



Welcome to Shoreline Spine & Pain Associates:

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

Personal Injury: The following information is necessary to initiate your claim and treatment.

Please be sure to provide the date of injury, insurance company name, address, telephone number, claim number and the name of the adjuster handling your claim.

If you have health insurance, we will require a copy of your insurance card, completion of Section One of the "Health Benefit Affidavit", along with verification of chiropractic benefits & eligibility. Please confirm with your health insurance carrier that we are an in-network provider. In the event that your claim is denied, exhausted, or terminated through an Independent Medical Exam (IME) we will submit all bills to your health insurance carrier. Your co-payment/co-insurance/deductible will be due at the time of service. If you do not have health insurance, please complete Section Two of the "Health Benefit Affidavit".

We also require the name, address and telephone number of your attorney. Please sign and date a physician's lien (given at time of initial appointment), which will be sent to your attorney. If you do not have an attorney at this time, we still require your signature on the lien in the event that you do retain legal services.

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 Assoc.
Info@Shorelinespineandpain.com



REGISTRATION FORM

Today's Date ____/____/____

Chart #: _____

PATIENT INFORMATION

Patient's Last Name M.I.			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) 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 #. ()
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WORK OR ACCIDENT INFORMATION (PLEASE FILL OUT ALL INFORMATION REQUESTED IF APPLICABLE)

Is Injury Work or Auto related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury ____/____/____	Name/Address of Insurance Carrier (For Claims)	Adjusters Name and Phone #. ()
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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)		Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

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



HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Acts of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, Health Insurance, etc.) available to you before your claim can be processed for Personal Injury Protection Benefits (PIP).

Any medical expense in excess of \$2,000.00 will not be paid under PIP if those expenses will be compensated, paid or indemnified by an outside insurance carrier (HMO, Medicare, Health Insurance, etc.). Bills submitted to the PIP carrier over the \$2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment.

If you have health insurance benefits available to you, please complete **SECTION ONE** (do not write in your automobile insurance information).

If you do not have any health insurance benefits available through your own policy or that of a household member, please sign and date **SECTION TWO**.

SECTION ONE: BENEFITS INFORMATION

Your name: _____

Name of your Health Insurance Company: _____

Address of your Health Insurance Company: _____

Policy Number: _____ Name of Policyholder: _____

Signature: _____ Date: ____/____/____

SECTION TWO: NO HEALTH BENEFITS

I hereby certify that I do not have any accident and/or health benefits available to me through my own policy or that of a household member.

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: ____/____/____

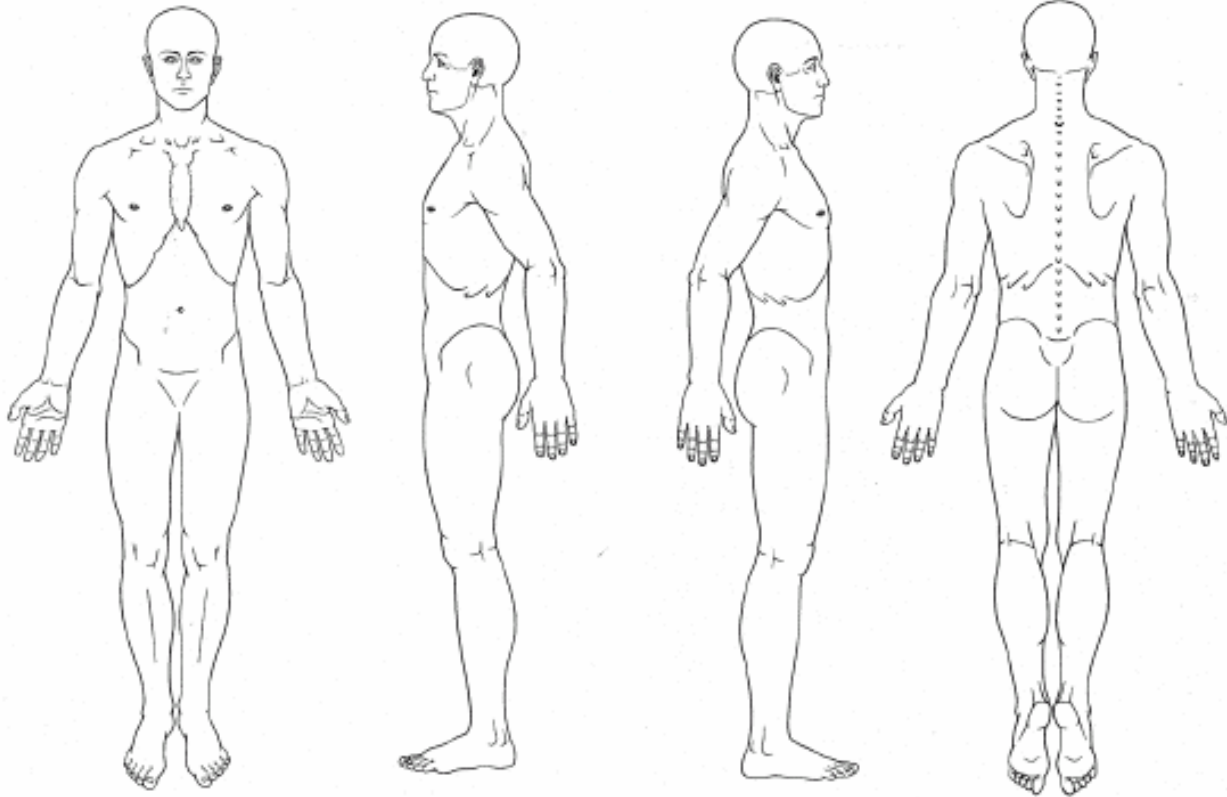
File: _____

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: ____/____/____

Shoreline Spine & Pain Associates
2415 Boston Post Rd., Unit 11
Guilford, CT 06437
Phone: (203) 453-2001
www.Shorelinespineandpain.com



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)



Patient's Guide to Insurance Verification

We encourage you to verify your insurance benefits and have developed the following guide to assist with the process. Please record all relevant information to cross-check with our verification process.

You will find a customer service number on your insurance card. Please contact a service representative and ask the following questions about each recommended service.

It is always recommended that you record the name of the person with whom you discussed your coverage.

Name: _____

Date: ____/____/____

We have recommended the following treatments:

Procedure	Procedure Code	
Examination	99211-99215	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal manipulation	98940, 98943	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electrical muscle stimulation	97014	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mechanical Traction	97012	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exercises and stretches	97110	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neuromuscular Re-education	97112	<input type="checkbox"/> Yes <input type="checkbox"/> No
Manual Therapy	97140	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADL/Self Care	97535	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please ask the following questions.

Are the recommended treatments covered? Yes No

Is Dr. Chris Coulis a covered provider / part of your network? Yes No If no, ask next question

Is there an out of network benefit? Yes No Details: _____

Do I need a primary care physician referral? Yes No

Is there a deductible? Yes No Amount: _____

Has it been met this year? Yes No

How many treatments may I receive? _____

Is there a maximum allowable payment for each service? _____ Amount: _____

Can you send me confirmation of this conversation? Yes No Confirmation #: _____

As you complete this process, please feel free to call our office at 203-453-2001. If you would like to cross check the information that you obtain, please fax this form to 203-453-2010. As always, we request your feedback on how we might improve this form.