

ABOUT MEDICARE CHIROPRACTIC COVERAGE

Your Medicare coverage of chiropractic care is limited. They will only pay for the chiropractic adjustment (manipulative treatment) when it meets Medicare's rules. There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or counsel.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

Non-covered items will appear on your insurance claim form. They will show as a Medicare Non-covered service like this: "72010-GY". The "72010" code is for an x-ray. The "-GY" means that it is not-covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract.

ALWAYS-COVERED SERVICES

A typical example of a Medicare COVERED service is when you are injured or you are in much pain due to a bad spinal condition. You should expect Medicare to pay for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your chiropractic adjustment, we will discuss this matter with you. We will also give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

MY FINANCIAL RESPONSIBILITY

I have received the above information, "About Medicare Chiropractic Coverage." I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductibles applicable, copayments, or non-covered services as may be required by my insurance plan.

X _____
Signature of patient or person acting on patient's behalf

X _____
Date

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X _____
Signature of patient or person acting on patient's behalf

X _____
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 a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

Butler Chiropractic Clinic 1501 Cross Timbers Rd # 200, Flower Mound, Texas 75028 972-221-7533

Date: _____

Name _____ Sex: Male or Female

Married ___ Spouse name: _____ Single ___ Divorced ___ Widowed ___

Address _____ City _____ State _____ Zip _____

Home _____ Work _____ Cell _____ Date of Birth _____

Referred by _____ Social Security # _____

Occupation _____ Employer _____

Email Address: _____

Emergency contact: _____ Phone: _____

Have you ever received Chiropractic Care? Yes No If yes, when & by who? _____

1. Primary reasons and location for seeking chiropractic care:

Primary reason: _____

Secondary reason: _____

Other factors contributing to the primary and secondary reasons: _____

Complaint Began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain/complaint imaginable)

How frequent is complaint present, how long does it last? _____

Does anything aggravate the complaint? _____

Does anything make the complaint better? _____

3. Have you had previous treatments, medications, surgery, or care you've sought for these current complaints:

4. Past Health History:

A. Prior illnesses requiring hospitalization or treatment: _____

B. Previous injuries auto accidents, broken bones, etc.: _____

C. Allergies to treatment: _____

D. Medications:

Medications and reason for taking

Surgeries:

Type or surgeries and approximate date

E. Females/ Are you pregnant or think you may be pregnant? YES or NO

What was the date of the beginning of your last menstrual period? _____

5. Family Health History:

Mother /Father health issues? _____

6. Social and Occupational History:

A. Level of Education:

high school some college college graduate post graduate studies

B. Job description: _____

C. Work schedule: _____

D. Recreational activities: _____

E. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet): _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize **Butler Chiropractic, 1501 Cross Timbers Rd., Flower Mound, Texas 75028** to provide me with chiropractic care, in accordance with Texas state statute.

Patient or Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

Butler Chiropractic Clinic 1501 Cross Timbers Rd # 200, Flower Mound, Texas 75028

Patients Signature: _____

Please Circle the Appropriate Answer

- | | | |
|---|-----|----|
| 1. Do you need glasses to read? | Yes | No |
| 2. Do you need glasses to see things at a distance? | Yes | No |
| 3. Has your eyesight often blacked out completely? | Yes | No |
| 4. Do you often have bad pains in your eyes? | Yes | No |
| 5. Are your eyes often red or inflamed? | Yes | No |
| 6. Are you hard of hearing? | Yes | No |
| 7. Have you ever had fluid leaking from your ear? | Yes | No |
| 8. Do you have constant noises in your ears? | Yes | No |
| 9. Do you have to clear your throat constantly? | Yes | No |
| 10. Do you often feel a choking lump in your throat? | Yes | No |
| 11. Are you often troubled with bad spells of sneezing? | Yes | No |
| 12. Is your nose continually stuffed up? | Yes | No |
| 13. Do you suffer from a constantly running nose? | Yes | No |
| 14. Have you at times had bad nose bleeds? | Yes | No |

Heart-Lung

- | | | |
|--|-----|----|
| 15. Do you frequently suffer from heavy chest colds? | Yes | No |
| 16. Do you get hay fever? | Yes | No |
| 17. Do you suffer from asthma? | Yes | No |
| 18. Are you troubled by constant coughing? | Yes | No |
| 19. Have you ever coughed up blood? | Yes | No |
| 20. Do you wake up drenched with sweat during the middle of the night? | Yes | No |
| 21. Have you ever had a chronic chest condition? | Yes | No |
| 22. Has a doctor ever said your blood pressure was too high? | Yes | No |
| 23. Has a doctor ever said your blood pressure was too low? | Yes | No |
| 24. Do you have pains in the heart or chest? | Yes | No |
| 25. Are you often bothered by thumping of the heart? | Yes | No |
| 26. Does your heart often race like mad? | Yes | No |
| 27. Do you often have difficulty breathing? | Yes | No |
| 28. Are your ankles often badly swollen? | Yes | No |
| 29. Do cold hands or feet trouble you, even in hot weather? | Yes | No |
| 30. Do you suffer from frequent cramps in your legs? | Yes | No |
| 31. Has your doctor ever said you had heart trouble? | Yes | No |
| 32. Does heart trouble run in your family? | Yes | No |

Digestive System

- | | | |
|--|-----|----|
| 33. Do severe pains in the stomach often cause you to double over? | Yes | No |
| 34. Do you suffer from constant stomach trouble? | Yes | No |
| 35. Does stomach trouble run in your family? | Yes | No |
| 36. Has a doctor ever said you had stomach ulcers? | Yes | No |
| 38. Do you suffer from frequent loose bowel movements? | Yes | No |
| 39. Have you ever had severe bloody diarrhea? | Yes | No |
| 40. Do you constantly suffer from bad constipation? | Yes | No |
| 41. Do you usually feel bloated after eating? | Yes | No |

Musculoskeletal

42. Are your joints often painfully swollen?	Yes	No
43. Do your muscles and joints constantly feel stiff?	Yes	No
44. Do you usually have severe pains in the arms or legs?	Yes	No
45. Are you crippled with severe arthritis?	Yes	No
46. Does arthritis run in your family?	Yes	No
47. Do weak or painful feet make your life miserable?	Yes	No
48. Do pains in the back make it hard for you to keep up with your work?	Yes	No
49. Are you troubled with a serious bodily disability or deformity?	Yes	No
50. Does pressure or pain in the head often make life miserable?	Yes	No
51. Are headaches common in your family?	Yes	No
52. Do you often have spells of severe dizziness?	Yes	No
53. Do you frequently feel faint?	Yes	No
54. Have you fainted more than twice in your life?	Yes	No
55. Do you have constant numbness or tingling in any part of your body?	Yes	No
56. Were you ever knocked unconscious?	Yes	No
57. Have you at times had a twitching of the head, face or shoulder?	Yes	No
58. Did you ever have a seizure or convulsion (epilepsy)?	Yes	No
59. Has anyone in your family ever had seizures or convulsions (epilepsy)?	Yes	No
60. Did a doctor ever treat you for a tumor or cancer?	Yes	No
61. Do you suffer from any chronic disease?	Yes	No

Genito-Urinary

62. Are you a sleep walker?	Yes	No
63. Are you a bed wetter?	Yes	No
64. Were you a bed wetter between the ages of 8 to 14?	Yes	No
65. Are you crippled with severe arthritis?	Yes	No
66. During the day, do you unusually have to urinate frequently?	Yes	No
67. Do you often have severe burning when you urinate?	Yes	No
68. Do you sometimes lose control of your bladder?	Yes	No
69. Has a doctor ever said you had kidney or bladder disease?	Yes	No

Women Only

70. Are you pregnant?	Yes	No
71. Have your menstrual periods usually been painful?	Yes	No
72. Have you often felt weak or sick with your periods?	Yes	No
73. Have you often had to lie down when your periods came on?	Yes	No
74. Have you usually been tense or jumpy with your periods?	Yes	No
75. Have you ever had severe hot flashes or sweats?	Yes	No
76. Have you often been troubled with a vaginal discharge?	Yes	No

Men Only

77. Have you ever had treatment for your genitals?	Yes	No
78. Have you ever passed blood while urinating?	Yes	No
79. Do you have trouble starting your stream when urinating?	Yes	No
80. Do you have to get up every night and urinate?	Yes	No

Immune System

81. Does working tire you out completely?	Yes	No
82. Do you usually get up tired or exhausted in the morning?	Yes	No
83. Does every little effort wear you out?	Yes	No
84. Do you suffer from severe nervous exhaustion?	Yes	No
85. Are you frequently confined to bed by illness?	Yes	No
86. Are you considered a sickly person?	Yes	No
87. Do severe pains and aches make it impossible for you to do your work?	Yes	No
88. Do you wear yourself out worrying about work?	Yes	No
89. Are you always ill and unhappy?	Yes	No

Patients Signature: _____

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Flower Mound, Texas 75028**

Health Insurance Portability & Accountability Act (HIPAA) Consent Form

Your Protected Health Information will be used by this office or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or 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 at the Front Desk. This office reserves the right to modify the privacy practices outlined in the Notice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information. 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 or her Protected Health Information for the purposes of treatment, payment, or health care operations. Use or disclosure of protected 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 Protected Health Information. 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, _____ (print) acknowledge that I have reviewed the above information and **DO NOT** give my permission to release any information to my insurance carrier. I do understand that PHI will be used within the office for purposes of my care to those individuals designated by the doctor.

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

At the beginning of your treatment our office will make every attempt to verify your policy benefits, however, this office and your insurance DOES NOT guarantee a quote of benefits for payment of services provided. Should your insurance provide Chiropractic benefits, your insurance will be filed on a weekly basis as a courtesy to you. You will be responsible for your deductible and/or co-payment. Your insurance should pay within 45 days from the date in which it was filed. 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.

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 third 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 to be paid in the form of an insurance settlement(s), claim(s), judgment(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 account to the above named doctor and treating facility, as evidenced by the medical bills submitted by the doctor and/or treating facility, shall be paid directly 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 named doctor and/or treating facility. In the event my insurance settlement proceeds are paid directly to my attorney, I hereby irrevocably instruct my attorney to withhold all such sums and amounts as 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 my settlement award(s).

Patient Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

I hereby authorize and release the doctor and any individual he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, chiropractic care or any clinical services that he/she deems necessary in my case. I understand that, as with any health care procedure, 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".

Patient Signature: _____ Date: _____