



- **Traditional Medicare – 2026 Deductible: \$283.00; 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 \$75-\$150*), Progress Exams (*\$20-\$75*)**
- **X-rays (*\$25/view*)**
- **Maintenance or wellness care**
- **Supplies and vitamins**
- **Modalities or therapies (*\$15 each*)**
- **Extremity adjustment/manipulations**

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 Phone - Home, Mobile, or Work 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 Hawaiian 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: _____

Where would you like statements sent?

Self Other (Details below)

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

Name: _____

Primary: _____ ID#: _____

Address: _____

Secondary: _____ ID#: _____

Phone: _____ Email: _____

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

Account No: _____

HISTORY OF PRESENT ILLNESS

HISTORY OF PRESENT ILLNESS (Please describe)

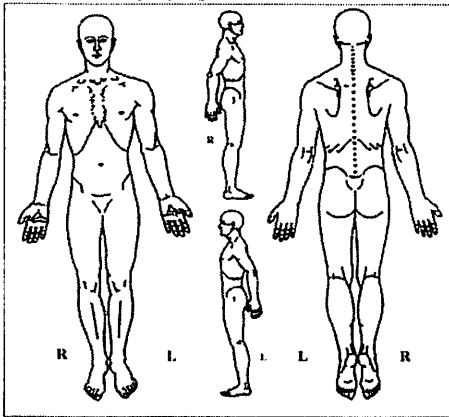
Major Complaint: _____ **Secondary Complaints:** _____

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

Which daily activities are being affected by this condition? _____

MAJOR COMPLAINT

Location of Symptoms and Radiation



P ___ Pain T ___ Tender
 N ___ Numb H ___ Hypoesthesia
 S ___ Spasm

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:

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

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:

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:

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: _____



Last updated: 11.13.24

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 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 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.

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 _____

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.

Patient Signature: _____ Date: _____

Assignment of Benefits

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF PAYMENT TO BUTLER CHIROPRACTIC.** This payment will not exceed my indebtedness to the above assignee and I have agreed to pay, in current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my claim to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Assignment and Conveyance of Lien Interest (LOPs/Attorney, PI, Automobile Accidents, Workers Comp, etc)

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 named 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: _____

Functional Rating Index

For use with Neck and/or Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item, please **circle** the number which most closely **describes your condition right now**.

1. Pain Intensity

0-----1-----2-----3-----4
 No Mild Moderate Severe Worst
 pain pain pain pain possible
 pain

2. Sleeping

0-----1-----2-----3-----4
 Perfect Mildly Moderately Greatly Totally
 sleep disturbed disturbed disturbed disturbed
 sleep sleep sleep sleep sleep

3. Personal Care (washing, dressing, etc.)

0-----1-----2-----3-----4
 No Mild Moderate Moderate Severe
 pain; pain; pain; need pain; need pain; need
 no no to go slowly some 100%
 restrictions restrictions assistance assistance

4. Sitting (driving, traveling, etc.)

0-----1-----2-----3-----4
 No pain Increased Increased Increased Increased
 after pain after pain after pain after pain after
 any sitting several hours 1 hour ½ an hour any sitting

5. Work (house work, garden work, etc)

0-----1-----2-----3-----4
 Can do Can do Can do Can do Cannot
 usual work usual work 50% of 25% of work
 plus no extra usual usual
 extra work work work work

6. Recreation (golfing, pickleball, social events, etc)

0-----1-----2-----3-----4
 Can do Can do Can do Can do Cannot
 all most some a few do any
 activities activities activities activities activities

7. Frequency of pain

0-----1-----2-----3-----4
 No Occasional Intermittent Frequent Constant
 pain pain; 25% pain; 50% pain; 75% pain; 100%
 of the day of the day of the day of the day

8. Lifting

0-----1-----2-----3-----4
 No Increased Increased Increased Increased
 pain with pain with pain with pain with pain with
 heavy heavy moderate light any
 weight weight weight weight weight

9. Walking

0-----1-----2-----3-----4
 No pain; Increased Increased Increased Increased
 any pain after pain after pain after pain after pain any
 distance 1 Mile ½ Mile ¼ Mile walking

10. Standing

0-----1-----2-----3-----4
 No pain Increased Increased Increased Increased
 after pain pain pain pain pain with
 several after after after after any
 hours several hours 1 hour ½ an hour standing

Name: _____ (Printed)

Total Score: _____

Signature: _____

Date: _____