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.

Please note- 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

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.

Thank you for your understanding regarding these policies.

Signature:____ Date:_________

*****For Medicare/ Medicaid patients only*****

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 **mandatory**, 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 Express / 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:___________________

Southwestern Vermont Medical Center

100 Hospital Drive
Bennington, VT 05201

Authorization for Release of Information

Patient Name: ______________________________ Date of Birth: __________ MR #: __________
Please Print

Address: ____
Please 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:

____

____

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   Date Processed: __________ Date   ☐ Copy of Authorization given to the individual

Initial of person finalizing request: __________

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Release of information

Name: ______________________________________

Date of birth: _________________________________

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, surgical notes, laboratory results, radiology reports and images.

Said information may be released via fax, mail, email and/or phone.

__ This form expires in one year

__ This form does not expire

Signature: ____________________________________ Date: _______________