

**Patient Information Form**

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

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Business / Employer: \_\_\_\_\_ Type of work: \_\_\_\_\_

Check one:  Married  Single  Widowed  Divorced  Separated

Spouse's name: \_\_\_\_\_ SSN \_\_\_\_\_

Spouse's date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Parent's name (if minor): \_\_\_\_\_ Work phone: \_\_\_\_\_

Whom may we contact in case of emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Financial Arrangements**

Who is FINANCIALLY RESPONSIBLE for this bill? \_\_\_\_\_

I will be paying today by:  CASH  CHECK  CREDIT CARD

Credit Card # \_\_\_\_\_ Exp. date: \_\_\_\_\_

Signature of credit card holder: \_\_\_\_\_

I hereby authorize to charge my credit card the balance owed if my account becomes delinquent.

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

**Insurance Information**

Type of insurance:  Medicare  Personal Health  Auto  Wok. Comp.

Name of insured: \_\_\_\_\_ D.O.B. \_\_\_\_\_ SSN: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**PLEASE SEE REVERSE SIDE FOR COMPLETE FINANCIAL ARRANGEMENTS**

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:**

- A. 99202 – Exams
- B. 97032 – Electrical Stimulation
- C. 97140 – Manual Traction
- D. 97140-59 Myofascial Release
- E. 97810 – Acupuncture / Meridian Therapy
- F. 72010/72040/72100 – X-rays

NOTE: WILL PAY ONLY 80% OF CHIROPRACTIC ADJUSTMENT

- 98940 – 1-2 areas of adjustment
- 98941 – 3-4 areas of adjustment
- 98942 – 5-6 areas of adjustment
- 98943 – extra spinal (knees, elbows, ankles, wrists)

**Because:**

1. You had more than one visit (chiropractic) in one day.
2. Your condition (diagnostic code) is not on the approved list by Medicare.
3. The frequency of visits for your condition exceeds Medicare guidelines.
4. Medicare may consider this visit to be maintenance in nature and has determined that maintenance care is not a covered benefit. The Medicare description of maintenance is "treatment to prevent disease, promote health, prolong and enhance quality of life, or to stabilize a chronic condition or to prevent deterioration."

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.

## FINANCIAL POLICY FOR MEDICARE PATIENTS

Our office does not accept assignment with Medicare. What this means to you is that you will be expected to pay for your care and wait for reimbursement from Medicare. **We do all of the billing to Medicare on a weekly basis**, but their payment will be coming to you. We will also provide Medicare with your supplemental insurance group and ID numbers so that they can forward the claims on to that company.

Your supplemental policy has informed us that they only reimburse on charges that are "allowed" or paid by Medicare. In a chiropractic office, this consists of the manipulation or adjustment only. No other chiropractic services are reimbursable by Medicare. This means you will have some services that you will pay for that neither Medicare nor your supplemental insurance will cover, such as the initial examination and any necessary x-rays.

In our office we also offer a vast assortment of therapies such as electrical stimulation, inter-segmental traction, Myofacial release, therapeutic exercise, acupuncture with and with out needles, Orthopedic Nutrition to list just a few. Again these therapies are not Medicare reimbursable services. These items however will be listed on Medicare statement and the Medicare explanation of benefits will reflect them as "**non-covered**" expenses. Medicare pays 80% of Manipulation (adjustments).

By signing this form you are acknowledging that you understand this financial policy and that you agree that we may release any information necessary for the processing of your claim to Medicare and to your supplemental insurance, including but not limited to your name, address, phone number, social security number, date of birth, diagnosis, and treatment dates and services.

On the day of service you will also be required to sign Medicare stickers that we must put on your claim forms so that you will receive payment from Medicare. They must have your signature, we can not sign for you.

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Patient Signature

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Date signed