



Welcome to Shoreline Spine & Pain Associates:

In order to best meet your chiropractic needs, please complete the attached forms.

**Medicare:** The following information is necessary to initiate your claim.

We will require a copy of your Medicare card. If you have supplement health insurance, we will require a copy of your card.

We ask that you sign the attached Medicare Advance Beneficiary Notice (ABN) because Medicare pays for only a portion of chiropractic services and limits the number of reimbursable treatments based on your diagnosis. Reimbursable care is limited to spinal manipulation and does not include other therapies, services and goods that may be necessary during care.

Medicare will deny payment for your initial examination and consultation. If you are an established patient presenting with a new problem or you have not been seen in the last six months, Medicare will deny payment for a reexamination.

Please fill out the Release of Records with the name and address of any specific physician or other person you would like to receive a copy of your evaluation.

We thank you for your cooperation and if you have any questions, please do not hesitate to ask.

Sincerely,

**Shoreline Spine & Pain Associates**  
[Info@Shorelinespineandpain.com](mailto:Info@Shorelinespineandpain.com)

Patient's Name: \_\_\_\_\_

Medicare # (HICN): \_\_\_\_\_

## ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(s) that are described below.

Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **MEDICARE PROBABLY WILL NOT PAY FOR –**

**Items or Services:**

**Initial examination or reexamination. Any diagnostic (X-ray, Range of Motion and/or Muscle Testing) or therapeutic service (Extremity Manipulation, Electric Stimulation, Intersegmental Traction and/or Exercise Rehabilitation) furnished by a chiropractor or under his/her order is NOT COVERED other than what is listed below. The number of visits approved by Medicare is based on the diagnosis. The patient is responsible for services rendered after the number of visits is exceeded.**

**Because:**

**Chiropractic service, which is eligible for reimbursement, is specifically limited by Medicare to the manual manipulation (i.e., by use of hands) of the SPINE for the purpose of correcting a subluxation (Acute and Chronic).**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Examination \$\_\_\_\_\_ ; Spinal X-rays if necessary \$\_\_\_\_\_ = Estimated Cost: \$\_\_\_\_\_**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

? **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have.

I understand I can appeal Medicare's decision.

? **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

\_\_\_\_\_  
Patient's Signature or person acting on patient's behalf

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**NOTE: Your health information will be kept confidential.** Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.



## REGISTRATION FORM

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Chart #: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's Last Name		First	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Marital Status (Circle One)	
M.I.				Single / Mar / Div / Sep / Wid	
Social Security #.	Home Phone #.	Cell Phone #.	Birth Date	Age	Sex
- - -	( )	( )	/ /		<input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	Zip Code	Email Address
Occupation		Employer		Employer Phone #.	
				( )	
Employer Address		City	State	Zip Code	

Who may we thank for referring you?     Patient \_\_\_\_\_     Dr. \_\_\_\_\_

Insurance Plan     Hospital     Family     Friend     Close to Home/Work     Yellow Pages     Other \_\_\_\_\_

Primary Care Physician (PCP)	PCP Street Address	PCP Phone #.
		( )

**WORK OR ACCIDENT INFORMATION (PLEASE FILL OUT ALL INFORMATION REQUESTED IF APPLICABLE)**

Is Injury Work or Auto related?	Date of Injury	Name/Address of Insurance Carrier (For Claims)	Adjusters Name and Phone #.
<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____		( )
Claim #.	Injury Report Filed?		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Attorney Name		Attorney Address	Attorney Phone #.
			( )

**COMMERCIAL INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)**

Is patient covered by insurance?     Yes     No    Primary Insurance Type     HMO     PPO     Indemnity     Other \_\_\_\_\_

Please indicate primary insurance     Medicare     Medical Mutual     BCBS     United HealthCare     Cleveland Clinic     CIGNA  
 SummaCare     Emerald Health     Anthem Traditional     Anthem Sr. Advantage     CareSource     Other \_\_\_\_\_

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #	Co-Payment \$
	- -	/ /			

Patient's Relationship to Subscriber     Self     Spouse     Child     Other \_\_\_\_\_

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber     Self     Spouse     Child     Other \_\_\_\_\_

**IN CASE OF EMERGENCY**

Name of Local Friend or Relative	Relationship	Home Phone #.	Work/Cell #.
		( )	( )

The above information is true to the best of my knowledge. I assign directly to Shoreline Spine & Pain Assoc. all Medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize my doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X \_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

File #: \_\_\_\_\_

### HEALTH HISTORY

Name:

(Last, First, M.I.)

M

F

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the reason for your visit?

What do you think caused this problem?

### PERSONAL HEALTH HISTORY

Please list any current medical conditions or symptoms you are experiencing, or have experienced during the past year:

Please tell us about any hospitalizations, serious illnesses or surgeries:

Year

Reason

Hospital

Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Name

Condition

Dosage

Frequency Used

Please Provide details of any known allergies. (e.g., latex, medications, food)

Allergen

Reaction

**HEALTH HABITS**

**Exercise:**       Sedentary (No exercise)       Mild exercise (i.e., climb stairs, walk 3 blocks, golf)  
 Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 minutes)  
 Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

**Diet:**      Are you dieting? .....  Yes     No  
 If yes, are you on a physician prescribed medical diet? .....  Yes     No  
 # of meals you eat in an average day? \_\_\_\_\_  
 Please rate the quality of your diet:    *Perfect* 1 2 3 4 5 6 7 8 9 10 *Terrible*

**Caffeine:**       None     Coffee     Tea     Cola    # of Cups/Cans Per Day? \_\_\_\_\_

**Alcohol:**      How many alcohol containing beverages do you consume: daily \_\_\_\_\_ weekly \_\_\_\_\_

**Tobacco:**      Do you use tobacco? .....  Yes     No  
 Cigarettes \_\_\_\_\_ Pk/day    # of years \_\_\_\_\_  or Year Quit \_\_\_\_\_

**Sleep:**      Does your complaint disrupt your sleep?  Yes     No  
 How do you rate your quality of sleep?    *Perfect* 1 2 3 4 5 6 7 8 9 10 *Terrible*

**Stress:**      Please rate your stress management strategies:    *Perfect* 1 2 3 4 5 6 7 8 9 10 *Terrible*  
 Please rate your daily stress level:      *None* 1 2 3 4 5 6 7 8 9 10 *Terrible*

**Pregnancy / Children:**    # pregnancies \_\_\_\_\_    # Birth children \_\_\_\_\_

**FAMILY HEALTH HISTORY**

**PLEASE HELP US TO IDENTIFY YOUR POTENTIAL HEALTH RISKS BY PLACING A CHECK IN ANY COLUMN THAT APPLIES TO YOU OR YOUR BLOOD RELATIVES.**

Condition / Body System	Self	Grandparent	Parent	Sibling	Child
Aids / HIV					
Arthritis					
Bleeding disorders					
Cancer					
Endocrine / glandular (diabetes thyroid)					
Hepatitis					
Immune					
Stroke / TIA					
Circulatory Problems (blood vessels, heart)					
Ear , Nose, Throat					
Heart Problems					
High Blood Pressure					
Neurological (brain, nerves)					
Gastrointestinal (stomach, Intestines)					
Muscle / Joint / Bone					
Genitourinary (urine, kidney, prostate)					
Psychological					
Respiratory (lung, breathing)					
Skin					

***I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in completion of this form.***

Patient Signature \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

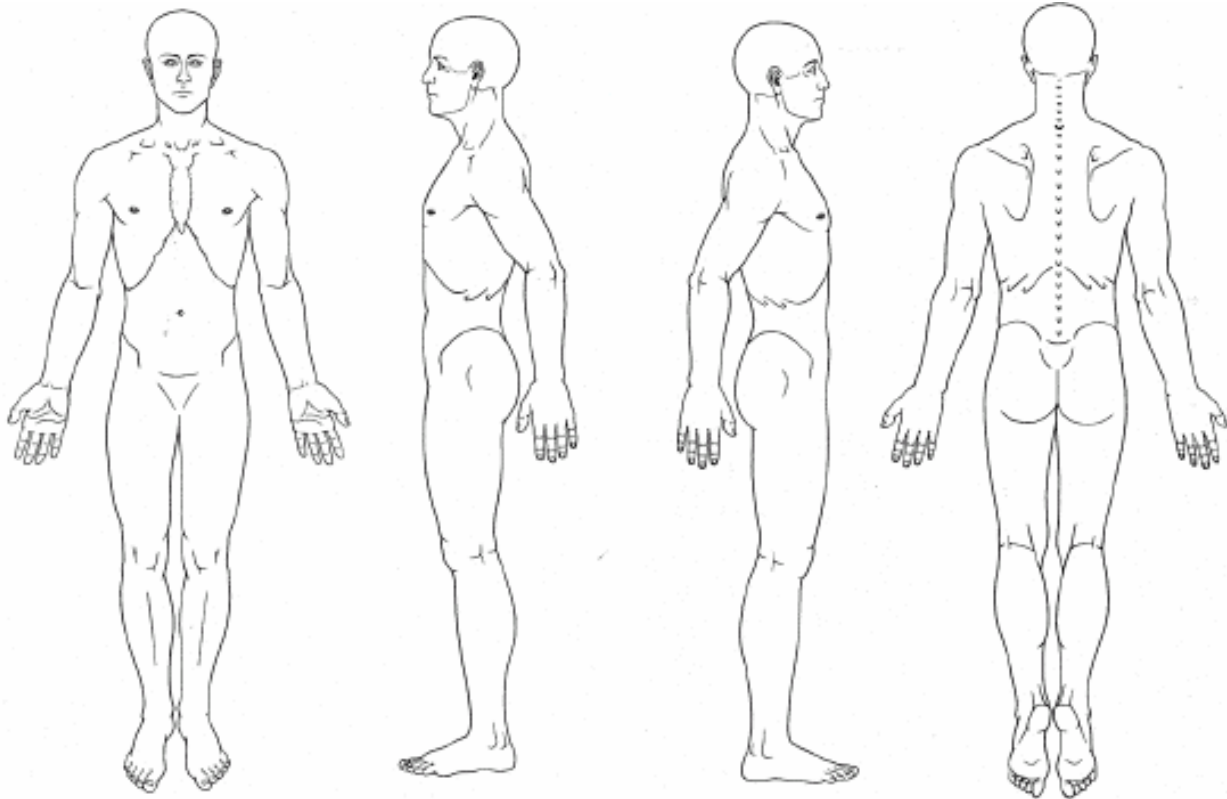
File: \_\_\_\_\_

***Pain Diagram***

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.

**DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.**

Numbness - - - - Pins & Needles oooo Burning xxxx Aching \*\*\*\* Stabbing ////



Please place a vertical mark on the line below to indicate the severity of your complaint.

**Neck Pain** No Pain | \_\_\_\_\_ | Worse Pain Imaginable

**Low Back Pain** No Pain | \_\_\_\_\_ | Worse Pain Imaginable

**Other** \_\_\_\_\_ No Pain | \_\_\_\_\_ | Worse Pain Imaginable

Patient Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_



## Credit / Financial Policy

Restoring your health is our foremost objective. Our treatment will always be rendered solely on the base of need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangements have been previously made. Our fees comply with the "usual and customary" rates for this region. We accept cash, checks, Visa, MasterCard, Discover and American Express. For patients who are unable to pay at the time of service, special arrangements are available upon request.

**REGARDING ALL INSURANCE** We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We will submit bills to your insurance carrier, but will not become involved in disputes between the insured and the insurance company. This courtesy will commence as soon as we are able to confirm coverage for chiropractic services and have the proper, signed insurance forms. Payment of non-covered services and co-payments is expected at the time of services. We strongly urge you to contact the insurance company to verify your benefits; sometimes incorrect information is provided to us.

If an insurance company fails to pay for services within ninety days, the undersigned is responsible for payment. Ultimately, you are responsible for all outstanding balances. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three days.

**MEDICARE:** Medicare pays for only a portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services and goods that may be necessary during care. Please be advised of the following Medicare restrictions and regulations.

- Medicare will pay for a maximum number of treatments per calendar year, based on your diagnosis. When the maximum number of treatments has been rendered, payment is expected at the time of service.
- Medicare will not pay for an initial examination. This fee is the patient's responsibility and will not apply to the patient's deductible.

**PERSONAL INJURY, WORKER'S COMPENSATION AND/OR LITIGATION:** If your complaint is the result of an occupational or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within fourteen days, all services must be paid for by the patient at the time rendered. It is our policy to bill the insurance company directly and will provide the attorney with a monthly statement.

Instances will arise when we exhaust all reasonable efforts to secure payment from your insurance company, but the insurance company refuses payment. We will do our best to assist you in securing payment, but all balances are ultimately your responsibility.

**ASSIGNMENT OF BENEFITS:** I hereby assign all insurance benefits, including Medicare, to be payable to Shoreline Spine & Pain Associates.

**MISSED APPOINTMENTS:** There is a \$30.00 charge for missed appointments without a 24 hour notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointments. If more than three appointments are missed without notification, we will recommend that you seek treatment at another facility, or schedule care when you are able to commit to the recommended treatment program.

In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

I have read this policy and understand that I am financially responsible for all unpaid balances for my care.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



### ***Informed Consent for Examination and Treatment***

I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.  
Date of last menstrual period \_\_\_\_\_.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

MCC Staff: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## RELEASE OF RECORDS

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I request and authorize Shoreline Spine & Pain Associates to release my chiropractic records to the organization, agency, or individuals named below.

I certify that this request has been made voluntary and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above-authorized information may not be accomplished without further written consent. Without my expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or, not later than thirty days (30) from the date of this document.

Please release my records to:

? Primary Care Physician:

\_\_\_\_\_

\_\_\_\_\_

? Other Physicians:

\_\_\_\_\_

\_\_\_\_\_

? Attorney:

\_\_\_\_\_

\_\_\_\_\_

? Myself / Other:

\_\_\_\_\_

\_\_\_\_\_  
*(Signature of patient or person authorized to sign for patient)*

\_\_\_\_\_  
*(Relationship to patient of person authorized to consent)*

? I decline your offer to send records to any of the above and will advise you in writing if I wish you to do so in the future.

\_\_\_\_\_  
*(Signature of patient or person authorized to sign for patient)*