

# Chiro-Med & Rehab

## Chiropractic Medicine Orthopedic Rehab

345 Elm Street Bennington, VT 05201

P: 802.753.7930 / F: 802.753.7924

chiromedoffice@gmail.com / www.cmrehab.net Office hours: M/Tu/Th: 9A-5P ~ Wed: 9A- 7P ~ Fri: 9A- 12P

### Welcome!

Please complete the enclosed forms for your visit with our office.

It is mandatory to have all forms completed prior to being treated. We will be unable to treat you unless every form has been completed and confirmed by the front desk.

Please feel free to submit your forms prior to your appointment via any of the above methods.

You may also text the office phone number with any questions and our front desk will reply promptly. Please note, the ability to respond is only during office hours.

<u>Please note</u>- it is IMPORTANT to bring any imaging and reports on a disc for review on your initial visit. Please confirm with the office prior to your visit that you and/or we have this required information. If you do not have it, you may need to return for a follow up visit to review imaging/tests that are pertinent to your care.

Thank you!

-The Chiro-Med team

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		<del>-</del> ; 		
Date of Birth		☐ Male	Female	SSN:
Mailing Address				_
				_Home Phone
Email Address				_ * Required for billing *
Occupation				_
Employer				Work Phone
				Primary physician 🖵 Other physician
	referred you:			
	ove, who is your family physic			
				d reason
IF WE HAV	E COPIES OF YOUR IN	SURANCE		U MAY SKIP THIS SECTION
FINANCIAL:	PRIMARY INSU	RANCE	SECO	NDARY PAYER OR RESPONSIBLE PARTY
NAME				
ADDRESS				
CITY,ST.ZIP				
POLICY #				
INSURED NAME				
RELATION				
SOC. SEC. #				
BIRTH-DATE				
GROUP #				
EMPLOYER NAME				
diagnose and treat reprovider and also a that I am responsible provider in collection rendered. I hereby	my condition(s). Further I aut uthorize the release of such le for all charges which may ing my account. I authorize order all parties to accept a til revoked by me in writing.	horize assigr information include lega Chiro-Med F	nment of my instance of my instance of my instance of my instance of me instance of my instance	s as deemed necessary by the physician to surance rights and benefits directly to this to process insurance claims. I understand on fees or other expenses incurred by the tain a daily treatment record of services signment in lieu of the original. This shall be a part of the original below the date.
	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
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 most of the time and how frequent.
AREA 1 pain is (1-10) Constant or Intermittent  At% of my day  Constant or Intermittent
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  Constant or Intermittent  Right Front  Back  Left
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 BraceWalker Cane Crutches Wheelchair
Please help us better understand your personal circumstances and assist us in providing you customized treatment and care.
I Am ☐ Working Full Time Part Time ☐ Homemaker ☐ Full Time Student ☐ Unemployed ☐ Retired Now: 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 SmokePacks 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
WOMEN ONLY 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
Patient Primary Intake Histor

			an camponi	ces, previous tests, the	rapy or conditions.
Are you allergic	to any medicatio	ns? NO	YES (If y	es, please list all that you	are allergic to below)
	,	wing procedure	s, please lis	t the date and place the	y were performed.
PROCEDURE	DATE(S)			PLACE PERFORMED	
(-Rays					
C.T. / MRI					
1yelogram					
Jitrasound					
E.M.G.					
Freatment by Another Physician					
For what?					
Shortness of breath  CURRENT MEDICA	/ Menstrual dysfun	ction / Mental I	(Ilness / Asti ONS YOU AR	nma / Liver disease / Alco	nereal disease / Pancreati phol or Drug problems.  ATION and SURGERY
Name of medicatio		tion and over the co	ounter) ' doses / da	Section 1	JRGERY AND ANY PERIODS ( ZATION (give dates)
lame of medicatio	n and Strength	# of	doses / da	Y HOSPITAL	
lame of medicatio	n and Strength	# of	ily (mother,	father, grandparents, broth condition Epilepsy	ZATION (give dates)  ners, sisters, children) had
AMILY HISTORY: H	n and Strength	# of	ily (mother,	father, grandparents, broth condition Epilepsy Glaucoma	ners, sisters, children) had
AMILY HISTORY: H condition Heart Disease	n and Strength	# of	ily (mother,	father, grandparents, broth condition Epilepsy Glaucoma Bleeding disorders	ners, sisters, children) had
AMILY HISTORY: H condition Heart Disease Hypertension Stroke Cancer	n and Strength	# of	ily (mother,	father, grandparents, broth condition Epilepsy Glaucoma Bleeding disorders Kidney disease	ZATION (give dates)  ners, sisters, children) had
AMILY HISTORY: H condition Heart Disease Hypertension Stroke Cancer Diabetes	as anyone in your i	immediate fam	ily (mother,	father, grandparents, broth condition Epilepsy Glaucoma Bleeding disorders Kidney disease Thyroid disease	ners, sisters, children) had who?
FAMILY HISTORY: H condition Heart Disease Hypertension Stroke Cancer Diabetes	as anyone in your i	immediate fam	ily (mother,	father, grandparents, broth condition Epilepsy Glaucoma Bleeding disorders Kidney disease Thyroid disease	ZATION (give dates)  ners, sisters, children) had

## Cancellation/ No show policy

Please be advised that it is this office's requirement to give a business days' notice if you are unable to attend your appointment. If you fail to do so, you will be charged a \$35 fee. This fee also applies to no-show occurrences as well as same day cancellations. Cancellations outside of office hours (i.e- a Saturday/Sunday cancellation for a Monday appointment or a cancellation during the week outside of office hours), are not accepted as we will not be able to take the appropriate steps to fill your appointment spot if we are not in the office. We understand emergencies happen, and will handle and will address each event as applicable.

## Late arrival policy

We understand that things beyond your control often happen and might prevent you from making it to your appointment on time. Our office policy is to allow a 10 minute grace period for such late arrivals. We respect your time and ask that you respect the office's/other patient's time as well. We apologize for the instances where we will not be able to accept a late arrival beyond the 10 minute grace period.

Signature:	Date:

## \*\*For Medicare/ Medicaid patients only\*\*

Thank you for your understanding regarding these policies.

Medicare and Medicaid will only cover Chiropractic adjustments. They will not cover office visits or any other procedure billed by a Chiropractor. If any other procedure is rendered, you are solely responsible for this charge. This office aims to notify you in advance should a non-covered charge happen. However, if you do not inform the office ahead of your appointment about a change in your symptoms or a new issue that requires an office visit, we will not have the ability to inform you ahead of your appointment regarding the charge. \*\*Initials \_\_\_\_\_\_

New patient exam- \$200
Existing patient, low complexity office visit/ Imaging review- \$80
Existing patient office visit/re-exam or new complaint - \$120
Daily treatment- \$65 (Visits are based on 30 minute encounter times)

### To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill or charge for incidentals. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a <u>mandatory</u>, similar policy. You will be required to present a credit card at the time you check in for your appointment. This information will be held securely in our HIPAA compliant billing software until your insurance(s) has paid their portion and notified us of the amount of your share. Once your claim has been processed by your carrier and posted to our system,we will notify you that you will have a charge pending. Any remaining balance owed by you will be charged to your card on file, and a copy of the charge will be mailed/emailed to you if requested.

This will be an advantage to you since you will no longer have to write out and send us checks. It will also be an advantage to us because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, coinsurance, and deductibles that are due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours, Chiro-Med & Rehab

I authorize Chiro-Med & Rehab to charge outstanding balances on my account to the following credit card:

Visa / Mastercard / American Expre	ss / Discover / Other:	_
Name on card (Please Print)		
Card#	Exp Date:	
V-Code (3 digits on back):	Zip Code linked to card:	
Email Address:		
Signature:	Date:	

A. Notifier: Chiro-Med & Rehab

B. Patient Name:

C. Identification Number:

good reason to think you need. W	/e expect Medicare may not pay for the D  E. Reason Medicare May Not Pay:	care provider have below.  F. Estimated Cost
Chiropractic office visit	Only adjustments are covered	New patient: \$200 New issue: \$120 Follow up or imaging review- \$80
<ul> <li>Ask us any questions that you</li> <li>Choose an option below abou</li> <li>Note: If you choose Option 1 or might have, but Medicare</li> </ul>	make an informed decision about your care.  I may have after you finish reading.  It whether to receive the <b>D</b> .  2, we may help you to use any other insurant cannot require us to do this.	
☐ OPTION 1. I want the D also want Medicare billed for an Summary Notice (MSN). I unde payment, but I can appeal to Medices pay, you will refund any part option 2. I want the D ask to be paid now as I am response option 3. I don't want the I	listed above. You may ask to be official decision on payment, which is sent to restand that if Medicare doesn't pay, I am restand that if Medicare by following the directions on the MS ayments I made to you, less co-pays or deducated above, but do not bill Medicare doesn't payment. I cannot appeal if Medicare work, and I cannot appeal to see if Medicare work.	e paid now, but I o me on a Medicare sponsible for SN. If Medicare uctibles. edicare. You may icare is not billed. with this choice I
notice or Medicare billing, call 1-800-	an official Medicare decision. If you have other MEDICARE (1-800-633-4227/TTY: 1-877-486-2 received and understand this notice. You may as	2048).
I. Signature:	J. Date:	

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 0938-0566. The time required to complete this information collection is estimated to average 7 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 comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

A. Notifier: Chiro-Med & Rehab C. Identification Number: B. Patient Name: 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. F. Estimated Cost E. Reason Medicare May Not Pay: D. Only adjustments are covered by Medicare Rehab and modalities \$65/ visit and Medicaid, no other services 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. Check only one box. We cannot choose a box for you. G. OPTIONS: listed above. You may ask to be paid now, but I □ OPTION 1. I want the D.\_\_ 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. listed above, but do not bill Medicare. You may OPTION 2. I want the D. ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

## H. Additional Information:

OPTION 3. I don't want the D.

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.

am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

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.

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listed above. I understand with this choice I

## Southwestern Vermont Medical Center

100 Hospital Drive Bennington, VT 05201



## **Authorization for Release of Information**

Patient Name:		Date of B	irth:	MR #:
Factoria Name.	Please Print			
Address:		D. D.		
		Please Print		
I hereby authorize SVHC the use that the information I authorize a privacy regulations. This authori	person or entity tradition is valid for	1 year unless otherw	ise specified	ind initial biorected by ledgian
Name and Address of Persons/O	rganizations auth	orized to receive info	rmation:	
Specific description of information	n that may be use	ed/disclosed and date	s of service:	
X-ray Films and Report		History and Physical		
Office Notes		Operative Note		
ER Report		Outpatient Departme	ent	
Discharge Summary		Other		
				Describe
placed on history of illness, diag psychiatric impairment, HIV/AIDS  The information will be used / dis	nostic or therapet 3 related illnesses	or genetic testing.	ing any treat	y health record with no limitations ment for alcohol and drug abuse,
Requested by the patient an			lose purpose	).
Insurance Claim	a for the panetti (	,		•
Other: (Describe)				
sign this form to ensure hea	Ithcare treatment.			s authorization. I do not need to
I understand that I may insp				in writing, except to the extent
that.			mymg Svrio	in writing, except to the extent
Action has been taken     If this authorization is     right to contest a claim	obtained as a co	ndition of obtaining co	overage, othe	er law provides the insurer with the
Signature of Patient	or Patient Representa	tive		Date
Relations	nip to patient, or repre	sentative's authority to act	for the patient	(if applicable)
Request Received:	Date Proce			copy of Authorization given to the ndividual
Date			ial of person	finalizing request:
				•





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## **Release of information**

Name:	
Date of birth:	Ŧ.
Telephone number:	
I authorize the release of requested information for medical care purposes only relating to my treatment at Chiro-Med & Rehab.	•
Information to be included- office notes, consultation notes, surglaboratory results, radiology reports and images.	jical notes,
Said information may be released via fax, mail, email and/or pho	one.
This form expires in one year	
This form does not expire	
Signature:	_ Date: