MEDICARE PATIENT INFORMATION

CONFIDENTIAL PATIENT INFORMATION

Name: _____ Sex: ___ Marital Status: _____ DOB: _____ Age: _____

SSN: _____ Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Would you like appointment reminders? E-Mail _ Yes _ No Text Message _ Yes _ No If yes, phone carrier: _____

Employer: _____ Occupation: _____

Spouse: (if applicable) _____ Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If child, guardian's name: _____ Phone Number: _____

Do you have Health Insurance? (circle) YES NO If yes, please provide front desk with copy of insurance card(s).

Who referred you to, or how did you hear about our office? _____

Is you visit due to an accident? (circle) YES NO If yes, please see front desk for an injury report)

Your present complaints/symptoms: _____

_____

List other doctor(s) seen for this condition: _____

_____

Personal Medical History (if any of the following are relative to your medical history, please circle all that apply).

Cancer	Muscular	Rheumatic Fever	Digestive Disorders	Polio
M.S.	Scarlet Fever	Sinus Trouble	T.B.	Convulsions
Nervousness	Backaches	H.B.P.	Epilepsy	Asthma
Numbness	Heart Trouble	Concussion	Dizziness	Arthritis
Diabetes	Hepatitis	German Measles	Venereal Disease	

Have you ever had chiropractic care? Yes No Date of last adjustment? _____
Have you ever had massage before? Yes No Date of last massage? _____
Have you ever had acupuncture before? Yes No Date of last session? _____
Describe any operations you've had and dates: _____
Have you been treated by a physician for any health conditions in the past year? Yes No, If so, please describe:
_____ Date of Last Exam: _____

Are you taking any medication? (circle) Yes No: If yes, please list: _____

Are you pregnant? Yes No Date of last menstrual period: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in the collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse coinsurance remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately and payable unless prior arrangements are made. I hereby authorize East Vancouver Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I certify that the above information is true and correct.

Patient's Signature _____ Date

((Printed name if signed on behalf of patient _____ Relationship

East Vancouver Chiropractic, Massage & Acupuncture
13025 NE Fourth Plain Blvd, Suite 102, Vancouver, WA 98682
360-718-8240

The following is an explanation of our office policies. We believe that a clear understanding will allow us both to concentrate on the most important issues: regaining and maintaining your health. We will be happy to answer any question you may have regarding our policies, your account or insurance coverage.

Complimentary Consultation

East Vancouver Chiropractic will conduct a special "no charge" consultation, or a brief conference, with anyone interested in finding out if chiropractic can help with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient's health needs are paramount. Therefore, the following Patient Care services policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

Patient Care Services

Payment in full for all services is due at the time of service unless other arrangements have been made. Payment arrangements may be made with the office and payments must be made no less than monthly. Please understand that all services rendered to you are charged directly to you and you are responsible for payment, regardless of your insurance coverage. Properly documented Worker's Compensation and Auto Accident Claims are NOT required to pay at the time of service if appropriate forms and liens are signed.

Our Policy on Health Insurance

Many Insurance policies cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to ensure you receive reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. It is important that you understand that health and accident insurance policies are an arraignment between an insurance carrier and you, the patient, their insured. Of course, East Vancouver Chiropractic will prepare any necessary reports and forms to assist you in collecting from your insurance company. Furthermore, any amount authorized to be paid directly to East Vancouver Chiropractic will be credited to your account upon receipt.

Appointments

In order to better serve our patients we ask that you call if you are unable to make your appointment or if you are running late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Our office has a $25.00 no show/late cancellation charge if we fail to receive a 24 hours notice for chiropractic and a $25.00 - $65.00 no show fee for massage and acupuncture therapy. Please call our office as soon as possible if you are not going to make your scheduled appointment.

Identification Policy

East Vancouver Chiropractic requires a copy of photo identification (ex: drivers license, passport, student ID) be on file in order to receive care. Also, we require an electronic photo to be taken and placed into your medical chart for verification purposes.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask the Doctor or any available staff member. We will make every effort to answer and address your concerns.

I have read the East Vancouver Chiropractic clinic policies and agree to honor them:

_____

Patient Signature Date

_____

Printed name if signed on behalf of patient Relationship

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see you record or get more information about it by contacting East Vancouver Chiropractic.

Our **Notice of privacy practice** describes in more detail how your health information may be used and disclosed, and how you can access your information.

- **You may refuse to sign this acknowledgement***

By my signature below, I acknowledge receipt of the Notice of Privacy Practice

_____

Patient's Signature Date Time

_____

Printed name if signed on behalf of patient Relationship

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): _____

_____

Additional Disclosure Authority

In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Name Relationship

_____

_____

_____

_____

We like to keep your primary care provider up to date with our findings and treatment. Please indicate if you would like chart notes sent to:

Primary Care Provider: Yes ____ No ____ If yes, providers name:_____

_____

Patient's Signature _____ Date

Printed name if signed on behalf of patient _____ Relationship

East Vancouver
CHIROPRACTIC
& Massage Therapy

NOTICE OF LIKELIHOOD OF INSURANCE DENIAL OF BENEFITS

I understand that my insurance company may deny payment for the services provided to you for the following reasons:

That the particular service is not reasonable and necessary under my insurance companies' standards.

For this reason, please read and sign the following statement:

"I have been informed by my physician that he believes that, in my particular case, my insurance may deny payment for the services identified above, for the reasons stated. If my insurance denies payment I agree to be personally responsible for payment of said services. "

Patient Signature Date

Printed name if signed on behalf of patient Relationship

ASSUMPTION OF FINANCIAL RESPONSIBILITY
****Explanation of benefits disclaimer****

I, the undersigned patient, completely understand that East Vancouver Chiropractic provides insurance billing and insurance benefit verification as a courtesy to their patients, I understand that the service East Vancouver Chiropractic provides for verification of insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits to East Vancouver Chiropractic, the balance of my account will be billed to me and due to the clinic.

It is the policy of East Vancouver Chiropractic to never enter into a dispute with your insurance company for any reason.

I, undersigned patient, completely understand the insurance services provided to me regarding my insurance coverage as stated above. I understand that my signature below serves as a "signature on file' to bill the above insurance company and allows this clinic to accept assignment of insurance benefits. I understand the above" Benefits Disclaimer" and my financial responsibilities to any services rendered by this clinic.

I understand that East Vancouver Chiropractic, may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any copay, deductible and coinsurance at time of service. This may offer a reduced fee for paying at the time of service rendered.

Patient Signature Date

Printed name if signed on behalf of patient Relationship

East Vancouver Chiropractic & Massage Therapy
13025 NE Fourth Plain Blvd.,Suite 102 Vancouver, WA 98682

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. #1 or #2** 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. #1 or #2** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
# 1: Chiropractic Adjustments	**#1: Medicare may determine that a particular service is not "Reasonable and Necessary" under Medicare program standards.**	**#1: $55**
#2: Chiropractic Examinations	**#2: Is not a covered service under Medicare Part B program standards.**	**#2: $75**

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. #1 or #2** 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. #1 or #2** 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. #1 or #2** 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. #1 or #2** 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: