PATIENT INFORMATION
MEDICARE

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

Todays Date

Name SS No

Address Apt No

City St Zip

Home Phone No Cell No Work No

Emergency Contact? No

May We Send You Health Information Via Email? YES NO

Email Address

Employer

Occupation

Duties/daily Activities @ Work

Best Way To Contact You? Home Work Cell

Sex M F Marital Status S M D W

Age Date Of Birth

Reason For Coming In Today?

Date Of Injury?

Medical Physician's Name?

Last Visit

Are You Currently Taking Any Medications ?

Name Of Drug Amount

Amount

Amount

Any Allergies To Medications?

Possibly Pregnant? YES NO Due Date

PAST ACCIDENTS, FALLS, INJURES, TRAUMAS OR SURGERIES

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

Please List Any Past Accident, Falls, Injuries, Major Illness, Traumas Or Surgeries

Date: What Happened?

Date: What Happened?

Are You Presently Taking any Medications? YES NO

Name of Drug: Amount:

Name of Drug: Amount:

Please check any of the following that give you difficulty:

Headaches	Stress	Flatulence / Gas	Hot Flashes
Head Feels Heavy	High Blood Pressure	Acid Reflux / Heartburn	Night Sweats
Heart Pain	Loss of Taste	Irregular Sleep	Indigestion
Menstrual Cramps	Ulcers	Wake up in Middle of Night	Shooting Head Pain
Muscle Spasms	Thyroid Trouble	Dizziness	Anemia
Tingling / Numb. of Hands	Fatigue	Heart Palpitations	Diabetes
Can't Get Back to Sleep	Sinus Pain	Menstrual Issues	Twitching of Face
Intestinal Gas	Tightness in Throat	Nervousness	Chest Pains
Low Back Pain	Grating Noise Neck	Ringing in the Ears	Liver Trouble
Mid Back Pain	Swelling	Arms / Hand Pain	Allergies
Fainting	Nervous Stomach	Irritability	Leg / Feet Pain
Loss of Balance	Tight Muscles	Cold Hands	Shortness of Breath
Heart Attacks	Arthritis	Cold / Heat Intolerance	Neck Pain
Constipation	Bloated After Eating	Hay Fever	Cold Sweats

Any Family members experiencing any of the above difficulties?

Whom? Which?

Family History of disease?

Whom? Which?

Hours of Sleep per Night? Is Your Sleep Interupted?

EXPLANATION OF CHIROPRACTIC MEDICARE

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FLORIDA CHIROPRACTIC CLINICS

MEDICARE DOES COVER CHIROPRACTIC, BUT WITH LIMITATIONS.

Medicare requires you to have an examination to verify there is a vertebral "subluxation" misalignment that necessitates the need for chiropractic adjustments. Medicare WILL NOT however, pay for this examination. Our office policy states that we require an x-ray be performed on you to visualize a spinal misalignment. This is once again, to allow Medicare to substantiate paying for your chiropractic adjustments. Medicare WILL NOT pay for these x-rays. Both the examination and x-ray are the financial responsibility of the patient unless a secondary insurance will cover these procedures.

Your condition may require more treatments or benefit from additional therapies that Medicare WILL NOT pay for.

MEDICARE WILL ONLY PAY FOR A CHIROPRACTIC ADJUSTMENT TO THE SPINE AND NOTHING ELSE!!!

These additional therapies can aid in you holding your adjustments longer, make the adjustment more comfortable, make surrounding soft tissue more pliable and have a variety of other health benefits. If you have a secondary insurance, we will verify with them to see if they may cover these additional therapies.

You always have the option of declining additional therapies; however we will recommend them to you if we feel they are necessary for your improvement or health. If you choose to have these additional services and your Secondary Insurance does not cover these services, you as the patient, are responsible for the payment.

If we recommend these additional therapies to you and you choose NOT to utilize them, PLEASE LET US KNOW!

The cost of ALL the additional therapies (excluding x-rays and exam and massage) that are performed in conjunction with your adjustment for that day is a $40 additional charge. So, to break a Medicare office visit down, Medicare pays for the adjustment only and the patient pays a $40 co-pay for the additional therapies if they decide to utilize them.

***** $40 Co-Payment....covers ALL additional therapies**

performed under the OFFICE VISIT.

(Does NOT cover the cost of exam, x-rays, or massage)

INFORMED CONSENT FOR CHIROPRACTIC CARE

(PATIENT AND DOCTOR AGREEMENT)

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

When a patient seeks chiropractic health care and we accept a patient for care, it is essential that both the patient and doctor to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risk, and alternatives. Our office's policy is as follows: "Your body, Your, Health, Your Choice." We will recommend what we feel is the best health care advice for you; however, it is your choice to do what you want with that advice whether it be to utilize our recommendations or to seek other means of health care for your condition.

CHIROPRACTIC has only one goal, the detection and correction of the VERTEBRAL SUBLUXATION. Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of HEALTH.
HEALTH: A state of optimal physical, mental, and social well-being, not merely the absence of disease, signs or symptoms.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Vertebral Subluxations are corrected and/or reduced by an adjustment. An ADJUSTMENT is the specific application of forces via hand or instrument to facilitate the body's correction of the vertebral subluxation. Our method of correction in this office is by specific adjustments utilizing the hands or an instrument as well. In addition, ancillary procedures such as physiotherapy and /or rehabilitative procedures may be included or recommended.
We do not offer to TREAT ANY DISEASES! We detect and correct vertebral subluxations as well as identify stresses the body may have on it that may limit its ability to function. We may recommend additional ancillary procedures that may benefit the reduction of these stresses however we DO NOT AND WILL NOT TREAT INDIVIDUAL DISEASES, NOR MAKE THAT CLAIM. We may have patients with certain diseases; however we treat the patient by removing and/or reducing the vertebral subluxation and their stress, not the DISEASE. If during the course of our care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider that may specialize in that area.

Like most health care procedures, the chiropractic adjustment carries with it some risks. The POSSIBILE RISKS may include temporary soreness or increased symptoms of pain. (It is not uncommon for patients to experience temporary soreness or increased symptoms of pain after the first few treatments). Dizziness, nausea, flushing, as well as fractures, may occur (These symptoms are relatively rare). When a patient has underlying conditions that may weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. Treatment plans will be modified accordingly. Spinal conditions like a disc herniation or bulge can potentially worsen with chiropractic care, however we take a very gentle approach to such conditions and oftentimes treatment is extremely effective. A certain extremely rare

type of stroke/cerebro-vascular injury can be associated with chiropractic care. This occurrence has been estimated at one in one million to one in twenty million but often even further reduced by cardiovascular screening procedures by our office. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices.

I understand that the practice of chiropractic, like the practice of all healing arts and medicine, is not an exact science, and I acknowledge that no guarantees can be given as to the results or outcome of my care.
OTHER TREATMENT OPTIONS which could be considered may include the following:

Over-the counter analgesics: The risks of these medications include irritation of the stomach, liver, kidneys, and other side effects in a significant number of cases.

Medical Care: typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
Hospitalization: in conjunction with medical care adds risk of exposure to virulent communicable diseases.
Surgery: in conjunction with medical care adds the risk of adverse reactions to anesthesia, as well as an extended convalescent period.

RISKS OF REMAINING UNTREATED: Delay of treatment allows a formation of adhesions, scar tissue, and other degenerative changes to take place. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make future rehabilitation more difficult.

I have read or had read to me this informed consent document. I have discussed, or been given the opportunity to discuss, any questions concerning my treatment. My chiropractor explained and answered any questions/concerns to my satisfaction prior to my signing this informed consent document. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name _____ Signature _____ Date

PAYMENT INSURANCE INFORMATION

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

Payment/Insurance Information

Our office policy states that payment is due when Services are rendered!

As a courtesy, we will file your auto and medicare insurance claims for you.

We are no longer in network with any health insurance. We can print you a receipt with the appropriate information for you to submit to your insurance company for possible reinbursement.

( ) Cash/check/credit card: payment is due when services are rendered.

( ) Automobile insurance: we must have a copy of your insurance card, verification of insurance and a copy of the accident report if available. Any charges not covered by the insurance company will be directly billed to you for payment.

( ) Medicare: we must have a copy of your medicare card.

Insured name:

Insured D.O.B.:

Relationship to insured:

Insurance company name:

I have read the above and checked one method of payment. I have agreed that the balance is my responsibility and will pay any balance that has gone unpaid over 60 days. If balance owed after stated period has not been met, i understand that i will be responsible for all fees incurred (attorney, collection agencies, court cost, interest and any other fees needed to collect the balance) such that the balance owed to this office is paid in full.

Please print name: Date:

Please sign to acknowledge form: _____

RECEIPT OF PRIVACY PRACTICES

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of, or had the opportunity to read, the NOTICE OF PRIVACY PRACTICES (located in the waiting room).

I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES.

I understand this form will be placed in my patient chart and maintained for a period of six years.

DATE:

PATIENTS NAME (PLEASE PRINT)

_____

SIGNATURE

PLEASE LIST BELOW THE NAME AND RELATIONSHIP OF PEOPLE TO WHOM YOU AUTHORIZE RELEASE OF PHI.

THIS FORM WILL BE MAINTAINED IN THE PATIENT'S CHART FOR A PERIOD OF SIX YEARS.

INSURANCE POLICIES & GUIDELINES

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

The purpose of this letter is to let you know how our facility works in the handling of your insurance claims. We do this to eliminate any questions, and to inform you of all our policies in advance to better enable us to serve you in your health care needs effectively. In this way, policies can be followed as intended.

We itemize all of our procedures. The reason for this is to let the insurance company personnel know exactly what services were performed on you on each of your visits, what was not performed on you each of your visits, and why. In reporting to your insurance company, we are responsible to them on your behalf to accurately inform them as to your condition, status, complications, exacerbations, unusual circumstances affecting your health and care that would affect your recovery and journey to optimal health. We are responsible for letting them know how long we anticipate your care will be, to what frequency we need to see you, and your progress. All of this involved a tremendous amount of staff and professional time and expense. However, we do this as a courtesy service for you as it lessens the burden of you having to communicate with the insurance company and not having the proper knowledge or information to provide them. It also lessens the responsibility and threat regarding when insurance companies will no longer cover your care. This makes a far easier process for you and for us. All we ask is your cooperation. Our usual procedures and their costs are listed separately, and a copy of these can be provided when asked.

Because we itemize and document every procedure in accordance with the insurance protocol, rather than just describe what is being done as an “office visit”, the charges per visit may vary in costs, especially when multiple services are rendered. For various reasons, we know that there are a lot of charges that may not be paid, such as maximum dollar amounts, limits per visits, procedures that the policy does not cover or deem medically necessary, etc. We expect to receive denials on claims, as it is the nature of the insurance industry. However, we are still going to bill for everything we do, whether we get reimbursed for our services or not, so that we can adequately document and communicate our visit procedures with the insurance companies.

Different insurance companies cover different procedures and in different amounts. Some companies pay 100% and some pay 60%. Some patients under their policy will have $0 deductible while others may have a $1000 deductible. Such things are based upon your individual policy. We can only make you aware of this as you may see multiple patients paying different amounts for their care.

As a courtesy to you, we will verify your insurance benefits prior to performing any procedures on you. WE CAN NOT GUARANTEE the information your insurance company provides us is accurate information, as numerous times, the information they provide us on verification of your benefits is not the same as what they provide to us when paying the claim. You, as the patient, are still responsible for the payment of services for any unpaid balance if the insurance company fails to provide us with proper valid information and there is a discrepancy between what was verified and what was acknowledged and paid/unpaid.

If you have a special financial situation that makes it difficult or impossible for you to meet your financial requirement of paying any unpaid balance remaining owed, please consult the DOCTOR or OFFICE MANAGER so we may discuss this matter with you. Special considerations or small weekly or monthly payments can sometimes be arranged to fit your needs and thus allow you to get the proper care you need at a fee you can afford.

Printed Name _____ Signature _____ Date

POWER OF ATTORNEY AND MEDICAL RELEASE

5290 Seminole Blvd. Suite A St. Petersburg, Fl. 33708

FLORIDA CHIROPRACTIC CLINICS

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS.AUTHORIZATION TO PAY.

Know by all those present that: The undersigned has made, constituted, and appointed, and by those present does hereby make, constitute and appoint **FLORIDA CHIROPRACTIC CLINICS, INC.**, and any of its duty authorized agents and employees as and to the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, money orders which are made payable to the undersigned alone or to the undersigned and the said **FLORIDA CHIROPRACTIC CLINICS, INC.** which checks, drafts, money orders are made payable for services which have been made by **FLORIDA CHIROPRACTIC CLINICS, INC.** at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, money order.

Furthermore, the undersigned allows **FLORIDA CHIROPRACTIC CLINICS, INC.**, or any of its agents to sign any paper that will be necessary to enhance, expedite, and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by those present, does give and grant **FLORIDA CHIROPRACTIC CLINICS, INC.** as attorney, full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, and supplies pertaining to me to release true copies of same to **FLORIDA CHIROPRACTIC CLINICS, INC**. or any insurer providing coverage to me in connection with the processing of any claim for benefits made or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____

(Name of Insured/Patient) (Name of Insurance Carrier)

To make medical payments otherwise payable to me for services rendered by FLORIDA CHIROPRACTIC CLINICS, INC., but not to exceed the charges of those services, payable and mailed directly to:

FLORIDA CHIROPRACTIC CLINICS, INC.

5290 Seminole Blvd. Suite A
St. Petersburg, FL 33708

Furthermore, I hereby **IRREVOCABLY ASSIGN** to **FLORIDA CHIROPRACTIC CLINICS, INC.**, the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by **FLORIDA CHIROPRACTIC CLINICS, INC**.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____day of _____, 20___.

_____ _____

PATIENT'S SIGNATURE PATIENT'S NAME (Please Print)

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Additional Services 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.** Additional Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
- Initial Exam / X-Rays - Laser Therapy - Kinetic Activity - Massage / Intersegmental Tx - Neuromuscular ReEducation - Therapeutic Exercises	Not a reimbursable procedure by Medicare if done by a Chiropractor.	75 - 100 50 50 50 50 50

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.** Additional Services 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.** Additional Services 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.** Additional Services 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.** Additional Services 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.