Informed Consent for Chiropractic Treatments and Care

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examinations, tests and physical therapy techniques, on me (or the patient for which I am legally responsible) which are recommended by the Dr. of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future rendered treatment to me while employed by, working for or associated with, or serving as backup for the Dr. of chiropractic named below.

I understand that, as with any healthcare procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disk injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. 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. I do not expect the Dr. to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedures which the Dr. feels at the time, based upon the facts then known, are in my best interest.

I understand that I will have the opportunity to discuss with a Dr. of chiropractic named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and can have my questions answered to my satisfaction before treatment begins. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have also had an opportunity to ask questions about its content, and by signing the Consent for Care section on the patient intake form I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand that Community Chiropractic is not a group practice. Each physician is operating an independent practice. Community Chiropractic is an entity whose purpose is only to provide administrative services to the physicians. All decision making. treatment and treatment protocols are the sole responsibility of the current treating physician.

Tamara Lund, DC, DACNB
or
Jose M. Barajas, DC.

Name: ______________________ Date: ______________

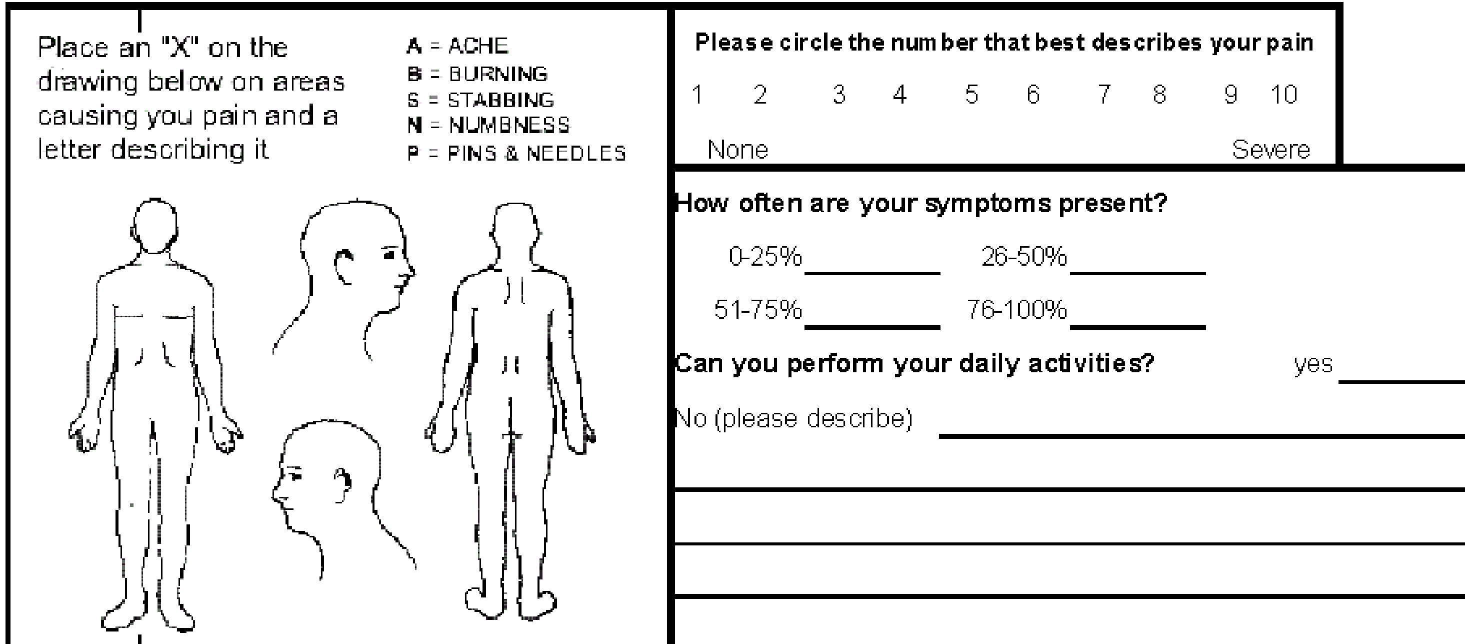
Describe your current problem and how it began: ____

____

Is this a work or auto claim? ______________ **Date most recent problem began:** ______________

Place an "X" on the drawing below on areas causing you pain and a letter describing it

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES



Please circle the number that best describes your pain

1 2 3 4 5 6 7 8 9 10

None Severe

How often are your symptoms present?

0-25% ________ 26-50% ________

51-75% ________ 76-100% ________

Can you perform your daily activities? yes ________

No (please describe) ______________________________

Describe your past health history please:

Prior Illness: ______________________________

Past Hospitalizations: ______________________________

Have you had any Spinal X-rays, MRI or CT Scans?

No ________

Yes, When and Where? ______________________________

Surgeries: ______________________________

Medications: ______________________________

Allergies: ______________________________

Infections:

Family History:

Cancer ________ Diabetes ________

High Blood Pressure ______________

Cardiovascular Problems/Stroke

Please check all of the following that apply to you.

Recent infection ________
Recent fever ________
HIV/AIDS ________
Diabetes ________
Corticosteroid Use ________
Birth Control Pills ________
High Blood Pressure ________
Stroke ________
Dizziness/Fainting ________
Numbness in Groin/Buttocks ________
Urinary Retention ________
Aortic Aneurysm ________

Osteoporosis ________
Recent Trauma ________
Prostate Problems ________
Frequent Urination ________
Pregnancy, #of births ________
Abnormal weight gain ________
Abnormal weight loss ________
Epilepsy/Seizures ________
Visual Disturbances ________
History of low back pain ________
History of neck pain ________
Arthritis ________

Thank you for choosing Community Chiropractic to serve your health care needs. To help us help you, please complete the following carefully.

Are you here for care directly relating to a work injury or automobile accident? If yes, please stop and notify a staff person. If no, please continue.

Patient Information

Last Name: ____________ First Name: ____________ MI: ____ Date of Birth: ____________

Mailing Address include city and zip

____

____

____

Please list contact numbers in order of preference

____________________ Home? Cell? Work?

____________________ Home? Cell? Work?

Emergency Contact information:

Last Name: ____________ First Name: ____________ MI: ____________

Phone #: ____________________ Relation to patient: ____________

Who is responsible for payment? (If not the same as above, please complete this section.)

Last Name: ____________ First Name: ____________ MI: ____________

Mailing Address: Same as above? ____________

____________________ Home Phone: ____________

____________________ Alternative Phone: (work, cell) ____________

____

Payment Information

Do you have insurance that covers chiropractic care? (if you aren't sure, allow us to check.)

__________ No. I agree to pay for care at the time of service. (please go to next section)

__________ Yes. (please complete this section and allow us to copy any insurance card(s) you have.)

Please read and select one of the following regarding insurance billing.

__________ I would like Community Chiropractic to bill my insurance company for me and have the insurance company make any payment directly to Community Chiropractic. I understand that if there is a balance due after my insurance company processes my claim I may receive a bill from Community Chiropractic and agree to pay any outstanding balance promptly.

__________ I would prefer to bill my own insurance company. I understand that if I choose this option that I will be responsible for paying my bill at the time of service. I further understand that I will need to notify the staff at each visit that I need the necessary paperwork.

1. Medicare patients please note that we are required by law to bill Medicare for you. Your option is to have their payment sent to either you or us.
2. We reserve the right to accept or refuse any insurance and/or opt in or out of any provider network agreements.
3. Your insurance policy is an agreement between you and them. We will do our best to help you understand what your benefits (or lack of them) are and assist you in filling out any necessary paperwork they may require but it is still your contract with them, not ours, and ultimately your responsibility to ensure we are reimbursed.

Who may we thank for referring you to our office? ____________________

Federal Health Records Initiative

Our Federal Government is pushing to build and maintain a national health care tracking system. They have asked that we inquire about the following information. You may "decline" to answer any or all. We will treat any answers with the same confidentiality we exercise for your medical records. See next section for privacy information

The "SSN", "Mother's Maiden Name" and "Birth State" information will eventually be used to tie all your health information from all your providers together to make a easily and quickly accessible record for a provider that needs it. If you provided us with a e-mail address your records can also easily be sent to you electronically, eventually.

SSN: ____________ Email address: ____________________

Marital Status: ____________

Primary Language: ____________

Race: ______ American Indian or Alaska native
______ Asian
______ Black or African American
______ Native Hawiian or Pacific Islander
______ White
______ Other
______ Decline to Answer

Ethnicity: ______ Not Hispanic or Latino
______ Hispanic or Latino
______ Unknown
______ Decline to Answer

Mother's Maiden Name: ____________

Your Birth State: ____________

Privacy Policy

We are required by law to exercise reasonable caution with regard to your health information. Your signature below acknowledges that we made a copy of our privacy policies available to you and you understand your rights.

Signature: ______________ Date: ________________

Consent for Care

I have been provided with, read and understand the Informed Consent for Chiropractic Treatments and Care notice and request services for myself or the patient I legally represent.

Signature: ______________ Date: ________________

Cancellation/No Show Policy for Doctor Appointment

If an appointment is not canceled within a reasonable amount of time you will be charged a twenty five ($25) fee that will not be covered by your insurance

Signature: ______________ Date: ________________

A. Notifier: Tamara F. Lund D.C. or Jose M. Barajas D.C

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

Advance Beneficiary Notice of Noncoverage (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
Chiropratic Initial Exam Codes 99201-205	**Medicare only pays for treatment for active treatment. Preventative Chiropractic care is not covered.**	**$40.00**

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:

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.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566