CATER CHIROPRACTIC

Medicare Patient Registration Information

Patient Information

Patient name _____ DOB ___/___/_____ Gender
Last First MI
☐ Male
☐ Female

Cell Phone # (____)_____-_____ Social Security # ____-____-_____

Address _____ City _____ State ____ Zip Code _____

Email Address _____ Who referred you to our office? _____

Is this visit due to an auto accident or work related injury? ☐ No ☐ Yes ⟶ ☐ Auto Accident ☐ Work Injury

Choose one: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Major Complaints / Reason For Visit

Briefly describe your symptoms _____
_____
_____
_____

Employer Information OR ☐ Retired ☐ Unemployed

Employer name _____ Employer Phone # (___)_____-_____

Occupation _____

Spouse Information

Last name _____ First name _____

DOB ___/___/_____ Phone # (____)_____-_____

Gender
☐ Male
☐ Female

Emergency Contact

Name _____ Phone # (____)_____-_____ Relation _____

Ethnic Origin

- ☐ Black or African American
- ☐ American
- ☐ Asian
- ☐ Hispanic/Latino
- ☐ American Indian or Alaskan Indian
- ☐ Other or Decline to Specify

Race

- ☐ Black
- ☐ White
- ☐ Asian or Pacific Islander
- ☐ Hispanic
- ☐ American Indian or Alaskan Native
- ☐ Other or Decline to Specify

Medication List

Please list all of your current medications:

Medication Name	Condition	Dosage

Allergies

Please list any allergies

_____

_____

Smoking History

☐ Non-smoker ☐ Former Smoker ☐ Current smoker

*Signature*_____ *Date*_____

Re:

ID#

Provider Name: Cater Chiropractic

Date of Service:

Claim Number:

Dear Participant:

Please provide additional information regarding services rendered on

Was the condition being treated the result of an Accident/Injury: Yes/No

Was the condition being treated due to your type of work: Yes/No

Date of Accident:_____

How did Accident/Injury occur:_____

Where did Accident/Injury occur:_____

If an adult, did injury result from an On-the-Job Accident/Injury? Yes/ No

*If yes, please provide a brief description of that party's involvement in the accident

_____

_____

Member's signature:_____ Date signed:_____

Note to provider: A copy of the inquiry is being sent to your office only as a courtesy. In order to proceed with the handling of this claim, a response is required directly from the plan participant.

CATER CHIROPRACTIC

Assignment and instruction for direct payment to doctor

Subscriber: _____

Patient: _____

Claim #: _____ D.O.S: _____

I hereby instruct and direct the_____ insurance company to pay by check made out and mailed directly to:

Cater Chiropractic

1211 N. Main St.

Salinas, Ca 93906

OR

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make the check out to me as follows.

Cater Chiropractic

1211 N. Main St.

Salinas, Ca 93906

Direct payment to Cater Chiropractic are for the professional or medical expense allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **This is a direct assignment of my rights and benefits under this policy**. This payment will not exceed the amount I owe to cater chiropractic. I have agreed to pay, in a current manner, any balance of the professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney, or attorney involved in this case.

Signature of Policy Holder: _____ Date: _____

CATER CHIROPRACTIC

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures/examinations including various models of physical therapy and diagnostic x-ray. On me (or by the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who are now, or may be employed in the future, treat me at this clinic. I understand that results are not guaranteed.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks to treatment, including, but no limited to fractures, disc injuries, strokes, dislocations, sprains and burns. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon all factors then known, is in my best interest.

The probability of these risks occurring. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we 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 as 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 chose 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 information of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Patient's Signature: _____ Date: _____

Financial Policy

Medicare Patients

In accordance with Medicare Act, Section 1843(I), this letter is to advise you that Medicare will only pay for services that it determines to be "reasonable and necessary" under the section 1862(a)(1) of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service.

Patient Signature _____

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

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 may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Exam:

Xray:

CATER CHIROPRACTIC

Consultation Form

Name:_____ Date:_____

Referral:_____ Dr: _____

History of complaint:_____

_____

_____

_____

_____

( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa

Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____

Detail:_____

Radiation:_____

What aggravates:_____What alleviates:_____

( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa

Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____

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Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____

Detail:_____

Radiation:_____

What aggravates:_____What alleviates: _____

( )H.A/Neck/UB/MB/DL/LB other:_____O:_____ Cons/Freq/Inter/Occa

Sharp/Dull/Muscle Ache/ Burning sensation_____Scale: 0-10:_____

Detail:_____

Radiation:_____

What aggravates:_____What alleviate:_____

Other Symptoms:_____

TX/X-Rays Received: _____

Chiro TX:_____

Medication/Supports:_____

Limitations on ADL's:_____

Exercise:_____Cardio:_____Wt.Lifting:_____Other:_____

Diet: Good/Average/Not Good Vitamins/Nutrients:_____

Type of work_____

In the past 6 months, have you had any of the following?

Headaches: Y/N_____
Dif. Sleeping:: Y/N_____
Dizziness: Y/N_____
Loss of Energy: Y/N_____
Blurred Vision: Y/N_____
Tired in the A.M:Y/N_____
Loss of Concen: Y/N_____
Buzz/Ring Ear: Y/N_____
Depression: Y/N_____
RunDown: Y/N_____
Nervousness: Y/N_____
Faint/Palpitation:Y/N_____

In the past 6 months have you had any of these general problems?

Sinus: Y/N_____
Kidney/Bladder: Y/N_____
C/S PN/Stiffness: Y/N_____
Colon/Constipation: Y/N_____
Shoulder (R or L): Y/N_____
Low Back: Y/N_____
Arm/Hand/(R or L): Y/N_____
Hip (R or L): Y/N_____
UB/MB/Ribs: Y/N_____
Leg Pain(R or L): Y/N_____
Chest Pains: Y/N_____
Poor Circ.: Y/N_____
Lung/Heart: Y/N_____
Stomach/Digestion:Y/N_____
Gall Bladder/Liver Y/N_____
Other:_____

Previous Pertinent Medical History:

Hospital/Surgery: Yes/No:_____

_____

Accidents (MVA/Falls) Yes/No:_____

_____

Job Accidents (Open/Closed) None:_____

_____

Meds Taken for any Condition:_____
Allergies:_____
Family History of back problems:_____
Other: _____

_____

_____

_____

CATER CHIROPRACTIC

Patient Information

Patient Number: _____ Date: _____

Last Name:_____First Name:_____DOB:_____Age:_____ M/F

Email:_____Referred By:_____

Thank you date:_____ Report Dates 1. _____ 2._____ 3._____

Presenting Complaints:

1. _____/10 2. _____/10 3. _____/10

4. _____/10 5. _____/10 6. _____/10

X-Ray Findings: Views Taken: _____

_____

_____

_____

_____

Onset:_____**Diagnosis:** _____

_____

_____

_____

TX Recommendations: Chiro:_____

_____

Disability Status:_____

_____Re Exam:_____

Therapy: IF IST Myofascial Class IV Laser Ice Massage

Recommended Exercises: Back:_____ Neck:_____

EXT EX: _____ General /Exercise: _____

Current Diet/Vitamins: _____

Recommended Nutrition:_____

Home Care Recommendations: _____

Denneroll: _____

Insurance Summary:

%	Exam	X-Rays	OV's	DED	MET	Amt to Ded	Copay	TX