MATTEO CHIROPRACTIC PLLC

941 South Fifth Street
Mebane, NC 27302
Phone: 919-563-0000

Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone: _____ Work Phone: _____

Street Address and Number: _____

City, State, and Zip Code: _____

Email Address: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Sex: Male Female # of Children _____ **Circle One:** Married Single Widowed Divorced

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Occupation: _____

Driver's License # _____ State _____ How were you referred to our office? _____

In case of emergency, please contact (include phone): _____

Please describe your condition(s) beginning with the most severe.

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

When did this/these conditions begin? _____ Is the condition getting (circle) better worse same

What is the cause of your condition(s)? _____

What makes the condition feel better or worse? _____

Have you seen any other Physician for this condition? (Please list name and dates.) _____

_____

Have you ever been treated by another chiropractor? (If yes, who/when/same condition?) _____

_____

Have you ever had similar symptoms to present condition? _____

Are you currently treating with any other physician? (If yes, please explain.) _____

_____

Please list your family Physician, location, (city and state), & Medications you are currently taking: _____

_____

Please list your complete surgical history (give dates and types of surgery): _____

_____

Have you ever been involved in an automobile accident? (If yes, please give dates & explain accident):

_____

Name of person responsible for payment (if different from applicant) _____

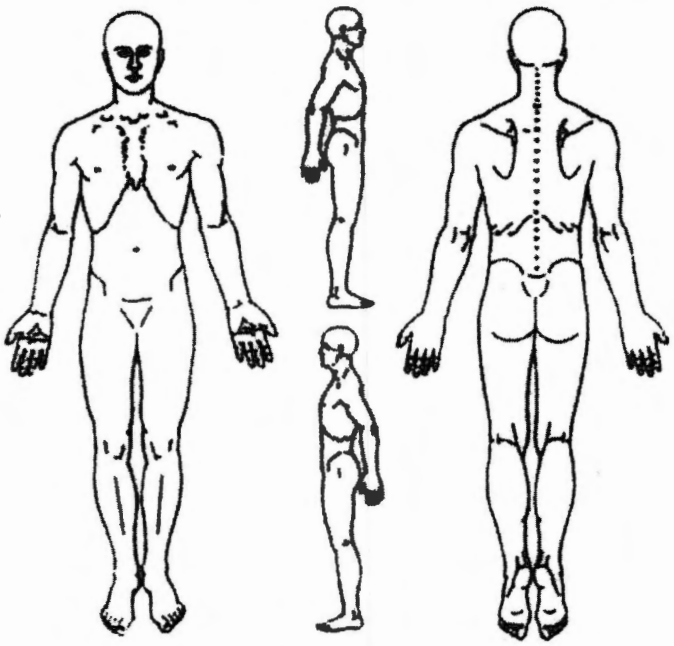
Would you like to file insurance for you? (Please Circle) YES NO Have you met your deductible? YES NO

Name of insurance company (if applicable) _____

Name of Insured (if not self) _____ DOB of Insured _____

If you are experiencing any of the following conditions, please indicate on the diagrams below.

A=ACHE **B=BURNING** **N=NUMBNESS**
P=PAIN **S=STABBING** **O=OTHER**



PLEASE CHECK THE SPACES BELOW FOR SYMPTOMS YOU ARE CURRENTLY HAVING.

1. _____ HEADACHES
2. _____ DIZZINESS
3. _____ NECK PAIN
4. _____ NECK STIFFNESS
5. _____ UPPER BACK PAIN
6. _____ SHOULDER PAIN
7. _____ ARM OR HAND PAIN
8. _____ NUMBNESS OR TINGLING
9. _____ MID BACK PAIN
10. _____ LOW BACK PAIN
11. _____ HIP OR BOTTOCK PAIN
12. _____ LEG OR FOOT PAIN
13. _____ EAR NOISES
14. _____ SINUS INFECTION
15. _____ VISION PROBLEMS
16. _____ ALLERGIES
17. _____ CHEST PAIN
18. _____ DIFFICULT BREATHING
19. _____ FREQUENT URINATION
20. _____ PROSTATE PROBLEMS
21. _____ ARTHRITIS
22. _____ BURSITIS
23. _____ STROKE

I hereby authorize Matteo Chiropractic PLLC to examine me, including x-rays if indicated by my exam, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the finders, and I wish all my chiropractic records be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. First day's fees are due and payable at the time of service.

BY SIGNING YOUR NAME BELOW, YOU CERTIFY THAT THE ACCURACY OF YOUR MEDICAL AND/OR ACCIDENT HISTORY AND CERTIFY THAT YOU PRESENT MATTEO CHIROPRACTIC PLLC FOR EVALUATION AND TREATMENT OF A HEALTH RELATED CONDITION AND FOR NO OTHER PURPOSE.

_____ _____

Signature of patient, or of Guardian authorizing care Date

MATTEO CHIROPRACTIC PLLC
Dr. Craig M. Matteo

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Mebane, NC 27302
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Form Instructions:
If you have been involved in an automobile accident: write date of accident in the blank, print, and sign at the bottom.

If you have NOT been in an automobile accident: print and sign at the bottom. This form allows us to file claims with your health insurance.

To any insurance company with coverage applicable to my claim(s) and to any attorney representing me:

ASSIGNMENT OF BENEFITS

In CONSIDERATION of the willingness of Matteo Chiropractic PLLC to treat me on credit without demand for payment at the time services are rendered, I hereby agree and stipulate as follows:

I irrevocably assign Matteo Chiropractic PLLC any proceeds or compensation that I am or may become entitled to receive as a result of my injuries on _____ to the extent of the chiropractic services rendered. I make this agreement without prejudice to any rights I may have to prosecute legal claims against any party who may be liable for my injuries, but I hereby authorize and instruct you to pay directly to Matteo Chiropractic PLLC, from any disability benefits, medical payments benefits, liability benefits, health and accident benefits, workers compensation benefits, judgements, settlements, or proceeds of any kind that would otherwise be payable to me, such sums are due or may become due to Matteo Chiropractic PLLC for its services rendered.

I appoint Matteo Chiropractic PLLC as my attorney in fact to affix my name as an endorsement upon the reverse of any check or draft upon which I am named payee and to deposit said check or draft and apply the proceeds to any unpaid balance I may have with Matteo Chiropractic PLLC.

I authorize Matteo Chiropractic PLLC to release any insurer with applicable coverage or to my attorney or successor attorney any information regarding my injuries, prior medical history, or treatment as may be necessary to facilitate collection of proceeds under this assignment.

I acknowledge that I remain personally liable for the total amount due to Matteo Chiropractic PLLC for services rendered, including any balance remaining after the application of insurance payments and settlement or judgement proceeds. If Matteo Chiropractic PLLC is required to take legal action against me to recover any unpaid balance on my account, I agree to reimburse Matteo Chiropractic PLLC for its cost of recovery, including reasonable attorney's fees.

_____	_____	_____
Legal Guardian OR Patient Printed Name	**Date**	**(relationship to patient)**
_____	_____	_____
Legal Guardian OR Patient Signature	**Date**	**(relationship to patient)**
_____	_____	
Authorized Provider Representative	**Date**	

NOTICE OF LIEN

Pursuant to N.C.G.S. 44-49 and 44-50, Matteo Chiropractic PLLC hereby asserts and gives notice of a lien upon any sums recovered in damages for personal injury in any civil action and also upon all funds paid to the above-names patient in compensation for or settlement of injuries sustained, whether in litigation or otherwise.

Matteo Chiropractic PLLC hereby requests that if its claim is not paid in full from the foregoing proceeds, a full disclosure and accounting of proceeds be provided in conformity with N.C.G.S. 44-50.1. Matteo Chiropractic PLLC agrees to be bound by any confidentiality agreements regarding the contents of the accounting.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

Matteo Chiropractic, PLLC is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from this Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This notice details how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purpose of:

(a) Treatment- In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

(b) Payment- In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that your received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

(c) Health Care Operations- In order for the Practice to operate in accordance with applicable law and insurance requirement and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and /or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) De-identified Information- Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate- To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations-

(i) For the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your consent as soon as possible; or

(ii) To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers- If, due to substantial communication barrier of inability to communicate, the Practice has been unable to obtain your consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities- Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.

(g) Abuse, Neglect or Domestic Violence – To a government authority if the Practice is required by law to make such disclosure. If the Practice Is authorized by law to make such disclosure it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities- Such activities, which must be required by law, involve government agencies and may include for example, criminal investigations, disciplinary actions, or general oversight activities relation to the community's health care system.

(i) Judicial and Administrative Proceeding- For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes- In certain instances, your PHI may have to be disclosed to a law enforcement official. For Example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

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(k) Coroner or Medical Examiner- The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.
(l) Organ, Eye or Tissue Donation- If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.
(m) Research- If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.
(n) Avert a Threat to Health or Safety- The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen that threat.
(o) Workers' Compensation- If you are involved in a Workers' Compensation claim; the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.
(p) Disclosure of immunizations to schools required for admission upon your informal agreement.

APPOINTMENT REMINDER

The Practice may, from time to time, contact your to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The following appointment reminder is used by the Practice:
(a) Telephoning your home, work or cell and leaving a message on your answering machine or with the individual answering the phone.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment of your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply.
(a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.
(b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your bests interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/ or disclosures, other than those described above will be made only with your written authorization.

YOUR RIGHTS

You have the right to:
(a) Revoke any Authorization and /or Consent, in writing, at any time. To request a revocation you must submit a written request to the Practice's Privacy Officer.
(b) Request restrictions on certain use and /or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable request.
(d) Inspect and obtain a copy of your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

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(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)
(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
(h) Receive notice of any breach of confidentiality of your PHI by the Practice.
(i) Prohibit the disclosure to your health plan or anyone else of any test, examination or treatment for which you have paid in cash or the equivalent, including legally binding assignments of proceeds.
(j) If you believe your privacy rights been violated, complain to this Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, telephone: 202-619-0257, email: ocrmail@hhs.gov: or to the North Carolina Attorney General, 9001 Mail Service Center, Raleigh, NC 27699-9001, telephone: 919-716-6400.
(k) Request copies of your protected health information (PHI) in electronic format.

You may contact the Privacy Officer of this Practice to obtain more information or the answer to any questions you may have about your privacy rights. The Privacy Officer's contact information is as follows: Kristen Lynch- Matteo Chiropractic PLLC, 941 S. Fifth Street Mebane NC 27302 phone: 919-563-0000.

THIS PRACTICE'S OBLIGATIONS AND PREROGATIVES.

Matteo Chiropractic PLLC:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this privacy notice detailing the practice's legal duties and the procedures for maintaining, protecting and disclosing your PHI.
(b) Is required by state law to maintain a higher level of confidentiality than federal law requires with respect to certain portions of your PHI. In particular, the Practice is required to comply with N.C.G.S. 130A-143 relating to the AIDS virus and other communicable diseases and with N.C.G.S. 131E-97 relating to patient records and personal financial records.
(c) Is required to abide by the terms of this privacy notice.
(d) Reserves the right to change the terms of the Privacy Notice and to make new privacy notice provisions effective for any of your PHI maintained by this Practice.
(e) Will distribute to you any revisions in the privacy notice prior to implementation.
(f) Will not retaliate against you for filing a complaint regarding breach of your privacy rights.

QUESTIONS AND COMPLAINTS

You may obtain additional information about your privacy practices or express concerns or complaints to the Privacy Officer and contact person appointed for this practice. The Privacy Officer is Kristen Lynch.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available in our reception area or upon request in our office**.** ***Effective September 23, 2013, document last updated May 06, 2014.***

MATTEO CHIROPRACTIC PLLC

Dr. Craig Matteo

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six (6) years.

_____

Patient Name (please print)

_____

Parent, Guardian or Patient's Legal Representative

_____ _____

Signature Date

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX (6) YEARS

List below the Names and Relationship of people to whom you authorize the Practice to release Protected Health Information ("PHI")

Name	Relationship

941 S. Fifth St. Mebane, NC 27302 919.563.0000 office 919.563.0063 fax

www.matteochiropractic.com

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby, request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible), by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such chiropractic services may be performed by Craig M. Matteo, D.C. and/or other licensed Physicians of Chiropractic whom may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Craig M. Matteo and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that treatment results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all other forms of healthcare, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below. I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course treatment for my present condition(s) and for any condition(s) which I seek treatment at this facility.

To be completed by the patient:	**To be completed by the patient's representative, if necessary:** (E.g. Patient is a minor or is physically or mentally incapacitated)
_____ *Print Patient's Name* _____ *Patient's Signature* _____ *Date (MM-DD-YYYY)*	_____ *Print Name of Patient* _____ *Print Name of Patient's Representative* _____ *Representative's Relationship to Patient* _____ *Signature of Patient's Representative* _____ *Date (MM-DD-YYYY)*

This form will be maintained in, and as part of, the patient's health record.

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UPDATED INSURANCE VERIFICATION FORM

In accordance to the new Federal HIPPA guidelines the following information is needed to verify and process your insurance.

Patient Name:	
Patient Date of Birth:	
Patient Social Security #:	
Patient's Address: (if different from Drivers License)	
Insured Subscriber Name:	
Insured Date of Birth:	
Insured Social Security #:	
Insured's Relationship to Patient:	

Please Provide Your Chiropractic Assistant with a copy of your Insurance Card and Driver's License.

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PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: _____ **Date:** _____

Your insurance does not pay for all of your healthcare costs. Some items and services are considered "non-covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed decision about whether or not you want to receive these items or services.

The services that may not be covered are listed below:

• Pads for Muscle Stimulation	$17.00
• Ice Packs/Heat Packs	$15.00 - $26.00
• Pillows	$50.00 - $60.00
• Braces	$30.00
• Biofreeze Gel	$15.00

I acknowledge that I have been informed in advance of receiving these services, and that these services are not covered by my health insurance plan. I have chosen to receive these services and understand I will be financially responsible for the charges indicated above.

_____ _____

Print Patient's Name *Patient's Signature*

_____ _____

Name of Parent or Legal Guardian (if applicable) *Signature of Parent or Legal Guardian (if applicable)*

_____ _____

Date *Date*

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items, and must be maintained in the patient's healthcare record.

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CANCELLATION POLICY

IT IS OUR OFFICE POLICY TO REQUEST A 24-HOUR NOTICE OF ANY APPOINTMENT YOU ARE UNABLE TO KEEP.

FAILURE TO PROVIDE NOTICE WILL RESULT IN ADDITONAL CHARGES TO YOUR ACCOUNT AS DESCRIBED BELOW:

MISSED APPOINTMENTS

1ST TIME: GRACE

2ND TIME: $20.00

REMINDER CALLS

WHILE WE DO MAKE COURTESY REMINDER CALLS, IT IS ULTIMATELY YOUR RESPONSIBILITY TO ATTEND APPOINTMENTS THAT YOU HAVE SCHEDULED WITH OUR OFFICE.

PLEASE NOTE: IF YOU DID NOT RECEIVE YOUR REMINDER CALL, THE MISSED APPOINTMENT POLICY STILL APPLIES.

_____

Patient Signature:

_____

Date:

_____

Witness:

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MEDICARE FINANCIAL WAIVER

NON-COVERED CHIROPRACTIC SERVICES

DEDUCTIBLE

Medicare requires you to pay a yearly deductible towards your medical expenses. Your deductible must be satisfied before Medicare will begin to pay. **Medicare deductible for 2017 is $183.**

X-RAYS

Medicare requires that subluxation be demonstrated on x-ray when submitting claims for consideration of payment. However X-rays performed in a chiropractic office are considered a Non-Covered service by Medicare and will be your financial responsibility.

EXAMINATION

In order for the Doctor to determine the extent of your condition, as well as the type of treatment you will need, he must first examine you prior to the initiation of treatment. Examinations are considered a Non-Covered service by Medicare and will be your financial responsibility.

PHYSICAL THERAPY, SUPPLEMENTS AND SUPPORTS

During the course of your treatment at our office, the Doctor may determine that certain physical therapy, vitamin supplements, and/or orthopedic supports are necessary to assist in the treatment of your condition. Medicare will not pay for these services, and payment your responsibility.

WHAT MEDICARE WILL PAY

After you have met your deductible, Medicare will pay 80% of the "allowable charge". The only allowable charge for chiropractic treatment is manipulation of the spine. Medicare must consider this service to be "Medically Necessary". The allowable charge for this service is $27.13 or $39.16 (depending on the level of service performed). **The remaining 20% is paid by the patient or secondary insurance if applicable.**

I UNDERSTAND THAT ALTHOUGH THE CHIROPRACTIC SERVICES LISTED ABOVE MAY BE NECESSARY FOR THE TREATMENT OF MY CONDITION, THESE SERVICES MAY NOT BE COVERED BY MEDICARE AND I WILL BE RESPONSIBLE FOR PAYMENT.

_____ _____

Patient Signature Date

Matteo Chiropractic PLLC.

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Service(s)** 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. Service(s)** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
A. X-Ray	Non-Covered Service	$70- $180
B. Examination	Non-Covered Service	$45
C. Traction	Non-Covered Service	$29
D. Electrical Muscle Stimulation	Non-Covered Service	$29
E. Heat/Ice Therapy	Non-Covered Service	$29
F. Ultrasound Therapy	Non-Covered Service	$30
G. Ice-Pack	Non-Covered Service	$15-$30
H. Pillows/ Supports	Non-Covered Service	$30-$60
I. Pain Gel Relief	Non-Covered Service	$15-$75
J. Pads for Muscle Stimulator	Non-Covered Service	$17
K. Extra-Spinal Adjustment	Non-Covered Service	$43

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. Service(s)** 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. Service(s)** 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. Service(s)** 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. Service(s)** 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.

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Appointment Reminders and Health Care Information Authorization

Your Chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organization to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to our health information if they decide to contest any of our claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (164.524).

This notice is effective as of the date shown in the signature portion of this document. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

To be completed by the patient:	**To be completed by the patient's representative, if necessary:** (E.g. Patient is a minor or is physically or mentally incapacitated)
_____ *Print Patient's Name* _____ *Patient's Signature* _____ *Date (MM-DD-YYYY)*	_____ *Print Name of Patient* _____ *Print Name of Patient's Representative* _____ *Representative's Relationship to Patient* _____ *Signature of Patient's Representative* _____ *Date (MM-DD-YYYY)*
_____ *Signature of Authorized Provider Representative*	