**Murphy Chiropractic & Wellness, P.A.**
**Dr. Jerry Murphy, D.C.**
1114 S. Long Drive
Rockingham, NC 28379
Phone: 910-817-7126
Fax: 910-817-7013

**What to Expect**

We want to thank you for choosing Murphy Chiropractic & Wellness to be a part of your healthcare team. Chiropractic care is not a "one and done" appointment, though we do see numerous patient's that feel much better after their first adjustment. Your treatment plan is specific to you and it is important that you do not miss your appointments. You will notice at the beginning of your treatment that you may be scheduled to come 2-3 times a week. You are being seen more frequently at the beginning because we are working to change your body's "bad habits." Your first adjustment may only last a few hours and each adjustment builds upon the one prior and in time your body will naturally begin to "hold" the adjustment for longer periods of time. When we see you reaching this point in your treatment, we will re-evaluate you and hopefully begin to transition you to wellness visits when you may come once a month!

**Appointments**

Our chiropractic appointments are scheduled every 15 minutes throughout the day and massage appointments can range from 30 minutes to an hour and a half. We make reminder phone calls daily for all appointments for the following day. Many times when we can't reach you by phone we are unable to leave a voicemail due to your mailbox being full or not being set up. We encourage all patients to please make sure your voicemail is set up, and please check your messages as it may be an appointment reminder.

Because we dedicate time to make these reminder calls, we have instated a missed/no show appointment policy. We require at least 24 hours' notice of cancellation or rescheduling. Failure to do so will result in a missed/no-show appointment fee. **This fee is not covered by insurance and will be your responsibility.** Forgetting your appointment, over-sleeping, or last-minute work or social obligations are not considered emergencies, so a missed/no-show appointment fee will be charged to you in those circumstances.

Also, if you to additional time with Dr. Murphy beyond a regular adjustment appointment, we ask that you let us know in advance so we can schedule you for a consultation in order to provide the extra time needed to discuss any questions, concerns or new complaints/areas of pain that you may have. We value your time and ours and are striving daily to keep your wait times as minimal as possible.

**Late for your appointment**

If you are more than 15 (fifteen) minutes late for your appointment you may not be treated or you may receive an abbreviated treatment within the time constraints of your originally scheduled appointment.

**Reschedule/Cancellation Policy**

In order to be respectful of other patient's needs, please be courteous and call us promptly if you are unable to show up for your appointment. We are a "high volume" office and appointments are in high demand. Your early cancellation or rescheduled appointment will be reallocated to someone who may be waiting for an appointment time to open.

If you need to reschedule or cancel an appointment, please do so at least 24 hours in advance. If you call after regular business hours, please leave us a voicemail.

If you reschedule or cancel your appointment on the **same day**, you will be charged a fee for your appointment. If you are scheduled for a massage appointment, and we do not receive confirmation by 5:00 pm the day before your appointment, your appointment may be rescheduled to a later date.

**Chiropractic** - $15 fee **Massage** - $25 fee

**Missed Appointment/No-Show**

If you miss an appointment without calling to notify the office at least 24 hours in advance you will be charged the fee(s) as listed above.

If you miss 3 or more consecutive appointments, you may be transitioned to a once a month wellness patient.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

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# Medicare Patient Paperwork

Date

First Name | Last Name | DOB | Sex ◯ Male ◯ Female | SSN XXX—XX—_____ | Address | City | State | Zip Code

Phone 1 ◯ Home ◯ Mobile ◯ Work ◯ Other

Phone 2 ◯ Home ◯ Mobile ◯ Work ◯ Other

Fax | Email | Employer | Employer Phone | Occupation

Job Status
◯ Not Employed ◯ Employed ◯ Part-Time Student ◯ Retired ◯ Full-Time Student

Marital Status
◯ Single ◯ Married ◯ Other

Receive Appointment Reminders
◯ Declined ◯ Voice ◯ Text ◯ Email

Height ' " Weight lbs

**Reason For Visit:** ◯ New Patient ◯ Adjustment ◯ Physical ◯ Consultation ◯ X-Rays ◯ Therapy ◯ Injury ◯ Report of Findings ◯ Auto Accident ◯ Re-Examination ◯ Other

**Referred By:** ◯ Provider ◯ Friend ◯ Family ◯ Other
Referred By Name

**How Heard of Us:** ◯ Walk in ◯ Referral ◯ Phone Book ◯ Website ◯ Advertisement ◯ Other

## Demographics

**Race:** ◯ White ◯ Black or African American ◯ American Indian or Alaska Native ◯ Asian ◯ Native Hawaiian or Other Specific Islander ◯ Other

**Ethnicity:** ◯ Hispanic or Latino ◯ Non- Hispanic or Latino ◯ Unknown ◯ Other

**Dominance:** ◯ Right ◯ Left ◯ Ambidextrous

## Emergency Contact Information

First Name | Last Name | Relationship | Phone 1 | Phone 2

## Daily Habits

**Do you smoke?** ◯ Never smoked ◯ Unknown if ever smoked ◯ Unknown if currently smokes ◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker

If yes, how many packs per day? How many years?

**Daily Caffeinated Beverages:** ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

**Weekly Alcoholic Drinks:** ◯ Unknown ◯ None ◯ 1 to 3 ◯ 4 to 6 ◯ 7 to 10 ◯ 11 to 15 ◯ 16 to 20 ◯ 21 to 25 ◯ Over 25

**Do you exercise regularly?** ◯ no ◯ light ◯ moderate ◯ heavy

## Health History

**Medications/Vitamins/Supplements:**

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Surgeries:**

| | | | |
|---|---|---|---|
| | | | |
| | | | |

**Traumas:**

| | | | |
|---|---|---|---|
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| | | | |

**Allergies:**

| | | | |
|---|---|---|---|
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| | | | |
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| | | | |

**Illnesses:** Please check all that apply

| | | | | |
|---|---|---|---|---|
| ☐ AIDS/HIV | ☐ Chronic Fatigue | ☐ Heart Disease | ☐ Miscarriage | ☐ Seizures |
| ☐ Anemia | ☐ Depression | ☐ Hepatitis | ☐ Multiple Sclerosis | ☐ Stroke |
| ☐ Arthritis | ☐ Diabetes | ☐ Hernia | ☐ Osteoporosis | ☐ Suicide Attempt |
| ☐ Asthma | ☐ Emphysema | ☐ Herniated Disc | ☐ Pacemaker | ☐ Thyroid Problems |
| ☐ Bleeding Disorders | ☐ Epilepsy | ☐ High Blood Pressure | ☐ Parkinson's Disease | ☐ Tuberculosis |
| ☐ Breast Lump | ☐ Fibromyalgia | ☐ High Cholesterol | ☐ Pinched Nerve | ☐ Tumors/Growths |
| ☐ Bronchitis | ☐ Fractures | ☐ Immune Deficiency | ☐ Prostate Problems | ☐ Ulcers |
| ☐ Cancer | ☐ Gallstones | ☐ Kidney Disease | ☐ Prosthesis | ☐ Vaginal Infections |
| ☐ Chemical Dependency | ☐ Glaucoma | ☐ Liver Disease | ☐ Psychiatric Disorder | ☐ Venereal Disease |
| ☐ Chicken Pox | ☐ Gout | ☐ Migraine Headaches | ☐ Rheumatoid Arthritis | ☐ Whooping Cough |

☐ Other _____

Is there any history in your family for any of the above conditions?

Who? _____

What did they have? _____

**Complaints:**

☐ **Neck** ☐ **Mid Back** ☐ **Low Back** ☐ **Left Shoulder** ☐ **Right Shoulder** ☐ **Left Knee** ☐ **Right Knee**

☐ **Left Elbow** ☐ **Right Elbow** ☐ **Left Wrist/Hand** ☐ **Right Wrist/Hand** ☐ **Left Ankle/Foot** ☐ **Right Ankle/Foot**

☐ **Other:** _____

**Does the pain travel anywhere else?** ☐ **No** ☐ **Yes. If yes, where?** _____

**Do you know what caused the problem?** _____

**Do you notice the pain during a certain time of day?** ☐ **No** ☐ **Yes. If yes, when?** _____

**Frequency:** ◯ **Constant (76-100%)** ◯ **Frequent (51-75%)** ◯ **Intermittent (26-50%)** ◯ **Occasional (1-25%)**

**Duration:** ◯ **Constant (>8 hrs)** ◯ **Frequent (6-8 hrs)** ◯ **Intermittent (3-5 hrs)** ◯ **Occasional (1-3 hrs)** ◯ **Infrequent (<1 hr)**

**Onset: When did the symptoms/pain begin?** _____

**Intensity:** ◯ **Slight** ◯ **Mild** ◯ **Moderate** ◯ **Severe**

**Is your condition:** ◯ Same ◯ Better ◯ Worse

**Rate your pain:** ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

*0 being no pain at all and 10 being the worst pain imaginable*

**Quality: Describe your pain:** ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb ☐ radiating ☐ sharp ☐ shooting ☐ sore ☐ stabbing ☐ stiff ☐ swelling ☐ tight ☐ tingling ☐ throbbing

**Aggravating Factors: What makes the problem worse?** ☐ nothing ☐ most movements ☐ bending ☐ carrying things ☐ coughing ☐ driving ☐ eating ☐ exercise ☐ going down stairs ☐ going from lying to sitting ☐ going from lying to standing ☐ going from sitting to standing ☐ heat ☐ housework ☐ ice ☐ jogging ☐ lifting ☐ lying down ☐ massage ☐ pulling ☐ pushing ☐ running ☐ sitting ☐ sleeping ☐ sneezing ☐ squatting ☐ standing ☐ standing for a long period of time ☐ stress ☐ stretching ☐ taking a deep breath ☐ turning ☐ twisting ☐ walking ☐ working

**Relieving Factors: What makes the problem better?** ☐ nothing ☐ anti-inflammatories ☐ bracing ☐ chiropractic care ☐ elevation ☐ exercise ☐ heat ☐ ice ☐ massage ☐ movement ☐ pain killers ☐ rest ☐ stretching ☐ walking ☐ wraps

**What daily activities are affected due to the problem?** ☐ bathing ☐ caring for children ☐ cleaning ☐ climbing stairs ☐ cooking ☐ doing laundry ☐ dressing ☐ driving ☐ eating ☐ exercising ☐ **going from laying down to sitting** ☐ going from sitting to standing ☐ grooming ☐ house work ☐ laying down ☐ lifting ☐ oral care ☐ sex ☐ shopping ☐ sitting ☐ sleeping ☐ social/recreational activities ☐ standing ☐ stretching ☐ toileting ☐ transferring ☐ using technology ☐ using phone ☐ walking ☐ watching tv ☐ working ☐ yard work

**Have you been given a diagnosis for this problem? If so, what was the diagnosis?** _____

**What treatment(s) have you tried for your condition?** ☐ None ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other _____

**Are you presently under the care of a physical and/or mental health care provider?** If so, by whom? _____

If so, what conditions? _____

**Energy Level:** ◯ Good ◯ Insufficient ◯ Erratic

**Sleep:** ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Restful ☐ Other _____

**Stress:** ◯ None ◯ Low ◯ Moderate ◯ Severe What causes stress? _____

**Have you had unexpected weight loss in the last 6 months?** ◯ Yes ◯ No If yes, how much? _____

## Review of Systems

**Musculoskeletal:** Please check all that apply ☐ None

☐ Arm/hand pain ☐ back pain ☐ Feet/leg pain ☐ hip ☐ Knee ☐ Lower back pain ☐ Mid back pain ☐ Muscle or joint pain
☐ Neck pain ☐ Redness of joints ☐ Shoulder(s) pain ☐ Stiffness ☐ Swelling of joints ☐ Upper back pain

**Cardiovascular/Respiratory:** Please check all that apply ☐ None

☐ Chest pain, pressure or discomfort ☐ Cold hands/feet ☐ Coughing up blood (hemoptysis) ☐ Coughing up phlegm
☐ Difficulty breathing ☐ Dizziness/lightheaded ☐ Fainting ☐ Irregular heartbeat ☐ Palpitations ☐ Persistent Coughing
☐ Shortness of breath ☐ Sudden awakening with a shortness of breath (paroxysmal nocturnal dyspnea)
☐ Swelling (edema) ☐ Tightness in chest ☐ Wheezing ☐ Other _____

**Head/Neck:** Please check all that apply ☐ None

☐ Dizziness ☐ Facial pain ☐ Grinding Teeth ☐ Headache ☐ Head injury ☐ Hoarseness ☐ Jaw Clicks ☐ Lumps
☐ Migraines ☐ Pain ☐ Sore throat ☐ Stiffness ☐ Swollen Glands ☐ Tooth problems ☐ Trouble swallowing
☐ Other _____

**Eyes:** Please check all that apply ☐ None

☐ Blurred Vision ☐ Burning ☐ Cataracts ☐ Double vision ☐ Dryness ☐ Flashing lights ☐ Glasses/Contacts ☐ Glaucoma
☐ Itching ☐ Pain ☐ Redness ☐ Specks ☐ Vision Problems ☐ Other _____

**Ears:** Please check all that apply ☐ None

☐ Buzzing in ears ☐ Decreased hearing ☐ Drainage ☐ Earache ☐ Ear infections ☐ Poor balance ☐ Poor hearing
☐ Ringing in ears (tinnitus) ☐ Other _____

**Nose:** Please check all that apply ☐ None

☐ Allergies ☐ Blocked Sinuses ☐ Discharge ☐ Excessive mucus ☐ Hay fever ☐ Itching ☐ Nose bleeds
☐ Sinus pressure/pain ☐ Stuffiness/blockage ☐ Other _____

**Throat/Mouth:** Please check all that apply ☐ None

☐ Bleeding ☐ Blue lips ☐ Braces ☐ Dentures ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness
☐ Mouth pain ☐ Non healing sores ☐ Redness ☐ Sore throat ☐ Sores on lips or tongue ☐ Swelling
☐ Thrush ☐ Tooth pain ☐ Other _____

**Urinary:** Please check all that apply ☐ None

☐ Blood in urine (hematuria) ☐ Burning or pain ☐ Difficulty urinating ☐ Frequent urinary tract infections
☐ Frequent urination ☐ Incontinence ☐ Kidney infections ☐ Kidney stones ☐ Unable to hold urine (incontinence)
☐ Up at night to urinate ☐ Urgency ☐ Water retention ☐ Other _____

**Gastrointestinal:** Please check all that apply ☐ None

☐ Change in appetite ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Nausea
☐ Rectal bleeding ☐ Swallowing difficulties ☐ Yellow eyes or skin (jaundice) ☐ Other _____

**Endocrine:** Please check all that apply ☐ None

☐ Change in appetite ☐ Cold intolerance ☐ Constipation ☐ Diarrhea ☐ Dry skin ☐ Excessive thirst
☐ Frequent urination ☐ Heat intolerence ☐ Sweating

## Review of Systems

**Vascular/Hematologic:** Please check all that apply ☐ None

☐ Calf pain with walking (claudication) ☐ Cold hands and feet ☐ Ease of bleeding ☐ Ease of bruising ☐ Leg cramping

**Neurologic:** Please check all that apply ☐ None

☐ Dizziness ☐ Easily angered/irritated ☐ Fainting ☐ Frequent crying ☐ Memory confusion ☐ Nervousness ☐ Neuralgia

☐ Numbness ☐ Poor concentration ☐ Seizures ☐ Suicidal thoughts ☐ Tingling ☐ Tremors ☐ Weakness

☐ Worry/anxiety ☐ Other _____

**Psychiatric:** Please check all that apply ☐ None

☐ Anxiety ☐ Depression ☐ Memory loss ☐ Nervousness ☐ Stress ☐ Other _____

**Female:**

Are you pregnant? ○ Yes ○ No Date of last period _____ Number of days between periods _____

Age started _____ Age stopped _____

Number of pregnancies _____ Number of deliveries _____ Number of miscarriages _____

Number of abortions _____ Number of Cesareans _____ Operations ☐ Cervix ☐ Uterus ☐ Ovaries

Please check all that apply ☐ None

☐ Clotting ☐ Dark color ☐ Discharge ☐ Food cravings ☐ Heavy bleeding ☐ Hot flashes ☐ Infections

☐ Irregular periods ☐ Itching or rash ☐ Leg cramps ☐ Light bleeding ☐ Little/no sex drive ☐ Menstrual pain/cramps

☐ Missed periods ☐ Mood swings ☐ Painful breasts ☐ Pain with sex ☐ STD's ☐ Vaginal discharge

☐ Vaginal dryness ☐ Vaginal sores ☐ Water retention ☐ Other _____

### Acknowledgment of Non-Pregnancy Status

I hereby expressly acknowledge that I am not pregnant at the present time and that Dr. Murphy and Murphy Chiropractic and Wellness, P.A., is hereby expressly authorized and directed to complete a radiographic examination (X-rays) in connection with my chiropractic treatment.

_____ _____/_____/_____

***Patient's Signature*** Date

**Male:** Please check all that apply ☐ None

☐ Discharges ☐ Erectile dysfunction ☐ Hernia ☐ Impotence ☐ Low sex drive ☐ Masses or pain ☐ Painful urination

☐ Pain with sex ☐ Painful discharge ☐ Prostate problems ☐ Sores ☐ STD's ☐ Other _____

# ASSIGNMENT OF INSURANCE BENEFIS

_____ _____/_____/_____
***Patient's Name*** Patient's Date of Birth

_____ _____/_____/_____
***Insured's Name*** Insured's Date of Birth

I authorize and direct that payment be made directly to:

***Murphy Chiropractic and Wellness, P.A., 1114 S Long Drive, Rockingham, NC 28379***

For any and all insurance benefits or reimbursement for services rendered by Murphy Chiropractic and Wellness, PA which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

## Release of Information

By signing below, I authorize the release of any information concerning my health and health care services to my insurance companies, other health care professionals, or hospitals when necessary for diagnosis, assessment, or treatment of my health condition. I also authorize the release of any health information and billing records to another party if they are potentially responsible for payment of my services.

## Payment Agreement

I understand that there is no guarantee that my insurance companies or my pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges. I also understand that if my account becomes delinquent, Murphy Chiropractic and Wellness, PA will utilize the services of a collection agency. If this action is needed, I will be responsible for any additional fees accumulated to collect my outstanding balance.

## Consent to Care

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below or any other office or clinic.

I have had an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. In do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the facts then known to him or her, is in my best interest.

I have read, or have read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

## *HIPAA Privacy Practices*

I acknowledge that I have received and/or have been given the opportunity to review this Chiropractic Office's Notice of HIPPA Privacy Practices for protected health information.

## Consent of Treatment of a Minor

I hereby authorize Dr. Murphy and Murphy Chiropractic and Wellness, P.A., together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward.

_____
***Patient Name***

_____ _____/_____/_____
***Patient or Legal Guardian Signature*** ***Date***

# AUTHORIZATION OF ASSIGNMENT AND LIEN

I hereby authorize and direct any and all insurance carriers, attorneys, and/or other legal entities which may elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future to pay directly and exclusively in the name of Murphy Chiropractic and Wellness, PA such sums as may be owing to Murphy Chiropractic and Wellness, PA for charges incurred by me at the office relating to my condition.

I further grant a lien to Murphy Chiropractic and Wellness, PA with respect to my charges. This lien should apply to all payers and to the full extent permitted by law. For the purposes of this document benefits shall include, but not be limited to proceeds for any settlement, judgement, or verdict as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payment benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, disability benefits, worker's compensation and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in North Carolina; I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers to facilitate collection under this Assignment and Lien.

I further authorize and direct all payers to release to Murphy Chiropractic and Wellness, PA any information regarding any coverage or benefit which I may have including, but not limited to, the amount of coverage, the amount paid thus far, and the amount of any outstanding claims.

I hereby direct this office to file a copy of this Assignment and Lien, together with any applicable charges, with any and all payers, regardless of whether a claim has been established with said payers.

I hereby authorize Murphy Chiropractic and Wellness, PA to endorse/sign my name on any and all checks listing me as a payee, which are presented to this office for payment of an account relating to me. I further authorize Murphy Chiropractic and Wellness, PA to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me.

I hereby authorize and direct my attorney to disclose upon the request of Murphy Chiropractic and Wellness, PA, any settlement amounts or any offers made on my case from any potential payers.

I understand that I may remain personally responsible for the total amounts due to Murphy Chiropractic and Wellness, PA for their services. This Assignment and Lien does not constitute any consideration for this office to await payments and it may demand payments from me immediately upon rendering services at its option. If this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Murphy Chiropractic and Wellness, PA for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Murphy Chiropractic and Wellness, PA and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

Patient Name (please print):_____ Date: _____/_____/_____

Patient Signature:_____

**If patient is under the age of 18:**

Name of Custodial Parent or Legal Guardian (please print):_____

Parent/Guardian Signature:_____

# Medicare Member Consent for Non-Covered Services

Provider Name: _____ Phone Number: _____

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

Chiropractic services that are covered by your health plan's chiropractic benefit, and eligible for reimbursement include:

- Manual manipulation of the spine to correct subluxation.

As your Doctor of Chiropractic, I want to provide you with the best care possible. In addition to spinal manipulations, there are other chiropractic services that are necessary to support my treatment, or that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health plan.

Services that are **not covered** by your health plan's chiropractic benefit, and not eligible for reimbursement, are outlined below. These services will be your financial responsibility **should you elect to receive them**. Your financial responsibility is limited to services received during the treatment plan as defined below.

**Treatment plan start date:** _____ **Treatment plan end date:** _____

Note: The defined treatment plan can not be more than 12 weeks long and should align with any applicable authorization denial

| Non-Covered Service | Cost Per Visit* | Member Initials/Date |
|---|---|---|
| Exam(s) | | |
| Manipulation (for maintenance care or wellness) | | |
| X-ray(s) | | |
| Therapies/Modalities (Circle All Applicable Therapies)<br>Electrical Stimulation Acupuncture Other: _____<br>Ultrasound Exercise Education | | |
| Durable Medical Equipment (Circle All Applicable Products)<br>Braces Orthotics<br>Ice Pack Other:_____ | | |
| Massage | | |
| Other: | | |

*Patient's billed amount may not exceed the provider's usual and customary amount

**For office use only**

These services are not eligible for reimbursement through your health plan because (check one):

- ☐ They were determined to be maintenance or elective care, rather than treatment to improve a clinical condition, through the organization determination process
- ☐ They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition

**Provider/Authorized Health Care Representative Signature:**_____

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. **I understand that I have the right to refuse this care and request a prior authorization prior to receiving care. I understand that by signing this form, and receiving care at this time, I acknowledge that I am fully aware that the services listed above are not covered by my health plan and that I will be fully responsible for the total billed charge(s) related to the non-covered services.**

_____ Date: _____

Patient's Name

_____

Patient or Authorized Representative Signature

**A copy of this signed form must be provided to the patient upon request**

**A. Notifier:**

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

# Advance Beneficiary Notice of Noncoverage (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 |
|---|---|---|
| | | |

**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:**

**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: |
|---|---|
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