Adult NPT

CHIRO HEALTH

Caring For the Whole Person

The information collected on this form is essential if we are to render the best professional care possible. We appreciate your consideration in filling this out completely so we have accurate records.

Personal Info

Last Name: _____ First Name: _____ MI: _____ Suffix: _____

DOB: ____/____/_____ Sex: M F Age: _____ SSN: _____/_____/_____ Marital Status: M S D W

Weight: _____ Height: _____ Employment: FT PT RETIRED STUDENT Job: _____

Address: _____ City: _____ St: _____ Zip:_____

Home PH: (____)_____ Cell PH: (____)_____ Email: _____

Smoking: Y N Frequency: _____ Start Date: ____/____/_____ End Date: ____/____/_____

Insurance

Insurance Company: _____ PLEASE PRESENT CARD Relation to Primary Holder: _____

ID No: _____ Group No: _____ Plan Name: _____

No of Visits: _____ Deductible amt: $ _____ Co-pay amt: $ _____

About your Condition

What brings you into the clinic: _____

_____

How long: ☐ Just today ☐ A few days ☐ Several days ☐ A few weeks ☐ Months ☐ Years

Did it begin: ☐ Gradually ☐ Suddenly Is it getting worse? Y N Is this due to an injury? Y N

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Exercising ☐ Driving ☐ Hobbies

What makes it worse: _____

What makes it better: _____

How frequently do you feel your symptoms:

☐ Occasionally (0-25%) ☐ Intermittently (26-50%) ☐ Frequently (51-75%) ☐ Constantly (76-100%)

How old is your mattress: _____ Is it: ☐ Comfortable ☐ Uncomfortable

Sleep position: ☐ Back ☐ Stomach ☐ Side ☐ Combination How long do you sleep: _____ hrs.

Women ONLY: Are you pregnant? Y N Due Date: _____ / _____ / _____ No of weeks: _____

Have you ever been under chiropractic care? If so, when: _____

How would you rate your HEALTH right now? (0 = Unhealthy, 10 = Optimum Health)

1 2 3 4 5 6 7 8 9 10

Office Use Only

Patient Category: ☐ Chiropractic ☐ Nutrition ☐ PI/Auto

Pay Type: ☐ Cash ☐ Insurance ☐ Medicare ☐ PI

# of Visits: _____ Co-pay Amt: $_____ Prepaid: Y N

Addon Type: ☐ Standard Process ☐ Pure Trim

☐ Sombra ☐ Lifewave

Notes/Nutrition: _____

_____

_____

_____

_____

_____

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(CONTINUE ON BACK)

Please list ALL medications and supplements you are taking with the reason for each

Medications

1. _____ why:_____
2. _____ why:_____
3. _____ why:_____
4. _____ why:_____
5. _____ why:_____
6. _____ why:_____
7. _____ why:_____
8. _____ why:_____
9. _____ why:_____
10. _____ why:_____

Informed Consent

Risk factors

Doctors of Chiropractic (DC), Md and DPT who use manual therapies such as spinal or extremity adjustments and/or therapies are required to advise patients that there may be some risk associated with such treatment. In particular, you should know that:

- While very rare, reports of fracture to bone, disk injuries, damage to muscles or ligaments have occurred following adjustments. In most of these cases, osteoporosis and/or serious degenerative diseases are a factor. ***Please let your doctor know of these conditions prior to any treatments***.
- While extremely rare, reported cases of stroke following a cervical adjustment have been noted. However, the possibility of a cervical related stroke has been estimated to occur in one to every million to five million adjustments.

You have choices. You may choose to receive the medical model of care, which could include drug therapy or surgery. Other therapists may be able to perform similar treatment protocols as well. The risk of such may be more, less, or equal to chiropractic.

Your treatment is designed to provide the optimum conditions to restore and maintain good health. Duration of treatment is based upon the nature of the problem. Treatment duration is only an approximation of time or a number of treatments based upon similar instances or the opinion of the doctor. This does not guarantee an outcome, nor is it a contract of an kind.

Please read and sign.

I acknowledge I have discussed or had the opportunity to discuss the nature of the information presented and therefore consent to chiropractic examination, adjusting and therapy.

Patient Signature: _____ Date: _____/_____/ _____

Expectations of Payment

Payment is due at the time of the visit. Financial arrangements can be made but must be done at the time of the **FIRST VISIT**. Every effort will be made to collect from your health, auto, or worker's compensation insurance companies, but ultimately ***you are responsible for the balance due***. We also will work with an attorney regarding personal injury claims; including waiting for settlement before being paid. (Medical payment benefits are billed and payment is expected upon receipt of reimbursement). Please note that it is not the standard practice of this clinic to reduce balances due.

Point of Service discounts are available ***to all patients***. If you wish to pay a discounted fee, you must do so prior to leaving the clinic. Point of Service discounts cannot be used after the fact as this may be considered fraudulent. Please visit with the doctor or staff if you wish to have a discounted payment before leaving the clinic.

I authorize Dr. Mark E. Lee DC and Lee Family Chiropractic/Chiro Health to be paid in full for all serviced rendered. I expect my attorney, insurance company or any entity to do everything necessary to assure that no reductions are made without prior authorization from Dr. Mark E. Lee DC.

Patient Signature: _____ Date: _____/_____/ _____

Authorization to Release Medical Information

I authorize Dr. Mark E. Lee DC, Lee Family Chiropractic/Chiro Health, and/or staff to release my personal healthcare information necessary to receive payment of services by any, or all parties associates with me and my healthcare treatment. I will not and do not hold Dr. Mark E. Lee DC or anyone associated with his clinic personally liable for the release of this information when deemed necessary to do so.

Patient Signature: _____ Date: _____/_____/ _____

Protected Privacy

We are committed to do everything possible to protect your "non-public personal information". However, there are times when we must collect and send this information for and in your behalf, to be paid for services rendered. You have the right to inspect your personal healthcare information. You also have the right to amend any errors you may find in your record.

Medicare Patients ONLY

Patient Name: _____ Medicare #: _____

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items/services. We expect that Medicare will not pay for the items/services described below. Medicare does not pay for all healthcare costs, and only pays for covered items/services when Medicare rules are met. The fact that Medicare may not pay for a particular item/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 ***will not pay*** for:

Item/Service	Cost	Reason Medicare May Not Pay
1. Exams (99203)	$ 165	It is widely known that Medicare does not pay for exams, or physiotherapy (1,2,3) when performed by a chiropractor. Supplies are not re-imbursable when offered in house (clinic). Maintenance care is not a covered service. Nutritional supplies/supplements and orthotics are not covered by Medicare.
2. Muscle Stim (G0283)	$ 30	
3. Massage (97124)	$ 40	
4. Nutritional Supplies	varies	
5. Orthotics	varies	

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items/services, knowing that you may have to pay for them out of pocket. Before you make a decision about your options, please read this entire notice **carefully**. Ask us to explain, if you don't understand, why Medicare may not pay. Ask us how much these items/services will cost you, (**Estimated cost: $** _____) in the case you have to pay out of pocket or through a secondary insurance.

PLEASE CHOOSE ONE OPTION, CHECKING ONLY ONE BOX. SIGN & DATE BELOW.

☐ **OPTION 1: YES:** I want to receive these items/services (1, 2, 3, 4, 5). 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: YES:** I want to receive maintenance care, but **do not** bill Medicare for the service. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3: NO:** I have decided not to receive these items/services. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay**.

Signature:	Date: / /

NOTE: Your health information will be kept confidential, in our offices. If a claim is submitted to Medicare, the information on this form may be shared with Medicare. Your health information shared with Medicare will be kept confidential with Medicare.

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