CF CHIRO-FIT

Acknowledgment of Clinic Terms

Our GOAL

- The goal of CHIRO-FIT, Inc. is to increase affordability while decreasing the hassles of chiropractic care.

What we DO

- We do at CHIRO-FIT, Inc. offer affordable and accessible chiropractic adjustments to the public.
- We do use our hands to apply a specific and controlled thrust to the targeted joint in the spine (vertebral subluxation) and extremities of the body by our licensed Doctor of Chiropractic. The applied force to the joint is termed as an adjustment or manual manipulation

What we DON'T - *(Limitation of Services)*

- We do NOT accept, bill, prepare, respond or submit documentation to any third-parties or insurance companies. You may choose to submit receipts to your insurance company or other third-party health care programs however, payment/reimbursement for such services by insurance companies is neither implied nor agreed to by this office. We take no responsibility for non-payment by insurance companies, Medicare, 3rd parties for services rendered at our office. Upon patients written request we will provide the patient and/or legal guardian/authority with a copy of their treatment records (fees may apply).
- We do NOT have: x-ray, extensive diagnostic equipment, e-stim, ultrasound, laser therapy in our clinics.
- We do NOT treat, prepare or submit reports for any motor vehicle accident, personal or work related injuries. If I am involved in such event, it is my responsibility to notify the chiropractor and seek care with a medical doctor or other healthcare provider who can treat your newly acquired conditions or injuries

FINANCIAL OBLIGATION

- Patient acknowledges that all payments for services will be paid immediately following services rendered.
- In the event a check for service payment is returned there will be an additional $30 fee applied to the existing owed amount to the patient.
- Initial exam, consultations fees will be paid for at time of completion.
- In event that the doctor feels x-rays are necessary we may refer you to your physician or imaging clinic to be taken by a medical radiologist.
- CHIRO-FIT, Inc. and/or the providing clinic doctor reserves the right to deny services to anyone for any reason, or if the doctor feels that the patient's health is not being best served within our clinic. Our patient's health & well-being is our number one interest.
- Again, we do not accept, bill, prepare, respond or submit documentation to any third-party insurance, Medicare, Medicaid or health insurance companies for payment. You may choose to submit receipts to your insurance company or other third-party health care programs however, payment/reimbursement for such services by insurance companies is neither implied nor agreed to by this office. We take no responsibility for non-payment by insurance companies and/or Medicare for services rendered at our office.
- All owed fees must be paid prior to receiving any future care.

I, _____ (Patient Printed Name) have read, fully understand and consent to all of the above statements.

All questions regarding the clinic policies and care provided at CHIRO-FIT, Inc. have been answered to my complete satisfaction. I therefore accept all chiropractic services rendered to me at this location.

_____ _____

(Patient Signature- If minor then signature of legal guardian (Date)

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INFORMED CONSENT

Please read this information carefully and ask Dr. Boston if there is anything that you do not understand.

The nature of chiropractic treatment: The doctors will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Hydromassage, mechanical massage, roller table massage, topical analgesics are also services provided in clinic.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. Irritation, bruising, soreness could also be associated with the additional massage & topical analgesics.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Chiropractic treatment: has been shown to be effective in the treatment of neck and back conditions such as pain, numbness, muscle spasm, decreased mobility, headaches etc. Routine chiropractic treatment can result in better function, improved joint motion, improved overall health and an increased active lifestyle. Alternatives to chiropractic wellness care are resources listed (but not limited to): Physical Therapy, Medical Doctors, Orthopedic Doctors, Surgeons.

I have read the explanation above and I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I consent to the chiropractic treatments offered or recommended to me by the treating doctor(s) of CHIRO-FIT, Inc.

Patient Printed Name: _____ Patient or Legal Guardian Signature: _____

Date: _____

Witness of Signature: _____ Date: _____

CF CHIRO-FIT

Advanced Beneficiary Notice of NonCoverage (ABN) | MEDICARE ELGIBLE PATIENTS

Notifier: CHIRO-FIT, Inc
520 SW 3rd St. Ste 1B
Ankeny, Iowa 50023

PRINTED PATIENT NAME: _____

NOTE: If Medicare doesn't pay for maintenance chiropractic care 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 maintenance chiropractic care below.

MAINTENANCE CHIROPRACTIC CARE – S8990	REASON MEDICARE MAY NOT PAY: Chiropractic Adjustments for the purpose of maintenance care is not payable service by Medicare.	Estimated Cost per Visit: $15 - $40

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 maintenance chiropractic care 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.
Additional Information: This ABN form is only good for up to one (1) year.

OPTIONS Check only one box. We cannot choose an option for you

☐ **Option 1**: I want the chiropractic maintenance care 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. By selecting this option we will refer you to another provider.

☐ **Option 2**: I want the chiropractic maintenance care 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 chiropractic maintenance care listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. By selecting this option we will refer you to another provider.

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 also receive a copy.

PATIENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____ Male or Female (circle)

Height: _____ Weight: _____

_____

Home Address City State Zip

Phone Number: _____

Email: _____ Communication Preference (circle one): Phone or Email

Employer _____ Job Title: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

1) Are you Medicare Eligible? (circle one) Yes or No

2) Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)? Yes or No

3) If <u>NO</u> complaints (seeking preventative/maintenance care) check the box M on the right and skip to line 13. [M]

4) If you had to pick one health problem we could help with, what would it be?_____

5) What would you rate your pain (if present) 1 2 3 4 5 6 7 8 9 10
No Pain Worse Pain Ever

6) When did the problem start? _____

7) How did it start? _____

8) Has this problem ever happened before? _____

9) Is it worse in morning or night? _____

10) How often do you feel the pain? _____ How long does the pain last?_____

11) Have you seen any other doctors for this problem? _____

i. What was the result? _____

12) Please list all surgeries and the year you received them: _____

_____

13) Have you been in any previous automobile or experienced workplace, personal injuries?_____

i. Did you receive treatment due to the injury? Yes or No

14) Do you ever experience any dizziness? Yes or No

15) Have you ever seen a chiropractor before? Yes or No

16) If yes, who/where was the chiropractor you seen? _____

17) In the last year, have you received any x-rays of your spine? Yes or No

If yes: Why did you receive them? _____

18) Where did you receive them? _____

19) Do you or a family member have a history of Arthritis? Yes or No

20) What are your normal hobbies/activities you partake in? _____

21) How often do you go to the gym? _____

22) What activities or hobbies have you been unable to do because of your problem? _____

23) History of: Hypertension, Heart conditions, Lung conditions, Stroke (circle all that apply)

24) Current Medical Conditions: _____

_____

25) Family Medical Conditions History: _____

_____

26) Medications: _____

TO BE COMPLETED BY PATIENT:

SUBJECTIVE: Please describe your pain:
How did your pain start?

_____

_____

What do you think is **causing** your pain?

_____

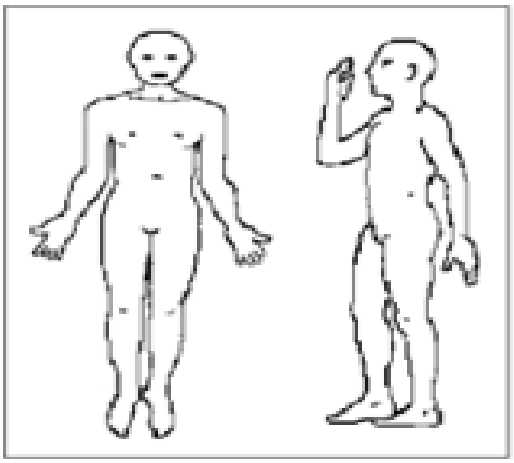
How long have you had the pain? _____
Is it **occasional**? ☐ Y ☐ N
Is it **continuous**? ☐ Y ☐ N

What makes the pain **better**? _____

What makes the pain **worse**? _____

Is it **due** to an:
- ❑ accident (MVA)
- ❑ worker's
- ❑ injury

Where is your pain? (See drawing.)
Is it **going anywhere** else? (Draw arrows.)



How does your pain **feel**?

❑ aching	❑ cramping	❑ burning	❑ shooting
❑ throbbing	❑ pressure	❑ electric shock	❑ numbing
❑ gnawing	❑ deep aching	❑ hot	❑ itching
❑ _____	❑ squeezing	❑ stabbing	❑ tingling

Do you have any other **symptoms** in addition to pain? ☐ Y ☐ N

❑ _____	❑ sleep problems	❑ nausea	❑ itching
❑ _____	❑ irritability	❑ vomiting	❑ weakness
❑ fear	❑ loss of appetite	❑ constipation	❑ confusion
❑ anxiety		❑ difficulty urinating	❑ sleepiness

Does the pain **disturb** your

❑ sleep	❑ walking	❑ concentration	❑ relationships
❑ eating	❑ housework	❑ energy	❑ enjoyment of life
❑ self-care	❑ work	❑ mood	❑ recreation?

Are you **depressed**? ☐ Y ☐ N Does the pain make you feel depressed? ☐ Y ☐ N

What have you tried to **treat** the pain? Do you have any **allergies**? ☐ Y_____ ☐ N

Medications:	Did it help? How much?		Side effects?	
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
Other treatment:	Did it help? How much?		Side effects?	
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N

Do you have any important **medical problems?**

❑ peptic ulcer disease	❑ edema/swelling of legs	❑ cancer _____
❑ high blood pressure	❑ kidney disease	❑ other _____

Patient Signature (if minor then legal guardian signature):_____

Date: _____