Application for Treatment

Name: _____ Date of Birth _____/ _____/ _____ S.S. # _____-____-_____

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____ Is it OK to send you our monthly e-newsletter? Yes No

Name of your Employer: _____

Physical requirements of your job: _____

Check if you are: □ Married □ Single □ Widowed □ Divorced □ Separated

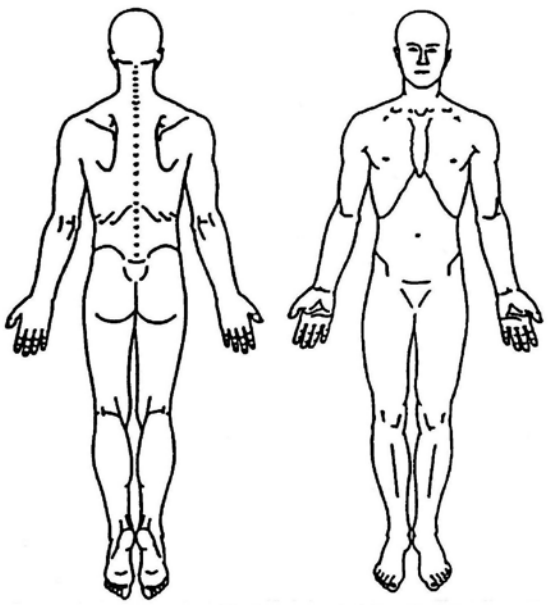
Name of Spouse/Responsible Party: _____ Relationship to Patient: _____

Primary Care Physician: _____ Telephone: _____

Address of Physician: _____

Referred to our office by: _____

Please mark the location/s of your pain or numbness on the diagram below, and number from <u>most</u> bothersome to <u>least.</u>



Briefly describe your major complaint/s:

<u>First time</u> you remember having this problem?

Clark Chiropractic Center • 418 E. Diamond Ave, Gaithersburg, MD 20877
(301) 926-1500 • Fax (301) 926-0462

MEDICAL HISTORY:

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 you at home? _____

_____

What do you like to do for fun? (hobbies, exercise, etc.)_____

How has this problem affected your ability to do these things?_____

How has this problem been affecting your sleep? _____

Have you ever been injured in an auto accident (sore afterwards)? □ Yes □ No

If yes, when, and what were your injuries? _____

_____

Please list <u>any</u> other accidents or physical traumas you have had during your life, including childhood: _____

_____

Please list any past surgeries: _____

Do you suffer from: □ Headaches □ Sinus problems □ Digestive Problems □ Painful Menstruation
□ Arthritis □ Loss of smell/taste □ Problem with balance

<u>Any</u> other health problems? _____

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

Medications you currently take: _____

Vitamins/Supplement you currently take:_____

Have you been treated previously by a chiropractor? □ Yes □ No

If yes, by whom and what were your results?

_____

Do you have <u>any</u> questions/concerns?_____

<u>I understand that fees are payable at the time treatment is received unless other arrangements are made in advance.</u>

Signature: _____ Today's Date: _____

Assignment of Insurance Benefits

Clark Chiropractic Center
Dr. Steven E. Clark, Chiropractor
418 East Diamond Ave. Gaithersburg MD 20877
(301) 926-1500 * Fax:(301) 926-0462

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:_____

Insured's Date of Birth:_____

Social Security Number of Insured:_____

Insurance Company Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Insured's Employer_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Signature:_____ Date:_____

A. Notifier: Clark Chiropractic Center, 418 E Diamond Ave, Gaithersburg, MD 20877 (301) 926-1500

B. Patient Name: **C. Identification Number: Acct. #**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. #1, #2** 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. #1 & #2** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
#1. Intersegmental Traction (97012) Exam (99203)	Not a covered service	$305.00
#2. Electric Muscle Stim (G0283/97032) Exam (99203)	Not a covered service	$305.00

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. #1, #2** 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 **D. #1, #2** 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 **D. #1, #2** 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 **D. #1, #2** 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.

OFFICE POLICY AND CONSENT TO TREATMENT

APPOINTMENTS

On your first visit the doctor will take a thorough history, and perform a thorough examination, possibly including x-rays. On your second visit the doctor 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. **Please schedule your appointments as far in advance as possible; and should you need to miss an appointment, please do your best to make it up within 7 days.**

PATIENTS WITH INSURANCE

As a courtesy, we will call to verify your insurance coverage, and explain it to you. **Please understand that we are sometimes given incorrect information, and insurance companies have no legal obligation to honor what they tell us.** It is always a good idea to call yourself to double check on your coverage, and to ask for the name of the agent that you speak with. 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 claims monthly. **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. 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.

CONSENT TO TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays on me by the doctor or authorized staff member. I have had the opportunity to discuss with the doctor or staff member the nature and purpose of these procedures, and any concerns I may have. I understand that results are not guaranteed.

I further understand that although chiropractic treatment is extremely safe, no medical or physical treatment is without risk. I do not expect the doctor to be able to anticipate and explain all possible risks, and wish to rely on his judgment as to the safety and appropriateness of any treatment provided to me.

I have read and understand the above, and I consent to all examinations and care as deemed appropriate by the doctor for my present condition, and for any future conditions for which I may seek care. I realize that I may ask any questions to the doctor either before or after I sign this contract, and I understand that my consent can be withdrawn at any time.

(Signature)_____ (Date)_____