

## PATIENT REGISTRATION AND HISTORY

### DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MI
ADDRESS: _____		
CITY: _____	STATE: _____	ZIP: _____
HOME PHONE NUMBER: _____		CELLPHONE NUMBER: _____
E-MAIL ADDRESS: _____		
SEX: <input type="checkbox"/> M <input type="checkbox"/> F DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____		
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
EMPLOYER: _____		OCCUPATION: _____
EMERGENCY CONTACT NAME: _____		RELATION: _____
PHONE NUMBER: _____		HOW DID YOU HEAR ABOUT US? _____

### INSURANCE INFORMATION

#### HEALTH INSURANCE INFORMATION

INSURANCE COMPANY: _____	
POLICY NUMBER: _____	GROUP NUMBER: _____
POLICY HOLDERS NAME: _____	DATE OF BIRTH: _____
RELATIONSHIP TO POLICY HOLDER: _____	

#### SECONDARY HEALTH INSURANCE INFORMATION

INSURANCE COMPANY: _____	
POLICY NUMBER: _____	GROUP NUMBER: _____
POLICY HOLDERS NAME: _____	DATE OF BIRTH: _____
RELATIONSHIP TO POLICY HOLDER: _____	

### MEDICAL DOCTOR(S)

*Please List ALL Doctors involved in your healthcare, present and past. (Use back if necessary)*

	Name	Phone
Primary / Family Doctor:	_____	_____
Orthopedic Doctor:	_____	_____
Pain Management:	_____	_____
Neurologist:	_____	_____
Chiropractor:	_____	_____
Other:	_____	_____



## CURRENT MEDICAL COMPLAINTS

What are your present complaints? (*Location of pain, etc.*) \_\_\_\_\_

Use an "X" on the drawing to mark where you are experiencing pain (*or other symptoms*).

When did these symptoms first appear? \_\_\_\_\_

Do your symptoms interfere with:    Sleep    Daily routine    Work    Recreation

Are you working less hours / days as a result of your injuries?    Yes    No

If yes, please explain \_\_\_\_\_

Activities or movements that are painful to perform:

Sitting    Standing    Walking    Bending    Lying Down

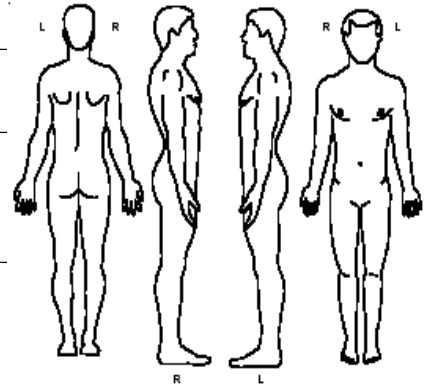
How would you rate your symptoms:    Mild    Moderate    Severe

How would you rate your current symptoms (pain):    0    1    2    3    4    5    6    7    8    9    10

No Symptoms

Worst Possible

Since the accident (*if applicable*), are your symptoms:    Improving    Unchanged    Worsening



## HOSPITALIZATION/ EXAM HISTORY

Have you been to the hospital for *this* condition?    Yes    No   If yes, name of hospital? \_\_\_\_\_

When did you go? \_\_\_\_\_ How did you get there?    Ambulance    Self    Others

Were x-rays taken?    Yes    No   If yes, what area(s)? \_\_\_\_\_

Were you prescribed any medication?    Yes    No

If yes, what medications? \_\_\_\_\_

Have you seen any other doctor or received any other treatment for your current condition?    Yes    No

If yes, explain \_\_\_\_\_

Doctor's name and address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date(s) seen: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

### **DIAGNOSTIC TESTING YOU MAY HAVE RECEIVED: (place "X" in boxes that apply)**

<u>Test</u>	<u>Region / Body Part(s)</u>	<u>Date(s)</u>	<u>Test</u>	<u>Region / Body Part(s)</u>	<u>Date(s)</u>
<input type="checkbox"/> Examination	_____	_____	<input type="checkbox"/> EMG / NCV	_____	_____
<input type="checkbox"/> MRI / CT	_____	_____	<input type="checkbox"/> Other	_____	_____

## MEDICAL HISTORY

**INJURIES YOU MAY HAVE HAD IN THE PAST**                      Description    Date (s)

Auto Accident (s) \_\_\_\_\_

Work Injuries \_\_\_\_\_

Broken Bones \_\_\_\_\_

Falls \_\_\_\_\_

Other \_\_\_\_\_

**SURGERIES YOU MAY HAVE HAD FOR THIS CONDITION:**   Spine Surgeries    Discectomy    Laminectomy    Fusion

Other Surgeries \_\_\_\_\_ Date \_\_\_\_\_

### **NON-SURGICAL TREATMENTS YOU MAY HAVE RECEIVED FOR THIS CONDITION: (place "X" in boxes that apply)**

- Medication (*OTC / Prescription*)                       Injections     Physical Therapy (*Dates:* \_\_\_\_\_)
- Massage     Chiropractic     Acupuncture
- Other: \_\_\_\_\_
- List ALL Meds: \_\_\_\_\_

Female patients: Start date of most recent menstrual cycle: \_\_\_\_\_ Are you currently pregnant?    Yes    No



## MEDICAL REVIEW OF SYMPTOMS

**HAVE YOU EVER BEEN DIAGNOSED AS HAVING OR SUFFERING FROM: (place "X" in boxes that apply)**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Muscle disorder          | <input type="checkbox"/> Lungs, Asthma          | <input type="checkbox"/> Osteoarthritis           | <input type="checkbox"/> Tension               |
| <input type="checkbox"/> Nervous System Disorder  | <input type="checkbox"/> Broken Bones           | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Cold Sweats           |
| <input type="checkbox"/> Bone Disorder            | <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Night Pain            |
| <input type="checkbox"/> Rheumatoid Arthritis     | <input type="checkbox"/> Pace Maker             | <input type="checkbox"/> Drug Addiction           | <input type="checkbox"/> Nausea                |
| <input type="checkbox"/> Allergies                | <input type="checkbox"/> Seizures/Convulsions`  | <input type="checkbox"/> Strokes                  | <input type="checkbox"/> Cold Feet             |
| <input type="checkbox"/> HIV                      | <input type="checkbox"/> A Congenital Disease   | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Gallbladder              | <input type="checkbox"/> Excessive Bleeding     | <input type="checkbox"/> Ulcer                    | <input type="checkbox"/> Fever                 |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Hernias                  | <input type="checkbox"/> Fainting              |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Ears, eyes, nose, throat | <input type="checkbox"/> Sudden Weight Loss    |
| <input type="checkbox"/> Coughing Blood           | <input type="checkbox"/> Kidney, Bladder (GU)   | <input type="checkbox"/> Tumors                   | <input type="checkbox"/> Loss of Taste         |
| <input type="checkbox"/> Stomach, Intestines (GI) | <input type="checkbox"/> Circulatory Problems   | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Loss or Memory        |
| <input type="checkbox"/> Vertigo                  | <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Loss of Balance          | <input type="checkbox"/> Jaw Problems          |
| <input type="checkbox"/> Ringing in the ears      | <input type="checkbox"/> Neck Pain/Stiffness    | <input type="checkbox"/> Back Pain/Stiffness      | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Arm / Hand Pain          | <input type="checkbox"/> Leg / Knee Pain        | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Shortness of Breath   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Pins / Needles in Arms | <input type="checkbox"/> Pins / Needles in legs   | <input type="checkbox"/> Bowel/Bladder Changes |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Sleeping Difficulties  | <input type="checkbox"/> Loss of Smell            | <input type="checkbox"/> High Cholesterol      |
| <input type="checkbox"/> Blurred Vision           | <input type="checkbox"/> Light bothers Eyes     | <input type="checkbox"/> Nervousness              | <input type="checkbox"/> Heart Disease         |
| <input type="checkbox"/> Pinched Nerve            | <input type="checkbox"/> Herniated Disc         | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Arthritis             |
| <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Thyroid Problems      |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Do you have any weakness, numbness, or tingling in your arms or hands?      | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you suffer from headaches?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you experience any joint pain? If yes, signify where _____               | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you suffer from poor energy, fatigue and/or loss of sleep?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you experienced any loss of balance or dizziness?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you experienced forgetfulness or loss of mental clarity?               | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any issues maintaining your ideal weight?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you experience hot flashes, night sweats, or irritability with sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have pain in the morning or increases pain in the morning?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Other: _____   |                          |                          |

### MEDICATION LIST

PLEASE LIST ANY MEDICATIONS, SUPPLEMENTS OR VITAMINS THAT YOU MAY BE TAKING (INCLUDING DOSAGE)

Medication: _____ Route: Oral    Intravenous    Other: _____ Frequency: _____ Began Use: _____ Dosage: _____	Medication: _____ Route: Oral    Intravenous    Other: _____ Frequency: _____ Began Use: _____ Dosage: _____
Medication: _____ Route: Oral    Intravenous    Other: _____ Frequency: _____ Began Use: _____ Dosage: _____	Medication: _____ Route: Oral    Intravenous    Other: _____ Frequency: _____ Began Use: _____ Dosage: _____

(Please List Any Additional Medications on the Back of this Form)

Please List any Known Allergies:

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## HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with the office services. HIPAA provides certain rights and protection to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this via telephone, email, text, U.S. mail, etc. We may send you other communications informing you of changes to office policy and new technology that you may find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services unless written consent is provided by the patient.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, \_\_\_\_\_ do hereby acknowledge receipt of the HIPAA Information form and do consent to the terms set forth in the HIPAA Information form and any subsequent changes in office policy. I understand that this shall remain in force from this time forward.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## CRISP WAIVER

*Chesapeake Regional Information System for our Patients*

Maryland Spine Institute has chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at [www.crisphealth.org](http://www.crisphealth.org). Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

\_\_\_\_ I have read the waiver and agree to participate in the CRISP program to better assist in the coordination of my care.

\_\_\_\_ I will be opting out of participation in the CRISP program.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

## OFFICE AND ATTENDANCE POLICY

I understand to achieve optimal results I must follow the Doctor's prescribed treatment plan including performing my exercises and all prescribed modalities during my visits. Also, if my insurance company has not paid my claim within sixty (60) days I will be responsible to follow up on the status of payment.

I understand that I must schedule appointments **at least one month ahead of time**. If for some reason an appointment needs to be cancelled/ rescheduled, I must notify the office by phone 24 hours in advance. I understand that the practice allows 3 emergency cancellations per year without penalty. There will be a **\$25.00 service charge for:**

- A missed/no-show or cancelled appointment
- Failure to notify the office by phone within 24 hours in advance of a cancellation

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## MANAGED CARE SERVICE RELEASE

I authorize treatment by Maryland Spine Institute for the reason I presented at Maryland Spine Institute. I understand that if appropriate, Maryland Spine Institute will bill my Health Plan for services to be rendered. However, I also understand that pursuant to Maryland law, Maryland Spine Institute is authorized to bill me under the following conditions:

- I. When I choose to receive services covered under my benefit plan without a referral and/or authorization from my Health Plan, I understand that my Health Plan may require that I get a signed referral from my primary care physician and/or authorization from my Health Plan to receive covered services. If my Health Plan determines that I did not get a referral and/or authorization when I should have, I understand that I am responsible for payment for the services rendered.
- II. When I receive services that are not covered under my benefit plan, and if my Health Plan decides that the services, I receive are not covered under my benefit policy, I understand that I will be responsible for payment for the services rendered.
- III. When I receive any type of testing/diagnostic imaging after being triaged at Maryland Spine Institute, and I then elect to leave prior to being seen by a Provider, I will be responsible for paying out of pocket for those tests that were performed. These charges will be paid prior to leaving center.
- IV. I hereby authorize the Medical Provider to treat my condition as he/she deems appropriate and to furnish any authorized requests for information regarding treatment. It is understood and agreed that the amount paid to the Doctor for x-rays is for examination only and the x-ray negatives will remain the property of this office. They will be kept on file where they may be seen at any time while the patient is being treated at this office. The patient also agrees that he/she is responsible for all bills incurred at this office. (The Doctor will not be held responsible for any preexisting medically diagnosed conditions, nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Maryland Spine Institute submits claims to insurance carriers as a convenience to all our patients. Due to rising nonpayment of bills, we request authorization to bill a major credit card or debit card to cover amounts determined by your insurance company to be your responsibility. We recommend using a credit card. Payment for all services and products is due at the time of service.

Upon receipt of an explanation of benefits from your insurance carrier any unpaid portion of your claim will be billed, in accordance with your insurance carrier's determination of "Patient Responsibility", to your credit card or debit card automatically. Please note that the timing of this transaction is determined by your insurance company. Portico (Heartland) may be able to send an email prior to this transaction. We advise having funds available for 90 days from today's date of service. In the event your insurance pays your visit in full, your card will not be charged.

All patients that have a deductible plan with a remaining deductible balance, must either provide a credit card to be stored in Open Edge for any fees not paid by insurance company, OR pay the required deductible fee prior to visit.

All credit/debit card information will remain confidential and securely stored by Open Edge. Maryland Spine Institute will not store any banking account data.

I hereby authorize Maryland Spine Institute to charge any and all outstanding balances after insurance company reimbursement or denial, to my credit/debit card. I understand that I will not receive a statement if there is no balance due after processing my credit/debit card for payment.

I authorize Maryland Spine Institute to release my medical information to any specialists I may be referred to for follow-up care, as well as the following medical offices for the purpose of review and examination. I further authorize you to provide such copies as requested.

*I acknowledge receipt of the Maryland Spine Institute Managed Care Service Release:*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PAYMENT POLICY

I agree to be responsible for all charges not otherwise paid by third-party insurance. I understand that I am fully responsible for charges incurred for medical services received, which charges I expressly agree are reasonable. In the event that my account is referred to any attorney for collection, I agree to be responsible for and to pay my bill and all court cost, private process fees, and other cost of collection as well as attorney's fees in the amount of 20% of my bill, which sum I expressly agree is reasonable. In the event that my check is return unpaid for any reason whatsoever, I agree to pay in addition to the amount of the check the greater of twice the amount of the check plus a \$35.00 administrative charge or the maximum amount allowed by law. I acknowledge that this sum is a reasonable amount to compensate Maryland Spine Institute for the costs incurred by the issuance of any returned check. I understand that this is an agreement under seal and subject to a twelve statute of limitations.

*I acknowledge receipt of the Maryland Spine Institute's Payment Policy.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## **INFORMED CONSENT FORM**

### **The Nature of the Chiropractic Adjustment:**

The primary treatment use as a Doctor of Chiropractic is spinal manipulative therapy. The provider will use that procedure to treat you. The provider may use my hands or mechanical instrument upon your body in such a way as to mover your joints. That may cause an audible “pop” or “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

### **Analysis/ Examination/ Treatment:**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Palpation	Vital Signs
Range of motion testing	Orthopedic Testing	Basic Neurological
Muscle strength testing	Postural Analysis Testing	Hot/Cold therapy
Electrical Stimulation	Mechanical traction	Radiographic Studies
Cold Laser Therapy	Spinal Decompression	Physical therapy

Other Services as deemed necessary by the provider.

### **The Material Risk Inherent in Chiropractic Adjustment:**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The provider will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the provider.

### **The Probability of Those Risk Occurring:**

Fractures are rare occurrences and generally results from some underlying weakness of the bone which the provider check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described rare.

### **The Availability and Nature of Other Treatment Options:**

Other treatment options for your condition may include:

Self – administered, over-the-counter analgesics and rest

Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers

Hospitalization

Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

### **The Risks and Dangers Attendant to Remaining Untreated:**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain in reaction further reducing mobility. Overtime this process may complicate treatment making it more difficult and less effective the longer it is postponed.

By signing below, I have acknowledged the above explanations of chiropractic adjustment and related treatments, as well as the informed risks involved. I hereby give my consent for recommended treatment.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



**MEDICARE NOTICE FOR NON-PAYABLE SERVICES**

*\* For Medicare Patients Only \**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**NOTICE TO PATIENT**

Medicare does not pay for all services and items provided in this office even though we have a good reason to think you need them. Medicare only pays for covered services and items (e.g., spinal manipulation by a chiropractor). The below services and items are **non-payable** under Medicare when delivered and/or ordered by a Doctor of Chiropractic and you are responsible to pay for them.

All are listed at the time-of-service rate:

- Chiropractic Examinations \$212.40
- Chiropractic X-rays \$120.15
- Muscle Stimulation \$25
- Physical Therapy/Therapeutic Procedures \$35
- Orthotics \$ 225
- Spinal Decompression \$ 60
- Cold Laser Therapy \$ 25
- Supplements \$40
- Lumbar Braces \$362
- TENS \$ 75
- Home Use Traction \$85
- Pillows \$72
- Biofreeze-Pro \$ 22

**PATIENT ACKNOWLEDGEMENT:**

I acknowledge that I have been told in advance that the services and items listed above are non-payable by Medicare and I agree to pay for these services and items at the time the service or item is provided.

I have had ample opportunity to ask questions about my financial obligation and other treatment options. I acknowledge that I am signing this notice voluntarily and that it is not being signed after the products or services have been provided. I understand I have the right to refuse care and that by signing this form I am fully responsible for all non-covered services and products.

\_\_\_\_\_  
**PATIENT SIGNATURE**

\_\_\_\_\_  
**DATE**





A. Notifier:

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
<u>Maintenance</u> 98940 98941 98942	Medicare does not cover maintenance chiropractic adjustments	\$50 - \$80
<u>Office Visits/Exams</u> 99203 99214 99213	Medicare does not cover office visits or exams	\$100 +

### 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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**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).**

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.



## **ASSIGNMENT, LIEN, RELEASE, LETTER OF PROTECTION AND POWER OF ATTORNEY**

I, \_\_\_\_\_ (“Patient”), hereby authorize, grant and recognize the establishment of a lien in favor of Maryland Spine Institute (MSI) for all treatments, services, and surgeries performed and to be performed for Patient. This Lien and Security Agreement may include, but is not limited to, fees and costs originating from evaluation, consultation, rehabilitation, diagnostic testing, facility usage, and other services rendered to Patient. Patient therefore agrees as follows:

**ACCORDINGLY, IT IS HEREBY AGREED:**

1. Patient hereby authorizes MSI to furnish a full report and records regarding case history, examination, diagnosis, treatment prognosis, x-rays, laboratory reports and the results of all tests of any type or character such persons as MSI deems appropriate.
2. Patient assigns to MSI any and all benefits payable by Patient’s insurance or health care plans, including medical payments coverage, as a result of charges incurred by Patient for services rendered by MSI. Patient also assigns to MSI any and all contractual rights. Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by MSI.
3. Patient fully understands that Patient is directly and fully responsible to MSI for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patients further understand that such payment is not contingent on any settlement, claims, judgments, or verdicts which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by MSI, Patient agrees to be responsible for any such outstanding balance, including interest at 9% per annum, reasonable attorney’s fees and costs.
4. Patient fully understands that the lien and assignment given to MSI herein is irrevocable.
5. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien assignment and make payment under the lien and assignment directly to MSI. Patient directs that attorney be bound by this lien and treat it irrevocably, as an assignment due to MSI. MSI is relying upon lien, assignment and directive to any attorney, and as a result of such reliance, MSI is providing care and treatment for which this lien, assignment and directive provide security for payment. Moreover, Patient agrees that it is Patient’s intent to impose upon Patient’s attorney an obligation to comply with the terms of this directive.
6. Patient hereby directs all insurers and other persons possibly responsible for Patient’s health care costs to make all payments for healthcare services rendered by MSI directly to MSI.
7. Patient agrees that in the event Patient receives any check, draft or other payment subject to this agreement, Patient agrees to act as fiduciary agent for MSI and will immediately deliver said check, draft, or payment to MSI to be applied to Patient’s debt for services rendered.
8. Patient hereby appoints \_\_\_\_\_ as Patient’s true and lawful attorney, irrevocable, and with full power of substitution for Patient and in Patient’s name to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by MSI. MSI is not obligated or compelled to exercise such powers but may do so in MSI sole discretion. Patient agrees to fully cooperate with MSI in collecting said amounts.
9. MSI agrees to submit a copy of this agreement with the initial claim form(s) which MSI submits to third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient’s file and may be requested by Patient, to be mailed to any designated address.
10. Patient hereby authorizes MSI to receive a complete copy of Patient’s insurance policy, including any endorsements, conditions, limitations or exclusions. Patient acknowledges that he/she received, and may in the future receive, valuable services from MSI for which MSI is owed compensation. Patient authorizes MSI to make reasonable inquiries regarding the status of his/her personal injury claim, including contacting Patient’s attorney. Patient agrees to instruct his/her attorney to fully cooperate with MSI’s inquiries. Patient also agrees to provide to MSI, current contact information for his/her attorney, including name, telephone, fax, mailing address, and email address.
11. A copy of these documents shall be as binding as the document bearing the original signatures.

**Patient Initials:** \_\_\_\_\_  
**(Signature page to follow)**



**ASSIGNMENT, LIEN, RELEASE, LETTER OF PROTECTION AND POWER OF ATTORNEY, CONT'D.**

Whereas, I have a right or cause of action out of personal injury, to wit:

I, \_\_\_\_\_, hereby authorize Maryland Spine Institute (MSI), to furnish upon request, to my attorney,

Any and all medical records, or reports of examination, diagnosis, treatment, or prognosis but not necessarily limited to those items as set forth herein, in addition to an itemized statement of accounts for services rendered therefore or in connection therewith, which my attorney may from time to time request in connection with my injuries describe above and sustained by me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ .

I, \_\_\_\_\_, hereby irrevocably authorize and direct my attorney to pay all charges/bills for medical services rendered (or any other responsible and customary charges incurred by my attorney) as submitted by Maryland Spine Institute (MSI) in connection with said injury before I receive any settlement payments. Said payment or payments are to be made from any money or monies received by my attorney whether by judgment, decree, or settlement of this case, prior to disbursement to me and payment of the amount as herein directed shall be the same as if paid by me. This authorization to pay the aforementioned practice (Maryland Spine Institute/MSI) shall constitute and be deemed as assignment of so much of my recovery I receive. It is agreed that nothing herein relieves me of the primary responsibility and obligation of paying my doctor or Maryland Spine Institute (MSI) for services rendered, and I shall at all times remain personally liable for such indebtedness unless by payment disbursed by my attorney. I accept the above assignment:

**Dated:** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

As the attorney of recorded for the above-named, I hereby agree to observe the terms of this agreement, and to withhold from any award in this case sums as are required for the adequate protection of Maryland Spine Institute.

**Dated:** \_\_\_\_\_ **Attorney Signature:** \_\_\_\_\_

**ACCIDENT INFORMATION**

Patient Printed Name:	DOB:	SS#
Patient Home Address:	City, Zip:	Phone:
Attorney Name:	Attorney Phone:	Date of Injury: State:



# PERSONAL INJURY ACCIDENT QUESTIONNAIRE PAGE 1

NAME: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

Time of Accident: \_\_\_\_\_ Circle One: Dusk Day Dawn Night

Conditions: Dry Damp Wet Snow Ice Other: \_\_\_\_\_

Location of Accident: \_\_\_\_\_

Describe Your Vehicle: Sub Compact Compact Mid-Size Full Size Other: \_\_\_\_\_

Other Party's Vehicle: : Sub Compact Compact Mid-Size Full Size Other: \_\_\_\_\_

Your Travel Direction: N S E W Accident Anticipated? Y N Patient Ejected? Y N

Did You: Remain Conscious Lose Consciousness Wearing a Seatbelt: Y N

Please describe the accident in your own words (use back of page if more space needed):

\_\_\_ I was the Driver: Where were your hands on the steering wheel? Left \_\_\_ Right \_\_\_ Both \_\_\_

\_\_\_ I was the Passenger: Where were you sitting? Front \_\_\_ Right Rear \_\_\_ Left Rear \_\_\_ Center Rear \_\_\_

Did your vehicle strike another vehicle? Yes \_\_\_ No \_\_\_ Was your vehicle struck by another vehicle? Yes \_\_\_ No \_\_\_

Angles of impact: 1<sup>st</sup> Collision: Front \_\_\_ Back \_\_\_ Left \_\_\_ Right \_\_\_

2<sup>nd</sup> Collision: Front \_\_\_ Back \_\_\_ Left \_\_\_ Right \_\_\_

Did you brace for impact? Yes \_\_\_ No \_\_\_ If yes: Braced with my hands \_\_\_ with my feet \_\_\_

Which way were you facing at the time of impact? Straight ahead \_\_\_ Left \_\_\_ Right \_\_\_

Did you strike anything inside the vehicle at time of impact? Yes \_\_\_ No \_\_\_

If yes, specify what part of your body struck what (i.e.... head, chest, shoulder, knee, & right or left):

Steering Wheel \_\_\_\_\_ Dashboard \_\_\_\_\_

Windshield \_\_\_\_\_ Roof \_\_\_\_\_

Left Side Door \_\_\_\_\_ Right Side Door \_\_\_\_\_

Left Side Window \_\_\_\_\_ Right Side Window \_\_\_\_\_

Other \_\_\_\_\_

Did the seat belt bend or break? Yes \_\_\_ No \_\_\_

Immediately following the accident, how did you feel? Dizzy/dazed \_\_\_ Disoriented \_\_\_ Unconscious \_\_\_ Nervous \_\_\_

Nauseous \_\_\_ Upset \_\_\_ Weak \_\_\_ Other \_\_\_\_\_

Did you go to hospital? Yes \_\_\_ No \_\_\_ Were you admitted? Yes \_\_\_ No \_\_\_ If yes, for how long? \_\_\_

If you went to hospital, when? At time of accident \_\_\_ Next day \_\_\_

How did you get to hospital? Ambulance \_\_\_ Police Car \_\_\_ Private Transportation \_\_\_

Name of Hospital: \_\_\_\_\_ Attended by Doctor: \_\_\_\_\_

What treatment was given?

none \_\_\_ placed in a cervical collar \_\_\_ x-rayed \_\_\_ given stitches \_\_\_ bandaged \_\_\_

given pain medication \_\_\_ given instructions regarding concussions \_\_\_

given instructions regarding sprains and strains \_\_\_ physical therapy \_\_\_

instructed to call an Orthopedic Surgeon \_\_\_ instructed to call a private physician \_\_\_



## PERSONAL INJURY ACCIDENT QUESTIONNAIRE PAGE 2

Have you seen any other doctor as a result of this accident? Yes \_\_\_ No \_\_\_

Doctor's Name / Info: \_\_\_\_\_

### **CHIEF Complaints or Symptoms:**

**Neck Pain?** Yes \_\_\_ No \_\_\_

If yes, check off the areas that the pain runs from the neck:

Left Shoulder \_\_\_ Left Arm \_\_\_ Left Forearm \_\_\_ Left Hand \_\_\_ Headaches \_\_\_  
Right Shoulder \_\_\_ Right Arm \_\_\_ Right Forearm \_\_\_ Right Hand \_\_\_ Upper Back \_\_\_

Ringling in Ears? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Blurred Vision? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Wrist Pain? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Jaw Pain? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

**Low Back Pain?** Yes \_\_\_ No \_\_\_

If yes, check off the areas that the pain radiates to:

Both Buttocks \_\_\_ Left Buttock \_\_\_ Left Thigh \_\_\_ Left Knee \_\_\_ Left Foot \_\_\_  
Right Buttock \_\_\_ Right Thigh \_\_\_ Right Knee \_\_\_ Right Foot \_\_\_

Hip Pain? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Knee Pain? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Foot Pain? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

### **Numbness?**

Hands? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Upper Arms? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Legs? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

Feet? Yes \_\_\_ No \_\_\_ if yes: Left \_\_\_ Right \_\_\_ Both \_\_\_

### **Other:**

Dizziness \_\_\_ Nervousness \_\_\_ Fatigue \_\_\_ Anxiety \_\_\_ Depression \_\_\_ Excessive Irritability \_\_\_

Fear of Driving \_\_\_ Loss of Concentration \_\_\_ Jaw Clenching \_\_\_ Grinding Teeth \_\_\_ Nightmares \_\_\_

Difficulty sleeping \_\_\_

### **Additional Symptoms / Complaints:**

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Have you lost any time from work due to your injuries? Yes \_\_\_ No \_\_\_

If yes, please provide dates: \_\_\_\_\_

Type of employment? \_\_\_\_\_

Have you had previous injuries or accidents? Yes \_\_\_ No \_\_\_

If yes, please describe previous injuries: \_\_\_\_\_

Please describe previous accidents: \_\_\_\_\_

Is there any residual pain from the previous injury? Yes \_\_\_ No \_\_\_



How much better did you feel prior to your current condition? (Example 100%, 80%, etc.): \_\_\_\_\_

## **CHECK LIST FOR PERSONAL INJURY CASES**

*For MSI to consider acceptance of your personal injury case, please complete the following:*

### **I. Auto / Worker's Compensation Insurance Company Details (All information required)**

Insurance Company \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Claim #: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_  
Phone #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_  
Attorney's Name: \_\_\_\_\_  
Attorney's Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Fax #: \_\_\_\_\_

\_\_\_\_ I've seen another doctor for this accident

Doctor's Name \_\_\_\_\_

Doctor's Office/Facility \_\_\_\_\_

Date of Examination \_\_\_\_\_

### **II. Credit for Injury Services Rendered**

I wish for Maryland Spine Institute to extend me credit for services rendered and accept assignment to be reimbursed by the insurance listed above. If payment is not made by my insurance provider(s), I accept full financial liability for all charges and services rendered. I understand that if I do not complete the above information, I will be held responsible for payments of services rendered at Maryland Spine Institute.

### **III. Auto/ Workman's Compensation Office Policy**

It has been our experience that it is wise to have a complete understanding with our patients of our office policy. It is important for you to know the office policy, fees, and insurance billing procedures. If you have been involved in an auto accident, or related injury, and have insurance that covers medical expenses at 100% we will gladly accept your case with the following regulations.

- If you have an attorney, notify us as soon as possible and ask him/her to send us a letter of representation. A release packet including your bills and records will be sent to the attorney on your behalf after your release.
- If you do not have an attorney, you will need to ask the adjuster to contact our office and provide all information for billing the insurance company. No bills or copies of bills will be given to you or the insurance company until your adjuster has called and given us an indication that they will do everything possible to protect the doctor's interest.
- When your case has been settled and all medical bills paid, if an overpayment exists on your account (due to having more than one insurance company) we will forward the overpayment to you as a credit to our clinic or a payment to you. A written request must be submitted to our office before a refund check can be issued. **If your bill is not PAID IN FULL, you will be responsible for the remainder of the balance.**
- You will need to provide our office with all insurance information (Personal Auto and Health) to ensure that the bill gets paid.
- If you have MedPay, you will need to let your insurance company know that we will be filing your bills under that policy to ensure that your balance is paid in full. In the event your account is overpaid, you will be refunded after your case is settled. And in the event the balance is underpaid, you will be responsible for the remaining balance.

***By signing below, I am stating that I have read the above policies and do understand I will not be presented with copies of bills until proper procedures have been followed. Maryland Spine Institute will honor the lien signed and hold your bill, so there is no cost to you for treatment in an agreement that we (MSI) will be treated fairly in the settlement process.***

**Patient Printed Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

