

**WELCOME TO OUR OFFICE. PLEASE FILL OUT THESE FORMS COMPLETELY.**

**IF YOU HAVE ANY QUESTIONS, PLEASE ASK.**

**Patient Information:**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M  F  DOB (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married  Single  Divorced  Widowed

How did you hear about our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information:**

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured DOB (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Insured DOB (MM/DD/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accident Information:**

Is this visit do to an accident? No  Yes  If so, what date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of accident? Auto  Work  Slip/Fall  Home  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you currently under Workman’s Compensation? No  Yes  If yes, what date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any ongoing lawsuit related to your visit today? No  Yes  If so, with who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To whom have you reported a claim to? Auto Insurance  Employer  Worker’s Compensation

**Social History:**

Job Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was the last day you worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any restrictions? (Check all that apply):

Restricted or light duty  Temporary disabled  Permanently disabled  Retired  Unemployed

What Hobbies do you have? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use: No  Yes  How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_ Quit? \_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_

Alcohol Use: No  Yes  How much daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much weekly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Alcohol abuse? No  Yes  Have you used illicit substances? No  Yes  Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been addicted to or misused prescription drugs? No  Yes  Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Treatments:**

Have you had Chiropractic Care? No  Yes  If yes, Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Injections  Physical Therapy  Acupuncture  Massage Therapy  Physiatry  Surgery (Back / neck)

comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**

Any known allergies? No  Yes

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had an allergic reaction to: Iodine  Codeine  Latex  Numbing Medication

Any history of an allergic reaction to medication, food, environmental or animals? No  Yes

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Are there any Family history of any of the following:

Alcohol Abuse No  Yes  Diabetes No  Yes  Stroke  No  Yes

Illegal Drug Use No  Yes  Prescription Drug Use No  Yes  Heart Disease No  Yes

Hypertension No  Yes  Cancer No  Yes  Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Doctor Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Present Medications:**

Please list all prescriptions, supplements and vitamins that you are taking: None  List provided

Name of Medication Dose/Frequency Name of Medication Dose/Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any of the following blood thinners? (Please check)

Coumadin / Warfarin  Aspirin  Aggrenox  Ticlid  Brilinta  None

**If you are having pain (neck, back or extremities etc.), health problems, symptoms, complaints, please list them in order of severity**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any activities, incidents or events that may have caused these symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a history of the following:**

Attention Deficit Disorder  High Blood Pressure  Rheumatoid Arthritis

Depression  Gout  Diabetes

Obsessive  Compulsive Disorder  Heart Disease

Heart Attack  Stroke  Pediculcer Disease

Schizophrenia or bipolar  Osteoporosis  Cancer

Kidney or liver disease  Childhood Abuse  Hepatitis ( A B C )

HIV / AIDS  Hypothyroidism  Pins/Needles in Arms & Legs

Constipation  Fatigue  High Cholesterol

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please include any other past/present medical history not already listed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other doctors you have consulted for these conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Pregnant? No  Yes  If so, Due Date ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above information is true and correct to the best of my knowledge.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or guardian (if patient is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Reviewed By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

**Uses and Disclosures**

Some examples of how we may use or disclose your healthcare information:

• Your health care provider or a staﬀ member may disclose your health information to another healthcare provider, hospital, or treatment facility in order to refer you for diagnosis, assessment, treatment, or testing.

• Your health care provider or a staﬀ member may disclose your health information, including your billing records, to another party such as an insurance carrier, an HMO, a PPO, or your employer or their insurance carrier, if they are potentially responsible for the payment of the services you receive.

• Your health care provider or a staﬀ member may disclose your health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voice mail, or with the person who answers the call.

• You have the right to refuse us authorization to contact you to provide appointment reminders, information about your treatment alternatives, or other health related information that may be or interest to you. If you refuse us authorization, it will not aﬀect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

• At any time, you may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. You are also entitled to an electronic copy of any records maintained in that format.

• We are permitted to use or disclose your health information when required to do so by applicable federal or state laws.

• We are permitted to use or disclose your health information to public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information to under state or federal law.

• We are permitted to use or disclose your health information to an appropriate governmental authority if we reasonably believe you are the victim of abuse, neglect, or domestic violence.

• We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government beneﬁt programs.

• We are permitted to use or disclose your health information to a law enforcement authority as required by laws to report certain types wounds or physical injuries or to comply with a court order, subpoena, or administrative request authorized by law.

• We are permitted to use or disclose your health information to a law enforcement authority if the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

• We are permitted to use or disclose your health information to a correctional institution if we provide healthcare services to you as in inmate.

• We are permitted to use or disclose your health information if we provide healthcare services to you in an emergency.

• We are permitted to use or disclose your health information if we provide care to you that is related to a workplace injury to the extent necessary to comply with Worker’s Compensation rules and regulations.

**Your Right to Revoke Your Authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. Your revocation request will not be honored if:

• We have already released your health information before receive your request to revoke your authorization.

• You were required to give your authorization as a condition of obtaining insurance; the insurance company may have a right to your health information if they decide to contest any of your claims.

• Any circumstance in which we are permitted or required to use or disclose your health information without your consent or authorization.

Your Right to Limit Use or Disclosure:

If there are healthcare providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want use to disclose your health information, please let us know in writing which providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your healthcare information. We are not required to agree to your restriction; however, if we agree with your restriction, the restriction is binding on us. If we do not agree to your restriction, you may seek care from another healthcare provider.

Other than the circumstances described above, any other use of disclosure of your health information will only be made with your written authorization.

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

1. **Notifier:** Sheitelman Physical Medicine

# Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ C. Identification Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn’t pay for **D. Items and Services** 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.** items and services below.

|  |  |  |
| --- | --- | --- |
| **D. Items and Services** | **E. Reason Medicare May Not Pay:** | **F. Estimated Cost** |
| Manual manipulation of the spine performed for **maintenance care.**  Exams-Re-xam X-rays  Manual Therapy/Massage Electrical Stimulation Exercise  Chiropractic Adjustments | Medicare **NEVER** pays for maintenance care.  These are ***non-covered*** items and services under Medicare when ordered and/by a chiropractic physician. | $79-$489  $150  $10-$59  $60  $59  $59-$69 |

# 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.**items & services 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 items & services 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 items & services 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 items & services 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.](mailto:AltFormatRequest@cms.hhs.gov.)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy f the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

INFORMED CONSENT FOR CHIROPRACTIC & MEDICAL CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, and social well-being, not merely the absence of disease or infirmity. One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxation are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor’s objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INITIALS DATE

You agree, in order for our collection company to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing service, as applicable.

I/We have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INITIALS DATE

Note: This office reserves the right to make future changes to these and other policies with the retaining, releasing, and maintaining the privacy of patient health information, and I understand that such changes will become retroactive, and therefore no notice to me will follow. I have read the Sheitelman Physical Medicine's Patient Privacy Notice and understand my rights as well as the practice’s duty to protect my health information, and have conveyed my understanding to the doctor. At this time, I do not have any questions regarding my rights or any of the information presented to me on this subject.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INITIALS DATE

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our financial policy. Upon arrival, please sign in at the front desk and present your current insurance card. You will be asked to sign and date, this is your verification of the correct insurance and consent to bill them on your behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN. CO-PAYMENTS /CO-INSURANCE AND DEDUCTIBLES: These payments must be made at check-in. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments/co-insurance and deductibles from patients is considered a violation of contract and fraud. Please help us uphold the law by making your co-payments/co-insurance at each visit and paying deductibles owed at the beginning of the year (including Medicare deductibles and 20% co-insurance). CLAIM SUBMISSION: As a courtesy to you, we will process your insurance claims for services rendered by our practice. Your insurance company may need additional information from you to process a claim and it is your responsibility to comply with their request. If your insurance company has not paid your claim within 60 days, the balance becomes your responsibility. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

NON-COVERED SERVICES: Not all services are covered by insurance; they vary from contract to contract. Some insurance companies arbitrarily select certain services they will not cover or which they may consider not medically necessary. In these instances, you will be responsible for these services. We will make every e‑ort to ascertain your coverage for our services before treatment and make you aware of our findings. However, this does not guarantee payment from your insurance carrier. For services that are not covered by insurance, the Practice requires payment of 100% of the total charges at time of service unless prior arrangements have been made.

COVERAGE CHANGES: If your insurance changes, please notify us as soon as possible so that we can update our records and help you receive the maximum benefits allowed under your coverage. If you are insured by a plan that we accept, but you do not have a current insurance card, payment is expected in full at time of service until we can verify your coverage.

NONPAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full or make payment arrangements with us. Please be aware that if your balance remains unpaid, we reserve the right to refer your account to a collection agency, and your account will become inactive until paid. Account balances turned over to a collection agency will accrue interest at the rate of 16% per annum, or 1.33% per month after 90 days. If your account is turned over to an attorney or pursued legally for collection, you will be responsible for all reasonable attorney’s fees, Filing fees, and service fees. All Returned Checks Are Subject to a $30.00 fee. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Our practice is committed to providing quality medical care. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our financial policies. Please let us know if you have any questions or concerns about the above information or any uncertainty regarding your insurance coverage.

Please check ALL boxes that apply:

I have Medical Insurance

I want Sheitelman Medical to Bill

my insurance

I DO NOT want Sheitelman Medical to Bill my Insurance

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING

I hereby authorize photocopies of this form to be as valid as the original

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

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