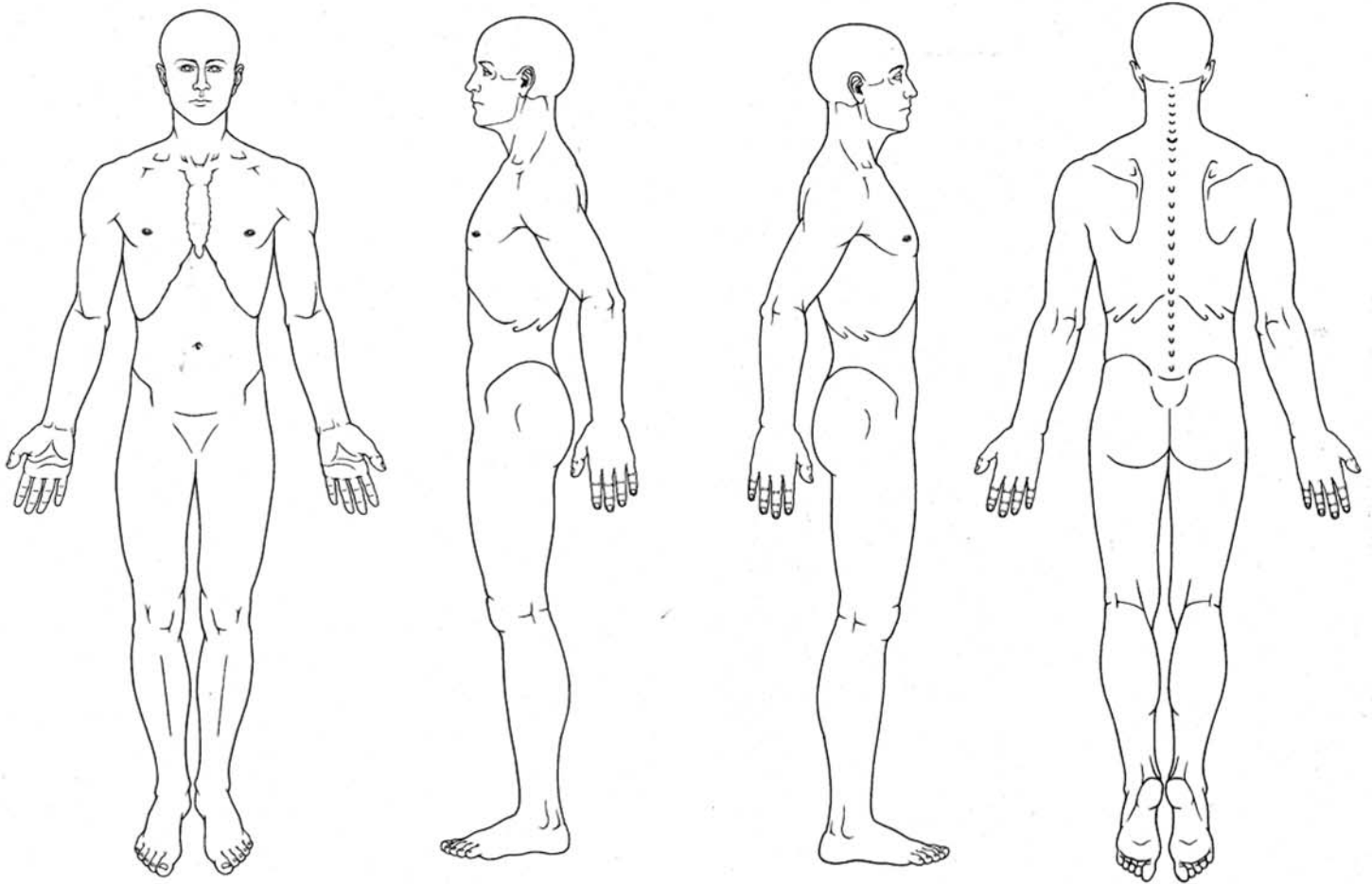
Date: _____

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 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 #: _____

As you complete this process, please feel free to call our Patient Services Manager, Nancy Morgan at 781-767-5555. If you would like to cross check the information that you obtain, please fax this form to 781-767-9751. As always, we request your feedback on how we might improve this form.