

Medical History:

Referred to our office by: _____

How old were you **the first time** you remember having a similar problem? _____

Have you been treated previously by a chiropractor? Yes No

If yes, what were your results? _____

Was there a specific activity that started your pain? _____

What seems to make your condition worse? _____

What seems to help? _____

What have you tried so far that has **not** worked? _____

When the pain is at its worst, how does it feel? _____

When the pain is at its worst, how much older do you feel than your actual age? _____

Has this problem been getting worse, better, or staying the same? _____

When it is at its worst, how does it affect you at work? _____

When it is at its worst, how does it affect your family life? _____

When it is at its worst, how does it affect your recreation? _____

Have you ever been in an automobile accident? Yes No

If yes, when and what were your injuries? _____

Please list any other accidents or traumas you have had in the past, and any resulting injuries: _____

Please list any past surgeries: _____

Do you suffer from: Headaches? Painful Menstruation? Sinus/allergy problems? Digestive Problems

Other health problems? _____

Is there a possibility that you are now pregnant? Yes No

Medications you currently take: _____

Fees are payable at the time treatment is received unless other arrangements are made in advance.

How will payment be made today? Cash Check Credit Card

Signature: _____ Today's Date: _____

Assignment of Insurance Benefits

Clark Chiropractic Center
Dr. Steven E. Clark, Chiropractor
4639 Mountain Road, Pasadena, Maryland 21122
Phone (443) 637-4936 Fax (443) 637-4946

I authorize permission to my insurance company that all bills submitted by Clark Chiropractic Center be paid directly to them. I understand that health and accident insurance policies are an arrangement between my insurance company and my self – not between my insurance company and this office. I further understand that filing insurance by this office is a courtesy provided to me.

I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms collecting from my insurance company.

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to the Insured: _____

Whose name is the policy Under? _____

Policy# _____ Group: _____

Social Security Number of Insured: _____

Insurance Company Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured's Employer _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

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:	98941 (Spinal Manipulation) past 12 visits 99202/3/4 or 99212/3/4 (Examinations & Re-exams) 72010 (Full spine x-rays) 97012,97032,97035 (Intersegmented traction, electric muscle stim, ultrasound.) Any medical supplies
Because:	Not Covered Services

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.



OFFICE POLICY

APPOINTMENTS

During your first week of treatment, Dr. Clark will recommend a treatment plan, laying out the number and frequency of appointments necessary to resolve your problem. You will get the best results, and save time and money, by following this schedule as much as possible. **Should you need to miss an appointment, it is important that you make it up within 7 days. Otherwise, a \$25 fee will be charged to your account.**

PATIENTS WITH INSURANCE

As a courtesy, we will file your insurance claims for you. You have been given an "Insurance Coverage Verification" form, which must be completed before we can submit your claims. After this is done, and any deductible has been met, we will collect your co-pay at the time of service and wait up to 60 days for your insurance to reimburse the rest.

We file all claims electronically twice per month. **Should your insurance company deny payment or take over 60 days to pay, you will need to pay any outstanding balance at that time, and resolve the problem with your insurance company. We will provide you with any records you may need to accomplish this, but we cannot fight the insurance company for you.** Your insurance policy is a contract between you and your insurance company. Our filing insurance claims is a courtesy provided to you without charge, and in no way relieves you of the responsibility for your bill.

We do not file for secondary insurance, but we will be happy to print out your claims so that you may do so.

ZERO BALANCE POLICY

Our office policy is that all accounts must be current before any further services can be rendered.

After 60 days, any amount due will automatically enter the collection process. Any fees incurred in collecting the overdue amount will be automatically added to the bill.

I understand and agree to the above office policy.

(Signature) _____ (Date) _____