



NEW PATIENT INTAKE

Chiropractic [medicare]

Account #: _____

*Thank you for choosing Bountiful Life Chiropractic Center. We are committed to providing you and your family the highest quality of chiropractic care so you may enjoy an active and healthy lifestyle. Prior to your consultation, please complete the following paperwork as thoroughly as possible in order for us to gain a clear understanding of your health goals. We will require a photocopy of your **driver's license** (or government identification), **Medicare card**, and **secondary insurance card** for our records. We comply with all federal privacy standards. As such, all information you provide is confidential.*

Are you on Medicaid? If yes, please provide your card to our front desk staff member.

Legal Name: _____

Date of Birth: _____ Age: _____ Nickname / Name you go by: _____

Caretaker's Name (if applicable): _____

Gender: Male Female

Primary Phone #: (____)____-____ Cell Home

Secondary Phone #: (____)____-____ Cell Home

*By providing us with a cell number, you will automatically be enrolled in **text appointment reminders**.*

Email: _____

Email appointment reminders *in addition* to text reminders? Yes No

Preferred method(s) of communication: Phone Call Text Email

Address: _____ City, State: _____ Zip: _____

Marital Status: Single Married Domestic Partner Divorced Widowed

Spouse/Partner's Name (if applicable): _____ Phone #: (____)____-____

Emergency Contact Name (if other than spouse): _____ Phone #: (____)____-____

Do you have children? Yes No If yes, how many? _____

How did you hear about our clinic? (check all that apply)

Google Search Facebook Instagram Referral from: (name) _____

(We will thank them with a special gift!)

Driving by Other (please describe): _____

SYMPTOM SURVEY

Please mark each applicable symptom with a 1 or 2

1 – Currently experiencing (in the last 6-8 weeks) | 2 – Have experienced in the past

GENERAL

- Chills
- Convulsions
- Dizziness/loss of balance
- Fainting
- Fever
- Headaches/migraines
- Insomnia
- Weight loss/gain
- Nerve pain
- Nervousness/anxiety
- Depression
- Numbness
- Sweats
- Tremors
- Cancer
- Diabetes - type 1 or type 2?
- Stroke
- Seizures

EYES

- Corrective lenses or contacts
- Far sighted
- Near sighted
- Cataracts
- Blind spots
- Sensitivity to light
- Eye pain

EARS, NOSE, & THROAT

- Allergies
- Colds
- Deafness
- Hearing loss
- Ear aches
- Ear discharge
- Ear ringing (tinnitus)
- Enlarged glands
- Enlarged thyroid
- Dental decay
- Gum trouble
- Loss of taste
- Hoarseness
- Nose bleeds
- Sore throats
- Sinus infections

Nasal obstruction

Loss of smell

MUSCULOSKELETAL

- Arthritis
- Bursitis
- Hernia
- Low back pain
- Mid back pain
- Neck pain/stiffness
- Arm pain
- Shoulder pain
- Leg pain
- Knee pain
- Foot pain
- Muscle cramps
- Fractures
- Sciatica
- Spinal curvature

GENITO-URINARY

- Bed wetting
- Blood in urine
- Frequent urination
- Inability to control bladder
- Kidney infection
- Kidney stones
- Painful urination
- Pus in urine

CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Heart disease
- Pain over heart
- Rapid heart rate
- Slow heart rate
- Poor circulation
- Cold extremities (hands/feet)
- Bruise easily
- Swelling of ankles
- Pacemaker
- Varicose veins

RESPIRATORY

- Asthma
- Bronchitis
- Chest pain

Chronic cough

Difficulty breathing

Spitting up blood

Spitting up phlegm

Wheezing

GASTROINTESTINAL

- Belching or gas
- Abdominal pain
- Constipation
- Diarrhea
- Difficult digestion
- Poor appetite
- Ulcers
- Vomiting
- Vomiting blood
- Abdominal bloating
- Excessive hunger
- Heartburn/reflux
- Hemorrhoids
- Jaundice/liver issues
- Nausea
- Gallbladder issues
- Colitis
- Irritable bowel syndrome

WOMEN ONLY

- Pregnant (currently)
- Possibly pregnant
- Painful menstruation
- Menstrual cramps
- Hot flashes
- Irregular cycle
- PCOS
- Lumps in breast(s)
- Vaginal discharge
- Nipple discharge
- Pregnancy complications
- Miscarriage
- Infertility

MEN ONLY

- Prostate problems
- Erectile dysfunction
- Hesitancy/dribbling
- Infertility

Have you seen a chiropractor before? Yes No If yes, when? _____

Surgeries (with approx. dates): _____

Illnesses (with approx. dates): _____

Accidents, Falls, Traumas (with approx. dates): _____

Have you had a concussion? Never One time Multiple times I think so, but not sure

Do you smoke or use other tobacco products? Never Occasionally Regularly I've quit

Do you drink alcohol? Never Occasionally Regularly I've quit

Do you drink caffeinated beverages? Never Occasionally Regularly I've quit

Please list current medications: _____

Please list current vitamins or supplements: _____

Are you allergic to any medications? Yes No If yes, which ones? _____

Are you allergic to any foods? Yes No If yes, which ones? _____

What condition(s) led you to seek chiropractic care? _____

When did you first notice it? _____

What were you doing when you first noticed it? _____

Have you had this condition / these symptoms before? Yes No If yes, when? _____

Do the symptoms radiate or travel to another area? Yes No Not sure

If yes, please describe: _____

How frequently do you experience symptoms? (circle one)

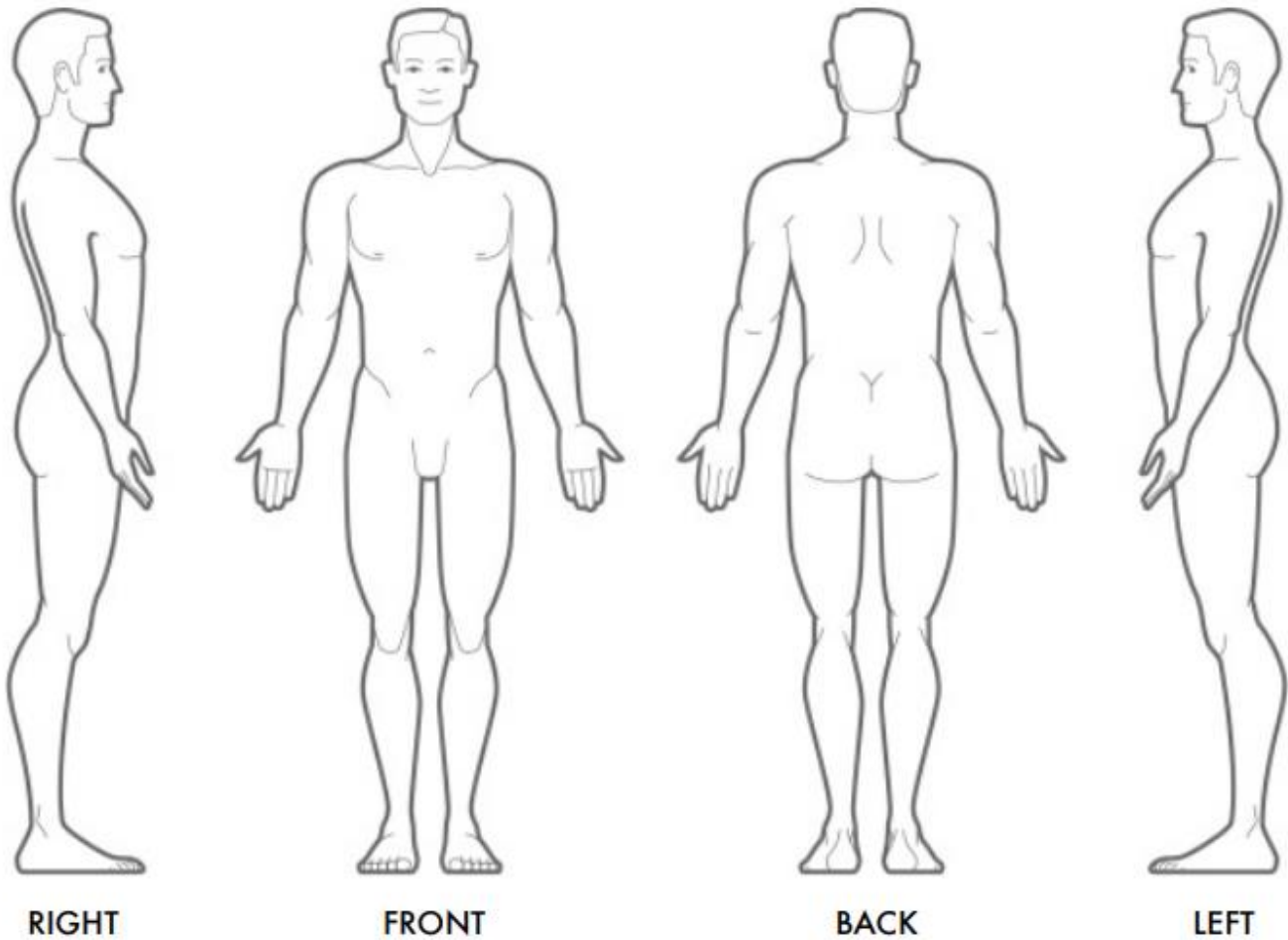
Intermittently
[0-25% of day]

Occasionally
[26-50% of day]

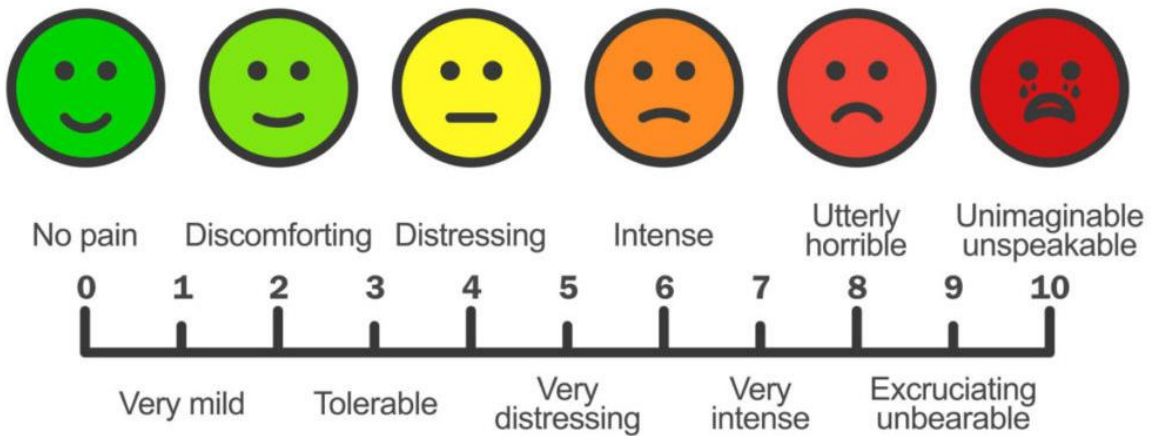
Frequently
[51-75% of day]

Constantly
[76-100% of day]

Place an "X" on the diagram below in the locations you are experiencing symptoms:



How would you rate the intensity of your pain? (circle a number)



Is the pain (circle all that apply): Sharp Dull Aching Burning Numb Throbbing Pins & Needles

What makes your symptoms better? _____

What makes your symptoms worse? _____

What movements/activities are difficult with your condition? _____

FUNCTIONAL RATING INDEX (FRI)

In order to properly assess your condition, we must understand how your symptoms have affected your ability to manage every day activities.

For each item below, please circle the answer which most closely describes your condition today.

1. PAIN INTENSITY	No pain (0)	Mild pain (1)	Moderate pain (2)	Severe pain (3)	Worst possible pain (4)
2. SLEEPING	Perfect sleep (0)	Mildly disturbed sleep (1)	Moderately disturbed sleep (2)	Greatly disturbed sleep (3)	Totally disturbed sleep (4)
3. PERSONAL CARE <small>washing, dressing, etc.</small>	No pain, no restrictions (0)	Mild pain, no restrictions (1)	Moderate pain, need to go slowly (2)	Moderate pain, need some assistance (3)	Severe pain, need 100% assistance (4)
4. TRAVEL <small>driving, riding in vehicle, etc.</small>	No pain on long trips (0)	Mild pain on long trips (1)	Moderate pain on long trips (2)	Moderate pain on short trips (3)	Severe pain on short trips (4)
5. WORK	Can do normal work plus unlimited extra work (0)	Can do normal work, no extra work (1)	Can do 50% of normal work (2)	Can do 25% of normal work (3)	Cannot work (4)
6. RECREATION	Can do all activities (0)	Can do most activities (1)	Can do some activities (2)	Can do few activities (3)	Cannot do any activities (4)
7. FREQUENCY OF PAIN	No pain (0)	Occasional pain, 25% of day (1)	Intermittent pain, 50% of day (2)	Frequent pain, 75% of day (3)	Constant pain, 100% of day (4)
8. LIFTING	No pain with heavy weight (0)	Increased pain with heavy weight (1)	Increased pain with moderate weight (2)	Increased pain with light weight (3)	Increased pain with any weight (4)
9. WALKING	No pain, any distance (0)	Increased pain after 1 mile (1)	Increased pain after ½ mile (2)	Increased pain after ¼ mile (3)	Increased pain, any distance (4)
10. STANDING	No pain after several hours (0)	Increased pain after several hours (1)	Increased pain after 1 hour (2)	Increased pain after ½ hour (3)	Increased pain with any standing (4)

OFFICE USE ONLY: Score _____ % _____

Patient Name:

Date:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **services listed** 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 services listed below.

Type of Service:	Reason Medicare May Not Pay:	Estimated Cost
Manual Manipulation of the Spine (Chiropractic Adjustment)	Medicare NEVER pays for maintenance care	\$50
X-Ray Studies and Exams	These are NON-COVERED services under Medicare when ordered and/or delivered by a chiropractic physician.	\$50-150
Extremity Adjustment Only	Medicare NEVER pays for extremity adjustments	\$50

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 **services** 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.

OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the service 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.
- OPTION 2.** I want the service 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 service listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information: 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.

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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

MEDICARE BILLING POLICIES

Our clinic participates with Medicare and adheres to their policies and procedures. You will have the opportunity to determine if we file your claims with Medicare depending on the choice you select on the ABN (Advanced Beneficiary Notice).

Our clinic guidelines for determining whether your visit is coded as ACUTE or MAINTENANCE care are as follows:

- **ACUTE:** A patient's condition is considered Acute when they are being treated for a new injury of the spine, identified by spinal x-ray or physical exam. Your doctor will determine whether a spinal x-ray, exam, or both, will provide the best tools necessary to begin acute care. Adjustments (98940, 98941, & 98942) are a COVERED service when reasonable expectations of recovery or improvement occur over a brief period of time, usually 6-10 adjustment visits.
- **MAINTENANCE:** A patient's care is considered Maintenance when services are provided that seek to prevent disease, promote health, prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. These services are NOT COVERED by Medicare, and are the patient's responsibility.
- X-rays, exams, and extremity adjustments (98943) are NOT COVERED by Medicare, and are to be paid at the time of service.

If you carry secondary insurance, Medicare will automatically forward your claims to them as long as we have the information on file. If you have chiropractic benefits available on your secondary policy, the funds will be sent directly to you or to our clinic, depending on what option you selected when you enrolled with them. For billing purposes Bountiful Life Chiropractic Center is a non-provider, out-of-network provider for medical insurance companies.

Resources from Chapter 15 | Section 30.5 (B) 240.1.3

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1601.pdf>

TERMS OF ACCEPTANCE

Chiropractic has only one goal - to serve the health needs of you, the patient. When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral or extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine, as well as extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, then do an analysis, and then develop a treatment for the extremity and synchronize this plan with the plan for the spinal treatment.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral.

We do not treat diseases or conditions in our office beyond the spine or extremities; however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you, the patient.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-RAY RELEASE

This is to certify that Dr. LaBounty & Dr. Miller have my permission to perform an X-ray evaluation.

To the best of my knowledge, I am not pregnant, and I understand that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

PAYMENT / INSURANCE

I understand that Bountiful Life Chiropractic Center will provide a receipt to assist me in making collection from any insurance company. I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I have read and understand the above, and I agree to these policies and procedures. All questions about this page have been answered to my satisfaction, and I therefore accept care at Bountiful Life Chiropractic Center on this basis.

Patient Signature: _____

Printed Name: _____ Date: _____