Back To Health Chiropractic
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MEDICARE

Patient Name: _____ D.O.B. _____ M/F

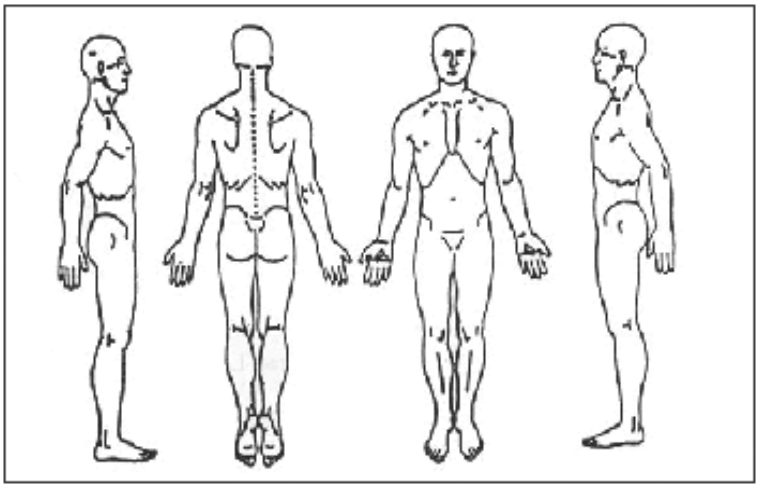
Single/Married/Divorced/Separated/Widowed/Other
Address: _____City: _____ State: _____ Zip: _____
Tel# (____)_____Cell Phone: (____)_____Social Security#: _____
Email address:_____
Occupation: _____ Your Employer: _____ Phone#: (____) _____
Address:_____ City: _____ State: _____ Zip: _____
Retirement date:____/_____/_____

Primary Insurance/HealthPlan_____
Subscriber's Name: _____ _____
Date of Birth_____/_____/_____ ID: _____ Group #: _____
SecondaryInsurance/HealthPlan_____
Subscriber's Name:_____ _____
Date of Birth_____/_____/_____ ID: _____ Group #: _____
Spouse's Name_____ Spouse's Employer: _____
City: _____ State: _____ Zip:_____

Primary Care Physician Name: _____Phone_____

Who Referred you here?_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



( ) Headache ( ) Neck pain ( ) Mid back pain ( ) Low back pain ( ) Arm/Hand ( ) Leg/Foot
( ) Other _____
Is This? ( ) Work Related ( ) Auto Related ( ) N/A
Date Problem Began: _____How? :_____

Current Complaint (how you feel today)

0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable pain

How often are your symptoms present?
Intermittent ( ) 0 – 25% ( ) 26 -50% ( ) 51 – 75% ( ) 76 -100% (Constant)

CONTINUED ON BACK

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT?
YES/NO Dates Taken: _____What areas were taken? _____

Facility where taken: ( ) Cortland regional Medical Center ( ) Cayuga Medical Center ( ) other _____

Height_____ Weight____

1.Please check all the following that apply to you:

( ) Numbness in arms/hands legs/feet

( ) Recent Fever

( ) Diabetes

( ) High Blood Pressure

( ) Stroke (date)_____

( ) Blood Thinners

( ) Prostate Problems

( ) Menstrual Problems

( ) Urinary Problems

( ) Pregnant? Due date____ #_____ of births. Vaginal or C-section_____

( ) Corticosteroid use (cortisone, prednisone, etc.)

( ) Marked Morning Pain/Stiffness

( ) Pain at Night

( ) Dizziness/Fainting

( ) Visual Disturbances

( ) Alcohol consumption_____

( ) Abnormal Weight ( ) gain ( ) Loss

( ) Pain Unrelieved by position/rest

( ) Taking Birth Control

( ) Thyroid condition

( ) Epilepsy/Seizures

( ) Smoke/packs ___ # of years_____

( )Cancer/Tumor(explain)_____

( )Surgeries_____

( ) Medications:_____

( ) Other Health Problems (explain)_____

Family History (Parents & siblings) of ( ) Cancer ( ) Diabetes ( ) High Blood Pressure

( ) Heart Problems/Stroke ( ) Rheumatoid Arthritis

Signature _____ 11-4-14

BACK TO HEALTH CHIROPRACTIC'S MEDICARE POLICY:

Back to Health Chiropractic participates with most local Medicare plans. If you have any questions, please ask our staff. We will help you to understand your coverage.

Covered services: The chiropractic manipulation/adjustment is typically the only covered service.

Non-covered services: All other services that are not the chiropractic manipulation/adjustment i.e.; exams, back supports, supplements, medical supplies, other therapies such as, electric stimulation, ultra sound, therapeutic exercises are not covered. Treatments that are considered by Medicare to be not medically necessary are also not covered.

Exams: An initial exam and periodic re-exams are needed to provide you quality care. Medicare requires these to demonstrate medical necessity. With few exceptions, Medicare carriers will not pay for exams. The cost for an Initial exam is $85 -$120. Re-exams are $50 to $20, depending on the time spent and the complexity of your problem(s).

Payment: Co-payment & Deductible on covered services and 100% of non-covered services is paid the day of service. Traditional Medicare pays 80% of covered services and you pay 20%. Other plans have different % or fixed co-payment amounts. The patient pays a deductible or fixed amount each year*, before Medicare will cover any fees*. (Traditional Medicare is currently $147) This is applied to Medicare covered services only. We will inform you what this amount is at your first visit.

Secondary Insurance: If you have secondary insurance, we bill them for you. Most secondary insurance only cover Medicare covered services (see above), they pay all or part your co-payments & deductible.

Medical Necessity: Medicare pays for "active treatment" of medically necessary treatment. You must be on a treatment plan with defined, measurable functional goals. There must be an end to treatment. If continued improvement can be shown after an initial course of treatment, your care will be covered. ***Medicare or any other insurance does not cover supportive & maintenance care****.* We will inform you in advance, if we think Medicare will not consider your treatment medically necessary and have you sign an Advanced Beneficiary Notice of Non-coverage or ABN that you have been informed if continued care benefits you.

Supportive Care is for minor flare-ups or natural fluctuations of chronic spinal problems. Example: "My lower back is starting to hurt again. I'd like an adjustment and I'll see how it goes and call if I need another treatment."

Maintenance Care is to help your problem from worsening. You feel good and you find that occasional adjustments keep you from getting worse.

Medicare will cover an exacerbation of a chronic problem. An exacerbation is a bad worsening of your problem, where you loose function. This usually requires several visits to help restore you to your usual status. There are times when we think your care is medically necessary, but Medicare may not. In these instances we will appeal Medicare's decision and make every attempt to have your care covered. If it was found your care was not medically necessary and we did not inform you in advance, you will not be held responsible for these expenses.

I have read and understood the above information: I realize I am financially responsible for all services not covered by Medicare, my deductible and co-payments. I authorize the release of any medical information to process my claims. I request payment of government or private benefits either to the party that accepts assignment or myself. This is a permanent authorization that I may revoke at any time in writing.

_____Date__/___/__

Signature of patient or the person who can act on their behalf