butler CHIROPRACTIC

- ***Traditional Medicare*** **– 2024 Deductible: $240.00.**
- ***Traditional Medicare*** – Up to **30 visits** **MAX** per calendar year.
- ***Medicare Advantage*** – Plans vary in benefits and requirements; Ex: Prior Authorization or Referrals needed.
- Our office will make every attempt to verify benefits; however, a quote of benefits from your insurance does not guarantee payment for services provided.

Medicare coverage for chiropractic is limited.

Medicare will ***only pay for your chiropractic adjustments*** when it meets Medicare rules. Please see below for services that are **NOT** covered by Medicare.

Non-covered services:

According to existing Medicare law, most of the available services in our office are **NON-COVERED.** Hopefully, the US Congress will change that someday and treat Doctors of Chiropractic like all doctors. The following services will not be covered by plans following Medicare Guidelines:

- Office visits to evaluate your condition: Exams *(vary from $40-$70)*, Re-Exams *($15)*
- X-rays *(vary from $40-$60 each)*
- Maintenance or wellness care
- Supplies and vitamins
- Modalities or therapies *($15 each)*

Non-covered items will appear on your insurance claim. Medicare should submit non-covered services to your supplement for payment consideration. If your supplement applies to a deductible or denies any non-covered items, you will be responsible for payment of these services.

I have read and understand all that I am personally responsible for any and all NON-COVERED services. Please print and sign your name below:

Print Full Name	Signature	Date
Witness	Date	

INTRODUCTION PATIENT CASE HISTORY

Today's Date: ___/___/____

PATIENT INFORMATION

Name: *(First MI Last)* _____ **Preferred Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female **Social Security #:** _____

Home: _____ **Mobile:** _____ **Work:** _____

Email: _____

Preferred Method of Contact: ☐ Text ☐ Email ☐ Home Phone ☐ Other: _____

*Referred By: *(Name)* _____

☐ Family ☐ Friend ☐ Co-Worker ☐ Doctor ☐ Other: _____

Race & Ethnicity: *(Choose up to 2)*

- ☐ African American or Black
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native Hawaii or Other Pacific Islander
- ☐ White
- ☐ Decline

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline

EMERGENCY CONTACT INFORMATION

Name: *(First MI Last)* _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship:

☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

FINANCIAL INFORMATION

Is today's visit the result of an accident?

☐ No ☐ Auto ☐ Work ☐ Other: _____

Will we be working with insurance? ☐ No ☐ Yes *(Details)*

Primary: _____ *ID#:* _____

Secondary: _____ *ID#:* _____

Where would you like statements sent?

☐ Self ☐ Other *(Details below)*

Name: _____

Address: _____

Phone: _____ *Email:* _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged

Account No: _____

SEAMLESS™ EHR

Revision Date 02.01.2017

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS *(Please describe)*

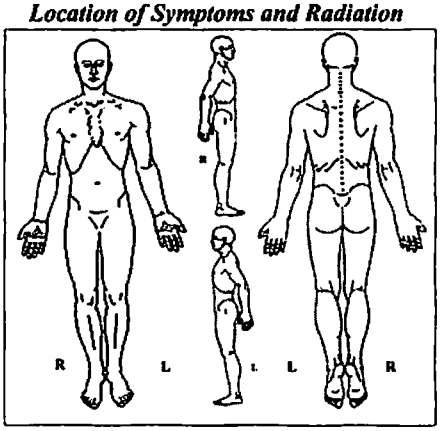
Major Complaint: _____ **Secondary Complaints:** _____

When did it start? ___/___/____ **What happened?** _____

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P __ Pain
N __ Numb
S __ Spasm
T__ Tender
H__ Hypoesthesia

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

***Women:** *Are you pregnant?*

☐ No *Last Menstrual Period:* ___/___/____

☐ Yes *Due date:* ___/___/____

Present Illness Comments:

_____

_____

_____

_____

_____

_____

Prescription Medications & Supplements: None

☐ Yes *(List – Name, dosage, frequency)* _____

_____

_____

_____

_____

_____

Allergies to Medications: ☐ No known drug allergies

☐ Yes *(List - Name and reaction)* _____

_____

_____

_____

_____

_____

PAST, FAMILY, AND SOCIAL HISTORY

PAST MEDICAL HISTORY

Have you *ever* had any of the following? *(Please select all that apply and use comments to elaborate.)*

Illnesses:

- ☐ Asthma
- ☐ Autoimmune Disorder (*Type*) _____
- ☐ Blood Clots
- ☐ Cancer (*Type*) _____
- ☐ CVA/TIA (stroke)
- ☐ Diabetes
- ☐ Migraine Headaches
- ☐ Osteoporosis
- ☐ Other: _____

Injuries:

- ☐ Back Injury
- ☐ Broken Bones
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Falls
- ☐ Other: _____

Hospitalizations: *(Non-surgical with Date)*

_____

_____

Surgeries: *(If yes, provide type & surgery date)*

- ☐ Cancer _____
- ☐ Orthopedic
  - Shoulder – R / L _____
  - Elbow/Forearm – R / L _____
  - Wrist/Hand – R / L _____
  - Hip – R / L _____
  - Knee – R / L _____
  - Ankle/Foot – R / L _____
- ☐ Spinal Surgery
  - Neck: _____
  - Back: _____
- ☐ Other: _____

_____

_____

Medical History Comments:

_____

_____

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_____

FAMILY HISTORY *(Please mark X to all that apply and use comments to elaborate.)*

☐ Unknown ☐ Unremarkable

	Mother	Father	Sibling1	Sibling2	Sibling3	Child1	Child2	Child3
Gender	F	M						
Age at death *(if Deceased)*								
Aneurysms								
CVA (Stroke)								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Other Family History								

Family History Comments:

_____

_____

_____

_____

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_____

_____

SOCIAL AND OCCUPATIONAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Children: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐
Other:_____

Student Status: ☐ Full Student ☐ Part Student ☐ Non-Student

Highest level of Education: ☐ High School ☐ College Grad.
☐ Post Grad. ☐ Other: _____

Employed: ☐ No ☐ Yes (*Occupation*) _____

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Smoking/Tobacco Use: *If current smoker, amount =* _____
☐ Every Day ☐ Some Days ☐ Former ☐ Never

Alcohol Use:
☐ Every Day ☐ Weekly ☐ Occasionally ☐ Never

Caffeine Use:
☐ Coffee ☐ Tea ☐ Energy Drinks ☐ Soda ☐ Never

Exercise frequency:
☐ Daily ☐ 3-4xs/week ☐ 2-3xs/week ☐ Rarely ☐ Never

Social History Comments: _____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature _____ Date _____

Print Name: *(First MI Last)* _____

REVIEW OF SYSTEMS

Many of the following conditions respond to Chiropractic and Acupuncture treatment.

Are you *currently* experiencing any of these symptoms? *(Please select all that apply and use comments to elaborate.)*

Constitutional: *(General)*
- ☐ Fever
- ☐ Fatigue
- ☐ Other: ____________
- ☐ *None in this Category*

Musculoskeletal:
- ☐ Joint Pain/Stiffness/Swelling
- ☐ Muscle Pain/Stiffness/Spasms
- ☐ Broken Bones____________
- ☐ Other: ____________
- ☐ *None in this Category*

Neurological:
- ☐ Dizziness or Lightheaded
- ☐ Convulsions or Seizures
- ☐ Tremors
- ☐ Other: ____________
- ☐ *None in this Category*

Psychiatric: *(Mind/Stress)*
- ☐ Nervousness/Anxiety
- ☐ Depression
- ☐ Sleep Problems
- ☐ Memory Loss or Confusion
- ☐ Other: ____________
- ☐ *None in this Category*

Genitourinary:
- ☐ Frequent or Painful Urination
- ☐ Blood in Urine
- ☐ Incontinence or Bed Wetting
- ☐ Painful or Irregular Periods
- ☐ Other: ____________
- ☐ *None in this Category*

Gastrointestinal:
- ☐ Loss of Appetite
- ☐ Blood in Stool or Black Stool
- ☐ Nausea or Vomiting
- ☐ Abdominal Pain
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Other: ____________
- ☐ *None in this Category*

Cardiovascular & Heart:
- ☐ Chest Pains/Tightness
- ☐ Rapid or Heartbeat Changes
- ☐ Swelling of Hands, Ankles, or Feet
- ☐ Other: ____________
- ☐ *None in this Category*

Respiratory:
- ☐ Difficulty Breathing
- ☐ Cough
- ☐ Other: ____________
- ☐ *None in this Category*

Eyes & Vision:
- ☐ Eye Pain
- ☐ Blurred or Double Vision
- ☐ Sensitivity to Light
- ☐ Other: ____________
- ☐ *None in this Category*

Head, Ears, Nose, & Mouth/Throat:
- ☐ Frequent or Recurrent Headaches
- ☐ Ear - Ache/Ringing/Drainage
- ☐ Hearing Loss
- ☐ Sensitivity to Loud Noises
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Other: ____________
- ☐ *None in this Category*

Endocrine:
- ☐ Infertility
- ☐ Recent Weight Change
- ☐ Eating Disorder
- ☐ Other: ____________
- ☐ *None in this Category*

Hematologic & Lymphatic:
- ☐ Excessive Thirst or Urination
- ☐ Cold Extremities
- ☐ Swollen Glands
- ☐ Other: ____________
- ☐ *None in this Category*

Integumentary: *(Skin, Nails, & Breasts)*
- ☐ Rash or Itching
- ☐ Change in Skin, Hair, or Nails
- ☐ Non-healing Sores or Lesions
- ☐ Change of Appearance of a Mole
- ☐ Breast Pain, Lump, or Discharge
- ☐ Other: ____________
- ☐ *None in this Category*

Allergic/Immunologic:
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Other: ____________
- ☐ *None in this Category*

Review of Systems Comments:

____

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature ______________________________ Date______________

Print Name: *(First MI Last)* ______________________________

butler CHIROPRACTIC

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information (referred to as "PHI" for the remainder of this document) will be used by this office or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your PHI may be used of disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice from the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use of Disclosure of Your Information

You may request a restriction on the use of disclosure of your PHI. It is the policy of this office that it will continue to provide treatment for a patient who restricts consent to the use and disclosure of his/her PHI for the purposes of treatment, payment or health care operations. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your PHI. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I, _____ (print) acknowledge that I have reviewed the above information and give my permission to this office to use and disclose my health information in accordance with it.

I give permission for Butler Chiropractic to share my personal health information with the following persons:

Person _____ Relationship _____

Person _____ Relationship _____

Patient Signature: _____ **Date:** _____

Assignment of Benefits

At the beginning of your treatment, our office will attempt to verify your insurance policy benefits. However, this office and your insurance DOES NOT guarantee a quote of benefits as payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you, and in the course of normal business practice for this office. You are responsible for your copayment/deductible and/or any balance your insurance company does not cover. By taking your insurance on assignment, our office agrees to wait for a portion of your bill for an estimated amount of time. In the event that your insurance company does not pay on a timely basis, you may be asked to contact your insurance carrier. Our office will not enter into a dispute with your insurance company on your behalf. *If your insurance company mails a check directly to you for our services, you must bring the misdirected check to our office within 48 hours.

Assignment and Conveyance of Lien Interest

I hereby execute and provide Irrevocable Lien Interest and Assignment of Proceeds to apply to all monetary proceeds from any 3rd party liability insurance policy and/or all monetary proceeds from any PIP/Medical payment insurance policy to which I am entitled, and from which I am paid in the form of an insurance settlement(s), claim(s), judgement(s), or verdict(s) resulting from any identified accident. The Insurance Carrier is instructed that pursuant to this Irrevocable Lien Interest and Assignment of Proceeds the total dollar amount of all sums which I owe on an account to the above named doctor and treating facility by the insurance carrier out of those settlement proceeds to which I am entitled or withheld from any settlement or award to which I shall be entitled and thereafter be paid directly to the above names doctor and/or amounts are determined to be owed, due, and payable on my account to such named doctor and treating facility and remit payment of all such sums directly to such named doctor and/or treating facility upon receipt of my settlement award(s).

Patient Signature: _____ **Date:** _____

Informed Consent to Treat

I hereby authorize and release the above named doctor and any individual in the employment of the doctor designated to administer treatment, physical examination, x-ray studies, chiropractic care, or any clinical services that he/she deems necessary to my case and plan of treatment. I understand that, as well as any healthcare procedure or treatment, that complications are possible following chiropractic manipulation and/or manual therapy techniques. The risks of complications due to chiropractic treatments have been labeled as "rare" and the probability of adverse reaction due to ancillary procedures is also considered "rare". By signing below, I acknowledge that I have read and agree to the above Consent for Treatment.

Patient Signature: _____ **Date:** _____