WELCOME TO CHIRO-MED & REHAB!

To insure proper case information, please provide us with the following information. If you need assistance in completing these forms, please ask.

Today's date _____

Name _____

Date of Birth _____ ☐ Male ☐ Female SSN: _____

Mailing Address _____

City, State, Zip _____ Home Phone _____

Email Address _____

Occupation _____

Employer _____ Work Phone _____

Employer's Address: _____

Were you referred by ☐ Yourself ☐ Friend ☐ Insurance Carrier ☐ Primary physician ☐ Other physician

Name of person who referred you: _____

If different from above, who is your family physician? _____

IF WE HAVE COPIES OF YOUR INSURANCE CARDS YOU MAY SKIP THIS SECTION

FINANCIAL :	PRIMARY INSURANCE	SECONDARY PAYER OR RESPONSIBLE PARTY
NAME		
ADDRESS		
CITY,ST.ZIP		
POLICY #		
INSURED NAME		
RELATION		
SOC. SEC. #		
BIRTH-DATE		
GROUP #		
EMPLOYER NAME		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I authorize Chiro-Med & Rehab to retain a daily treatment record of services rendered. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

_____ _____

Signature Date

WHAT PROBLEM BRINGS YOU TO SEE US TODAY?

WHEN DID THIS PROBLEM START?

Did it come on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over a long time.

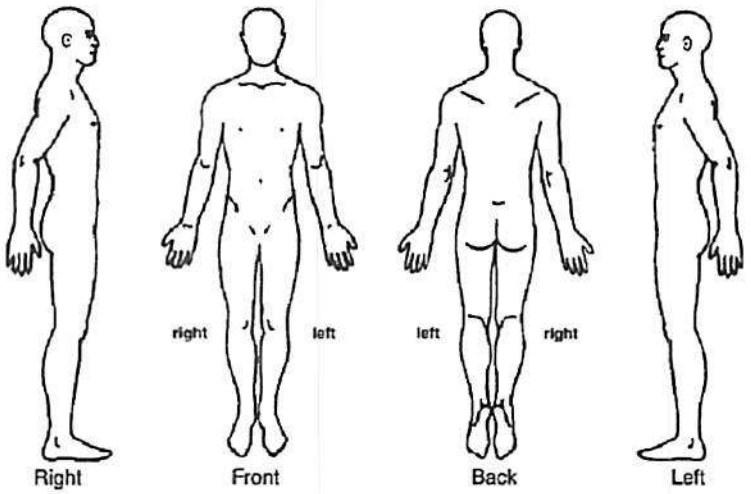
If you were injured was it: ☐ At Work ☐ At Home ☐ Due to Auto Accident ☐ Other Injury

ON THE FIGURES AT THE RIGHT, PLEASE MARK YOUR AREA(S) OF PAIN OR DISCOMFORT. **Circle** the areas (if more than one) of pain and tell us on a scale of 1 to 10, with 1 being light pain to 10 being very severe, how severe is your pain in each area <u>most of the time</u> and how frequent.

AREA 1 pain is (1-10) ___ Constant or Intermittent
At_____% of my day

AREA 2 pain is (1-10) ___ Constant or Intermittent
At_____% of my day.

AREA 3 pain is (1-10) ___ Constant or Intermittent
At_____% of my day



Please help us understand your pain: **Circle the words** for each area that best describes your pain and activity during your day.

Area 1 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 2 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

Area 3 is: Worse in AM At Night After exertion It is: Sharp Stabbing Dull Achy Throbbing Burning Tingling

I have difficulty with: Walking Sitting Standing Driving a car Sleeping My daily routine Bladder Control Depression

I currently am : Ambulatory without assistance Need to use: Support Brace_____Walker Cane Crutches Wheelchair

Please help us better understand **your personal circumstances** and assist us in providing you customized treatment and care.

I Am Now: ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired

Occupation: _____

☐ On sick leave ☐ On Temp disability ☐ On Full Disability My last day worked was _____

Age_____ Single Married Separated Filing for Divorce Divorced

Please feel free to discuss with us any situation in your personal relationships that may affect your recovery.

I Now ☐ Smoke____Packs per day Stopped _____ ☐ Use Alcohol Type and Amt _____

☐ Consume Caffeine: Type/ Amt _____ ☐ Use recreational drugs _____

I am now or have in the past been : ☐ Addicted to drugs alcohol ☐ Treated for alcohol or drug addiction

<u>WOMEN ONLY</u> Can you become pregnant? YES NO Date of last period _____ Normal Yes No

If not, why? _____ Date of last Mammogram _____ Normal Yes No

Are you now or could you be pregnant ? ? YES NO Pap Smear_____ Normal Yes No

Pertinent History/ Please advise us of any special circumstances, previous tests, therapy or conditions.

Are you allergic to any medications? NO YES (If yes, please list all that you are allergic to below)

If you previously had any of the following procedures, please list the date and place they were performed.

PROCEDURE	DATE(S)	PLACE PERFORMED
X-Rays		
C.T. / MRI		
Myelogram		
Ultrasound		
E.M.G.		
Treatment by Another Physician		
For what?		

PLEASE MARK ANY CONDITION THAT YOU NOW HAVE OR HAVE RECOVERED FROM IN THE RECENT PAST.

Severe headaches / Chest pain / Angina / Kidney Stones / Digestive problems / Hypertension / Renal disease Gout / Stroke / Heart murmur / Diabetes / Arthritis / Epilepsy / Arrhythmia / Endocrine disease / HIV / AIDS Fatigue / Congenital heart disease / Urinary, genital problems / Dizziness / Fainting / Anemia / Reumatic fever / Scarlet fever / Prostate problems / Ulcers / Gall Stones / Sexual dysfunction / Venereal disease / Pancreatitis Shortness of breath / Menstrual dysfunction / Mental Illness / Asthma / Liver disease / Alcohol or Drug problems.

CURRENT MEDICATIONS PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. *(Prescription and over the counter)*	
Name of medication and Strength	**# of doses / *day***

HOSPITALIZATION and SURGERY
PLEASE LIST ALL SURGERY AND ANY PERIODS OF HOSPITALIZATION (give dates)

FAMILY HISTORY: Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had

	condition	who?		condition	who?
	Heart Disease			Epilepsy	
	Hypertension			Glaucoma	
	Stroke			Bleeding disorders	
	Cancer			Kidney disease	
	Diabetes			Thyroid disease	

Do you require special care or have any concerns that might affect your treatment or recovery? NO YES (If yes please describe)

Thank you for assisting us in gathering the information our medical providers need to help determine a personal treatment plan for you. To verify that the information is correct as given to us by you, please affix your signature in the area (x) provided below.

Patient Signature:	*DATE:*

Dear Patient,

Cancellation/ No-show policy:

Please be advised that in the event that you are unable to make your appointment and do not give a 24 hour notice, you may be liable for a $35 cancelation/no-show charge. We understand that emergencies happen and will handle each situation as it arises. If you cancel the same day, you will be charged a $35 late cancellation fee.

Late arrival policy:

Please be aware that we understand things beyond your control can occasionally prevent you from making it to your appointment on time. We typically try to allow a 10 minute grace period, but please understand that the daily schedule may not always allow for that and we apologize if the office is unable to see you. We respect your time and attempt to try our best to always be on time. Late arrivals can create a back up for other patients that may be scheduled after you. We do understand that we ourselves occasionally run behind, so we try our hardest to be as understanding and accommodating as possible. We will not charge for a late arrival, even if it is decided that we cannot see you.

Thank you for your understanding.

X_____ Date_____

Please circle:

Have you been to another Chiropractor within the past 12 months? **Y / N**

***Failure to notify us of these visits can result in claims being denied and becoming an out of pocket expense to you.**

PLEASE NOTE- MEDICARE/MEDICAID/UN-INSURED PATIENTS:

Medicare and Medicaid insurance plans will not cover a Chiropractic office visit, they will only cover adjustments. Please be advised that if an office visit is rendered, you will be responsible for the charge. The initial office visit (uninsured patients as well) will be $200, and other office visits rendered after that visit will range from $65-$120 dependant on complexity. ****INITIAL_____**

A. Notifier: Chiro-Med & Rehab

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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____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._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Office visit	Only adjustments are covered	New- $200 Est. High- $120 Est. Low- $65

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._____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._____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._____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._____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: Medicare will deny the charge and then it will go to your secondary. If your secondary pays the charge, we will reimburse you minus any co-pay or co-insurance due.

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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Chiro-Med & Rehab
345 Elm Street, Bennington, VT 05201
P: 802-753-7930; F: 802-753-7924

I, _____, DOB _____
authorize the disclosure of specified information as described below, for continuation of treatment to Chiro-Med & Rehab

Information to be released:

_____

_____

_____

_____

Method of release: MAIL / FAX / EMAIL / PHONE

This authorization shall remain in effect from the date of signature until:

__ Specific expiration date _____

__ NO EXPIRATION DATE

Signature _____ Date _____

Southwestern
Vermont Health Care

Authorization for Release of Information

Patient Name: _____ Date of Birth: _____ MR#: _____
Print

Address: _____
Print

I hereby authorize SVHC the use or disclosure of my protected health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. This authorization is valid for 1 year unless otherwise specified.

Name and Address of Persons/Organizations authorized to receive information:
Chiro-Med & Rehab- 345 Elm Street, Bennington, VT 05201; P: 802-753-7930; F: 802-753-7924

Specific description of information that may be used/disclosed and dates of service:
- ☐ X-ray Films and Report
- ☐ Office Notes
- ☐ ER Report
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Note
- ☐ Outpatient Department
- ☐ Other: (Describe) _____

This authorization permits SVHC to disclose my protected health information from my health record with no limitations placed on history of illness, diagnostic or therapeutic information including any treatment for alcohol and drug abuse, psychiatric impairment, HIV/AIDS related illnesses or genetic testing.

The information will be used / disclosed for the following purpose(s):
- ☐ Requested by the patient and for the patient (not necessary to disclose purpose).
- ☐ Insurance claim
- ☐ Other: (Describe) _____

- ☐ I understand that this authorization is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to ensure healthcare treatment.
- ☐ I understand that I may inspect or copy the information used or disclosed.
- ☐ I understand that I may revoke this authorization at any time by notifying SVHC, in writing, except to the extent that:
  1. action has been taken in reliance on this authorization; or
  2. if this authorization is obtained as a condition of obtaining coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

_____ _____
Signature of Patient or Patient representative Date:

_____
Relationship to patient or representative's authority to act for the patient (if applicable).

Request Received:_____ Date Processed: _____
Date: Date:

☐ Copy of Authorization given to the individual

Initial of person finalizing request: _____
Created date: 4/14/03 Revised date: 5/5/03

100 Hospital Drive
Bennington, VT 05201
Phone: (802) 447-5323
Fax: (802) 447-5138