# PATIENT INTRODUCTION CARD

Name:_____Social Security No:_____

Address: _____

Date of Birth_____ / _____ / _____ Are you: □ Minor □ Married □ Single Other_____

Occupation:_____Employer Name+Address_____

Home Phone: _____ Work Phone:_____

***To make things more convenient for our patients, we will now be sending appointment reminders via text/email.***

Cell Phone: _____ Cell Phone Carrier: _____

E-Mail Address _____

I prefer to receive: □ Email □ Text Message □ Phone Call

Primary Phone: □ Home □ Cell □ Work

Previous Chiropractic Care: □ Yes □ No Dr's Name_____

Previous Physical Therapy: □ Yes □ No Facility:_____

Insurance Company:_____ID.#_____

Name of Insured_____ **If other:** Date Of Birth _____/_____/_____

Social Security No. _____ Name of Employer_____

Employer's Address_____

Emergency Contact _____ Phone _____

**Whom May We Thank for referring you?**_____

Patient Signature _____

Parent/Guardian Signature _____

*It Is Usual and Customary to Pay Services as Rendered Unless Otherwise Arranged*

## Updating Current Information

(Legal) First Name (Legal) MI (Legal) Last Name Preferred Name

**Language:** English / Spanish / Indian / Japanese / Chinese / French / German / Russian / Other _____

**Race/Ethnicity:** White / American Indian or Alaska Native Korean / Asian / Native Hawaiian/Other Pacific Islander / African American / Hispanic or Latino / Decline to Answer

**Smoking Status:** Never / Former / Some Days / Every Day

**Marital Status:** S / M/ W / D / O

**Do you live:** Alone / With Spouse / With _____

**Describe Major Complaint:** _____

**Began When?** _____ **Describe how this began:** _____

**Severity of Complaint:** None / Mild / Moderate / Severe /

**Quality of the complaint/pain:** Sharp / Stabbing / Burning / Achy / Dull / Stiff & Sore / Other: _____

**How frequent is the complaint present?** Off & On / Constant

**Does this complaint radiate/shoot to any areas of your body?** No / Yes (Describe) _____

**Does anything make the complaint better?** Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____

**Does anything make it worse?** Sit / Stand / Walk / Lying / Sleep / Overuse / Other: _____

**Which daily activities are being affected by this condition?** (Describe) _____

**For this CURRENT condition, have you:**

- **Received any other treatment?** None / DC / MD / PT / Massage / ER / Other: _____ **Where?** _____
- **Had any previous surgery or Intervention in this area?** (Describe) _____
- **Taken any Medications?** OTC / Prescriptions _____
- **Had any diagnostic testing?** X-Rays / MRI / CT / Other: _____ **When and Where?** _____

**Allergies to Medication:** ***NONE*** *(List)* _____

**Current Medications:** ***NONE***

*(Already have a list? We can make a copy.)* _____

- ***Past Health History:*** *(List)*

**Surgeries – Date, Time, Reason and Results:** ***NONE***

**Major Injuries/Traumas:** ***NONE*** _____

**Major Hospitalization:** ***NONE*** _____

**Previous Chiropractors:** Yes / No

**Doctor's Name and Location:** _____

- ***Family Health History:*** *(Please mark N/A if not relevant)*

**List *relevant* major health problems of immediate family:**

**Deaths in immediate family:** *(Cause, Relationship and what age?)*

- ***Social History:***

**Lifestyle:** *(Hobbies, Rec., Activities, Diet, Vitamins)*

**Exercise:** Never / Daily / Weekly / Walks / Run / Swim

Other: _____

**Habits:**

Alcohol – None / Casually / Moderate / Heavy / Beer / Wine

Caffeine- None / < 3 drinks / 3-6 drinks/day / > 6 drinks/day

Rec. Drugs- None / Recreational User / Addiction

- ***Auto Related:***

**Have you ever been in any auto accidents?** Yes / No

How Many? _____

What Happened? _____

**Are you currently experiencing any of these symptoms? (Check all that apply)**
**Many of the following conditions respond to Chiropractic and Acupuncture treatment.**

**General: *(constitutional)***
- ▫ Recent Weight Change
- ▫ Fever
- ▫ Fatigue
- ▫ *None in this Category*

**Musculoskeletal:**
- ▫ Low Back Pain
- ▫ Mid Back Pain
- ▫ Neck Pain
- ▫ Arm Problems _____
- ▫ Leg Problems _____
- ▫ Painful Joints
- ▫ Stiff/Swollen Joints
- ▫ Sore/Weak Muscles or Joints
- ▫ Muscle Spams/Cramps
- ▫ Broken Bones _____
- ▫ Other: _____
- ▫ *None in this Category*

**Neurological:**
- ▫ Numbness or tingling sensations
- ▫ Loss of Feeling
- ▫ Dizziness or Light Headed
- ▫ Frequent or Recurrent Headaches
- ▫ Convulsions or Seizures
- ▫ Tremors
- ▫ Stroke
- ▫ Headaches
- ▫ Have you ever had a head injury?
- ▫ Ever been in an auto accident?
- ▫ Other: _____

**Mind/Stress:**
- ▫ Nervousness
- ▫ Sleep Problems
- ▫ Memory Loss or Confusion
- ▫ Other: _____
- ▫ None in this Category

**Genitourinary:**
- ▫ Sexual Difficulty
- ▫ Kidney Stones
- ▫ Burning / Painful Urination
- ▫ Change in force / strain with urination
- ▫ Frequent Urination
- ▫ Blood in Urine
- ▫ Incontinence or Bed Wetting
- ▫ Other: _____
- ▫ *None in this Category*

**Gastrointestinal:**
- ▫ Loss of Appetite
- ▫ Blood in Stool
- ▫ Change in Bowel Movements
- ▫Nausea or Vomiting
- ▫ Abdominal Pain
- ▫ Frequent Diarrhea
- ▫ Constipation
- ▫ Other: _____
- ▫ *None in this Category*

**Cardiovascular & Heart:**
- ▫ Chest Pains
- ▫ Rapid or Heartbeat change
- ▫ Swelling of Hands, Ankles or Feet
- ▫ Heart Problems
- ▫ Blood Pressure Problems

**BLOOD PRESSURE PROBLEMS:**
Are you currently being treated? ▫Yes ▫ No
IF YES, Who is treating you?

_____
- ▫ Other: _____
- ▫ *None in this Category*

**Respiratory:**
- ▫ Difficulty Breathing
- ▫ Persistent Cough
- ▫ Coughing Blood
- ▫ Asthma or Wheezing
- ▫ Lung Problems
- ▫ Other: _____
- ▫ *None in this Category*

**Ears, Nose and Throat:**
- ▫ Bleeding gums/ Mouth Sores
- ▫ Bad Breath or Bad Taste
- ▫ Dental Problems
- ▫ Swollen Throat or Voice Change
- ▫ Swollen Glands in Neck
- ▫ Ringing in the Ears
- ▫ Ear - Ache/Ringing/Drainage
- ▫ Sinus / Allergy Problems
- ▫ Nose Bleeds
- ▫ Hearing Loss
- ▫ Other: _____
- ▫ *None in this Category*

**Endocrine, Hematologic, and Lymphatic:**
- ▫ Thyroid Problems
- ▫ Diabetes

Excessive Thirst or Urination
- ▫ Cold Extremities
- ▫ Heat or Cold Intolerance
- ▫ Change in hat or glove size
- ▫ Dry Skin
- ▫ Glandular or Hormone Problem
- ▫ Swollen Glands
- ▫Anemia
- ▫ Easily Bruise or Bleed
- ▫ Phlebitis
- ▫Transfusion
- ▫ Immune System Disorder
- ▫ Other: _____
- ▫ *None in this Category*

**Skin and Breasts:**
- ▫ Rash or Itching
- ▫ Change in Skin Color
- ▫ Change in Hair or Nails
- ▫ Non-healing Sores
- ▫ Change of appearance of a mole
- ▫ Breast Pain
- ▫ Breast Lump
- ▫ Breast Discharge
- ▫ Other: _____
- ▫ None in this Category

**Eyes and Vision:**
- ▫ Wear Contacts/Glasses
- ▫ Blurred or Double Vision
- ▫ Glaucoma
- ▫ Eye disease or Injury
- ▫ Other: _____
- ▫ *None in this Category*

**Women Only:**

**Are you Pregnant?**
- ▫Yes - Due Date ___/___/___
- ▫ No - Last Period ___/___/___

- ▫ Infertility
- ▫ Painful or Irregular Periods
- ▫ Vaginal Discharge
- ▫ Other: _____
- ▫ *None in this Category*

***Pregnancies with Outcome & Date***

_____

_____

Comments: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with chiropractic care, diagnostic testing, and/or therapeutic services, in accordance with this state's statutes.

**Patient or Guardian Signature** _____ Date _____

Treating Doctor Signature _____ Date _____

Thank you for your cooperation!

# Functional Rating Index

**In order to properly assess your condition, we must understand how much your <u>problems</u> have affected your ability to manage everyday activities.**
**For each item below, please circle the number which most closely describes your condition right now.**

**1. Pain Intensity**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

**2. Sleeping**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Perfect sleep | Mildly disturbed sleep | Moderately disturbed sleep | Greatly disturbed sleep | Totally disturbed sleep |

**3. Personal Care (washing, dressing, etc.)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; no restrictions | Mild pain; no restrictions | Moderate pain; need to go slowly | Moderate pain; need some assistance | Severe pain; need 100% assistance |

**4. Travel (driving, etc)**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain on long trips | Mild pain on long trips | Moderate pain on long trips | Moderate pain on short trips | Severe pain on short trips |

**5. Work**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do usual work plus unlimited extra work | Can do usual work; no extra work | Can do 50% of usual work | Can do 25% of usual work | Cannot work |

**6. Recreation**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| Can do all activities | Can do most activities | Can do some activities | Can do a few activities | Cannot do any activities |

**7. Frequency of pain**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain | Occasional pain; 25% of the day | Intermittent pain; 50% of the day | Frequent pain; 75% of the day | Constant pain; 100% of the day |

**8. Lifting**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain with heavy weight | Increased pain with heavy weight | Increased pain with moderate weight | Increased pain with light weight | Increased pain with any weight |

**9. Walking**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain; any distance | Increased pain after 1 mile | Increased pain after 1/2 mile | Increased pain after 1/4 mile | Increased pain with all walking |

**10. Standing**

| 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| No pain after several hours | Increased pain after several hours | Increased pain after 1 hour | Increased pain after 1/2 hour | Increased pain with any standing |

**Name** _____
**PRINTED**

_____
**Signature**

**Total Score** _____

_____
**Date**

excel.funct

# James. J Sanfilippo D.C.C.C.S.P
# &
# Peak Performance Physical Therapy

699 Kearny Avenue • Kearny, NJ 07032
(201) 997-7171 • Fax (201) 997-2087


THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient with James J. Sanfilippo, D.C./Peak Performance P.T. we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care Provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your healthcare records as well as your billing records may be disclosed to another party, such as an insurance carrier, a HMO, a PPO, or your employer. If they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health records may be used to contact you regarding appointment reminders, information about alternatives to your present care, 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 may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form please advise us in writing as to your preferences.

| | |
|---|---|
| You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.<br><br>We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.<br><br>We are further required by law to abide by the terms of this notice while it is in effect. | We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.<br><br>Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.<br><br>If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to:<br>James J. Sanfilippo, D.C.<br><br>If you would like further information about our privacy policies and practices please contact:<br>James J. Sanfilippo, D.C.<br>(201) 997-7171 |

This notice is effective _____. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy or this notice.

_____ _____ _____

Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

_____ _____ _____

Personal Representative Printed Personal Representative Signature Date

_____

Description of the authority to act on behalf of the patient.

James. J Sanfilippo D.C.C.C.S.P
&
Peak Performance Physical Therapy
699 Kearny Avenue • Kearny, NJ 07032
(201) 997-7171 • Fax (201) 997-2087

# OFFICE FINANCIAL POLICY

Dear Patient,

If you would like us to accept your insurance on an assignment basis, or do not have insurance, please read the following, sign your name, and fill in all the information at the back of this page. Your signature indicates that you understand and agree to this policy.

1. We accept assignment with most insurance companies and we are providers for most insurance companies.
2. Everyone is considered a cash patient until they bring in all the necessary insurance information/referrals and we are able to verify your insurance coverage.
3. All co-payments must be made at the time of service.
4. No patient is allowed to have a personal balance over $150.00, unless prior arrangements have been made with this office.
5. Be aware that your insurance company **may error and send payment to you** that was meant to pay your bill here. If this should happen, you will have 3 days to endorse the checks and bring them to our office. If they are not brought to our office within 3 days, we reserve the right to debit your credit card for the amount of the check.
6. We do not promise that an insurance company will pay for the usual and customary charges of this office. If your carrier has not paid a claim within 30 days of submission, we will ask you to take an active part in the dispute and recovery of your claim with your insurance company. If the claim has not been paid after 30 days, and you have not taken an active part, you will be responsible for the payment in full for any outstanding balances.
7. You authorize us to debit your credit card to collect full payment for any outstanding bills.
8. Special financial arrangements may be provided for hardship cases.

**OVER**

9. You are **responsible to notify this office** as soon as you know of **any insurance changes such as address, phone number, etc.**
10. If you re referred to another healthcare provider or facility in or out of network, you assume all charges and costs accumulated at the provider of facility. You agree not to hold Dr. Sanfilippo responsible for any of these costs, regardless of any insurance agreement or contracts.
11. You authorize us to deduct from your credit card, co-payments that are not paid at the time of visit.

We would appreciate this OFFICE FINANCIAL POLICY to be followed. We ask that you sign this form as acknowledgement that you have read our policy, that you understand and accept full financial responsibility. We would also like to photocopy your credit/debit card to ensure correct information is kept on file. **The credit/debit card will only be used if you do not make any payments towards your balance after 30 days.**

**DATE:** _____

**PATIENT'S NAME:** _____

**PATIENT'S SIGNATURE:** _____

**PARENT/GUARDIAN'S SIGNATURE:** _____

**CREDIT CARD TYPE:**
VISA _____ MASTERCARD _____ DISCOVER _____
AMERICAN EXRESS _____

**CREDIT CARD NUMBER:** _____

**EXPIRATION DATE:** _____

THANK YOU FOR YOUR COOPERATION.
WE GREATLY APPRECIATE IT!

# JAMES J. SANFILIPPO, D.C.C.C.S.P.

CHIROPRACTIC PHYSICIAN

699 Kearny Avenue ♦ Kearny, NJ 07032

(201) 997-7171 ♦ FAX: (201) 997-2087


**Patient Name:** _____

**Patient D.O.B. :** _____

*Informed Consent for Chiropractic Services*

**I have been informed of the following:**

1. That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms, etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies/Modalities" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice acupuncture, heat, or cold;
3. I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, sprain, strain, even more rare separation/fracture/dislocation, disc injury; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment/Services. The listed possible consequences and possible complications have been explained to me by the chiropractor;
4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
5. I have been afforded ample opportunity for questions and answers; and
6. The condition, possible benefits, risks of treatment (including x-ray) procedures, options, and financial obligations have been explained to me by the chiropractor.

Therefore by signing below;

**I consent** to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor involved in my case;

**I consent** to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor involved in my case;

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

# HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

## REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If Item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

## BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

## SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

## NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR TRICARE CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

## MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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 0938-1197. The time required to complete this information collection is estimated to average 10 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.