MSI
INTEGRATIVE HEALTHCARE
CHIROPRACTIC • REGEN • PHYSICAL THERAPY

PATIENT REGISTRATION AND HISTORY

DEMOGRAPHIC INFORMATION

_____
LAST NAME FIRST NAME MI

ADDRESS: _____

CITY: _____ STATE: _____ ZIP : _____

HOME PHONE NUMBER: _____ CELLPHONE NUMBER: _____

E-MAIL ADDRESS: _____

SEX: ☐ M ☐ F DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ 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)

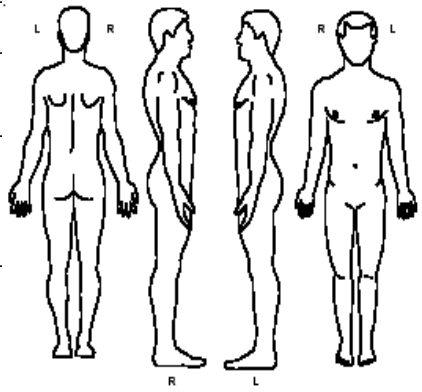
	Name	*Phone*
Primary / Family Doctor:	_____	_____
Orthopedic Doctor:	_____	_____
Pain Management:	_____	_____
Neurologist:	_____	_____
Chiropractor:	_____	_____
Other:	_____	_____

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—Past Three (3) Years: (place "X" in boxes that apply)

Test	Region / Body Part(s)	Date & Location(s)	Test	Region / Body Part(s)	Date(s)
☐ Exam	_____	_____	☐ EMG / NCV	_____	_____
☐ MRI/CT	_____	_____	☐ 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)***

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

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

_____

_____

_____

_____

_____

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 herby 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. 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 of 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. Open Edge 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: _____

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

_____ _____

Signature Date

COVID-19 INFORMED CONSENT FORM

Please read thoroughly, and sign below in acknowledgement and agreement of our COVID-19 policies.

I, the undersigned patient, consent to have Maryland Spine Institute (MSI), the providers and staff therein, perform chiropractic, therapeutic, and/or medical procedures, whether regarded as necessary or elective, during the time of the COVID-19 pandemic and after.

I understand receiving treatment at MSI at this time, despite my own efforts and those of the facility, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death.

I understand that this virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at MSI, I accept that the facility will implement infection-control procedures with which I must comply, before, during and after my treatment, for my own protection as well as that of the health facility providers and staff. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures to be necessary.

I must inform MSI of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of any future appointments, I will immediately provide the results of that testing to MSI.

Prior to each appointment, it is my responsibility to report to MSI the lack of symptoms associated with COVID-19, such as fever, cough, difficulty breathing, or new loss of taste or smell or if I have been exposed to COVID-19 within the past 14 days. I understand that my appointment must be rescheduled if symptoms or exposure are reported.

I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf,which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state.

I understand I must honestly disclose this information to avoid putting myself and others at risk.

All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my treatment until the COVID-19 pandemic is less prevalent, but I choose to have my treatment now.

If I am the parent or guardian of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

_____ _____

Patient/Authorized Representative Signature **Date**

Notice and Disclaimer. Health and medical information change constantly. This COVID-19 Informed Consent Form sets forth current recommendations for health professionals and is provided for informational purposes only and does not establish a new standard of care.

Election Not to File Health Insurance Claims

Under contractual obligations, Maryland Spine Institute is required to file claims for reimbursement with your plan for all covered services provided to you unless you instruct us in writing not to file.

During the course of your care plan, you have indicated or may later indicate that rather than using your own health insurance, you wish to pay for services or products in another way. To help you make an informed decision, please carefully review the following information.

If you elect NOT to file claims on your health insurance:

1. The clinic will rely on the information you provide to bill another payor.
2. You will not be required to pay co-payments/co-insurance and/or deductibles that would normally be required by your health benefit plan.
3. The cost of your treatment will be billed at the clinic's usual rates rather than the discounted rates that routinely apply to services covered by your health benefit plan.
4. If the combined payments received from other sources do not fully satisfy your bill, you may be personally liable for any unpaid balance.
5. None of the charges for your treatment will be applied towards satisfying the annual deductibles associated with your health benefit plan.

If you elect TO file claims on your health insurance:

1. Your health insurance should pay the cost of *covered* services associated with this accident/injury EXCEPT FOR copayments, co-insurance and/or deductibles, which you will be expected to pay directly to the clinic at the time services are rendered.
2. You will be responsible for paying to the clinic the cost of any *non-covered* services you elect to receive, and your payment will be due at the time services are rendered.
3. If your health benefit plan initially pays the clinic for your treatment and later determines that it is not legally responsible for payment, the plan administrator may require the clinic to refund to the plan all or part of the payments received. If that happens, you will become responsible for reimbursing the clinic the amount it was required to refund.
4. Your health benefit plan requires the clinic to submit claims in a timely fashion and while timely filing requirements vary, most plans require claims to be filed within 3-6 months from date of service. If your action or inaction causes a claim to be submitted late, the claim could be denied, and you would be responsible for paying this clinic for those services which were denied.

Election not to file health insurance claims:

1. By my signature below, I attest that I have read and understand the above information regarding the options available to me and have been given an opportunity to ask questions and to have those questions answered.
2. I hereby instruct the clinic not to file claims on my health insurance and I authorize the clinic to seek payment from, and send my treatment records to, other third-party payers who are potential sources of payment.
3. I understand that the clinic is relying on my decision not to file health insurance claims and that payment for services is due at the time of service.
4. I understand that no subsequent action on my part shall impair the clinic's right to bill and receive payments from third-party payers; subject only to any contractual obligation the clinic may have to my health benefit plan.
5. If you decide to terminate this agreement, all claims previously billed to you are not eligible to be retroactively billed to your insurance carrier.

_____	_____
Printed Name of Patient	**Printed** Name of Witness
_____	_____
Signature of Patient (or parent/legal guardian, as applicable)	Signature of Witness
_____	_____
Date:	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
Maintenance 98940 98941 98942	Medicare does not cover maintenance chiropractic adjustments	$50 - $80
Office Visits/Exams 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:

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.