A. Chiropractic Associates of Rochester – 190 Perrin Dr., Rochester, NY 14622 (585-544-1540)
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. services 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 D. Service below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New Patient Initial Exam:	This is not a covered service under Medicare / Medicare Advantage Plans	$40.00
Maintenance Care (once a month)	This is not a covered service under Medicare / Medicare Advantage Plans	$40.00
Extremity Manipulation	This is not a covered service under Medicare / Medicare Advantage Plans	$10.00
Soft Tissue (ART, Graston, etc)	This is not a covered service under Medicare / Medicare Advantage Plans	$10.00
Any supplies (pillows, lumbars, biofreeze, or any supplements	This is not a covered service under Medicare / Medicare Advantage Plans	Prices Vary

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 services in D.** 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.

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

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

H. 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. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

CHIROPRACTIC ASSOCIATES of ROCHESTER

585-544-1540 *Fax*: 585-544-1580
chirorochester@gmail.com
190 Perrin Drive Rochester, NY 14622
www.chiroROC.com

Tina Shores, D.C. | Colby Shores, D.C., CCSP

New Patient Information

Name:_____ Date: _____
Address:_____,_____,_____
(Street) (City) (State) (Zip)

Patient Contact #: (Home / Cellular) (_____)_____-_____ Preferred (H | C)
Email Address:_____
Sex:__Male | Female | Other:_____) Date Of Birth: _____/_____/_____
Referred By: _____ **Relationship:**_____

Emergency Contact

Name:_____Relationship:_____
Phone #:__(_____)_____ Work #: _(_____)_____

Medical History

Primary Care Physician:_____ Phone:_____
Office Name: _____
Are you being seen by other specialists?_____
Have you seen a Chiropractor in the past? (Y | N) Who?:_____
Date of last adjustment:_____ None_____

Date of Last:
Physical Exam:_____ Blood Test:_____ Urine Test:_____
MRI | CT Scan:_____ Prostate Exam:_____ DEXA:_____
Other:_____

Habits

____ Smoking Packs/ Day:_____
____ Alcohol Drinks / Week:_____
____ Caffeine Cups/ Day_____
____ High Stress Reason_____

Women Only

Are you pregnant? (Y | N)
# of Pregnancies:____ # of Deliveries:_____
Vaginal _____ C-Section _____
Birth Control? (Y | N)

Injuries / Surgeries you have had (Date or Year): _____
Motor Vehicle Accidents: _____
Broken Bones / Fractures: _____
Spinal Injuries (Neck, Back, Low Back, Pelvis): _____
Surgeries (Include all, i.e. Tonsillectomy): _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

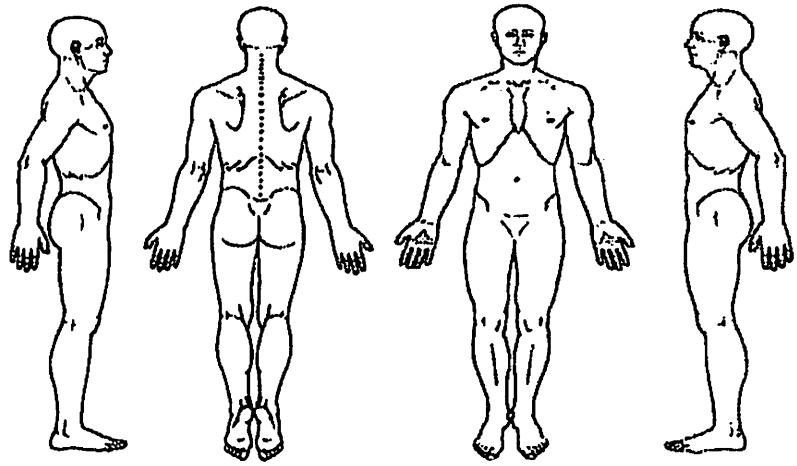
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

---

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: _____ ③ CT Scan date: _____
② MRI date: _____ ④ Other date: _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

_____

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*	
O	O	Headaches
O	O	Neck Pain
O	O	Upper Back Pain
O	O	Mid Back Pain
O	O	Low Back Pain
O	O	Shoulder Pain
O	O	Elbow/Upper Arm Pain
O	O	Wrist Pain
O	O	Hand Pain
O	O	Hip/Upper Leg Pain
O	O	Knee/Lower Leg Pain
O	O	Ankle/Foot Pain
O	O	Jaw Pain
O	O	Joint Swelling/Stiffness
O	O	Arthritis
O	O	Rheumatoid Arthritis
O	O	General Fatigue
O	O	Muscular Incoordination
O	O	Visual Disturbances
O	O	Dizziness

Past	*Present*	
O	O	High Blood Pressure
O	O	Heart Attack
O	O	Chest Pains
O	O	Stroke
O	O	Angina
O	O	Kidney Stones
O	O	Kidney Disorders
O	O	Bladder Infection
O	O	Painful Urination
O	O	Loss of Bladder Control
O	O	Prostate Problems
O	O	Abnormal Weight Gain/Loss
O	O	Loss of Appetite
O	O	Abdominal Pain
O	O	Ulcer
O	O	Hepatitis
O	O	Liver/Gall Bladder Disorder
O	O	Cancer
O	O	Tumor
O	O	Asthma
O	O	Chronic Sinusitis

Past	*Present*	
O	O	Diabetes
O	O	Excessive Thirst
O	O	Frequent Urination
O	O	Smoking/Use Tobacco Products
O	O	Drug/Alcohol Dependence
O	O	Allergies
O	O	Depression
O	O	Systemic Lupus
O	O	Epilepsy
O	O	Dermatitis/Eczema/Rash
O	O	HIV/AIDS

Females Only

O	O	Birth Control Pills
O	O	Hormonal Replacement
O	O	Pregnancy
O	O	

Other Health Problems/Issues

O	O
O	O
O	O

Indicate if an immediate family member has had any of the following:

O Rheumatoid Arthritis O Heart Problems O Diabetes O Cancer O Lupus O_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

NECK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your neck pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your neck pain?

No pain Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your neck pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving)?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your neck pain interfered with your ability to take part in recreational, social, and family activities?

No interference Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your neck pain?

Have made it no worse Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your neck pain on your own?

Completely control it No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE. Humphreys BK: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. II. Psychometric Properties in Neck Pain Patients. *JMPT* 2002; 25 (3): 141-148.

BACK BOURNEMOUTH QUESTIONNAIRE

Patient Name _____ Date _____

Instructions: The following scales have been designed to find out about your back pain and how it is affecting you. Please answer ALL the scales, and mark the ONE number on EACH scale that best describes how you feel.

1. Over the past week, on average, how would you rate your back pain?

No pain — Worst pain possible

0 1 2 3 4 5 6 7 8 9 10

2. Over the past week, how much has your back pain interfered with your daily activities (housework, washing, dressing, walking, climbing stairs, getting in/out of bed/chair)?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

3. Over the past week, how much has your back pain interfered with your ability to take part in recreational, social, and family activities?

No interference — Unable to carry out activity

0 1 2 3 4 5 6 7 8 9 10

4. Over the past week, how anxious (tense, uptight, irritable, difficulty in concentrating/relaxing) have you been feeling?

Not at all anxious — Extremely anxious

0 1 2 3 4 5 6 7 8 9 10

5. Over the past week, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, unhappy) have you been feeling?

Not at all depressed — Extremely depressed

0 1 2 3 4 5 6 7 8 9 10

6. Over the past week, how have you felt your work (both inside and outside the home) has affected (or would affect) your back pain?

Have made it no worse — Have made it much worse

0 1 2 3 4 5 6 7 8 9 10

7. Over the past week, how much have you been able to control (reduce/help) your back pain on your own?

Completely control it — No control whatsoever

0 1 2 3 4 5 6 7 8 9 10

_____
Examiner

OTHER COMMENTS: _____

With Permission from: Bolton JE, Breen AC: The Bournemouth Questionnaire: A Short-form Comprehensive Outcome Measure. I. Psychometric Properties in Back Pain Patients. *JMPT* 1999; 22 (9): 503-510.

CHIROPRACTIC ASSOCIATES OF ROCHESTER

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Tina Shores, D.C. | Colby Shores, D.C., CCSP

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years. These studies have demonstrated that chiropractic care is a highly effective treatment for spinal pain, headaches, and other symptoms. Maintaining spinal alignment through chiropractic care contributes to overall well-being. The risk of injury or complications from chiropractic treatment is substantially lower than that associated with many medical treatments, medications, and procedures used for similar conditions.

I acknowledge that I have received information regarding my condition and the proposed chiropractic treatment, as well as alternative options for care, including the benefits, risks, and potential side effects of treatment, and the consequences of not receiving the proposed treatment.

I understand and am informed that, as with all health care, chiropractic treatment carries some risks, including but not limited to: muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I trust the doctor to exercise judgment during the course of treatment based on the information available at the time and in my best interest.

My doctor has responded to all my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend for this consent to apply to all my present and future chiropractic care in this office.

Patient Signature_____Date_____

Witness_____Date_____

CHIROPRACTIC ASSOCIATES OF ROCHESTER

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HIPPA Policy

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices before signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree, then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement and consent on this Notice of Privacy Practices Acknowledgement/Consent Form, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

Insurance Financial Agreement 2026

Insurance Company:_____

Policy Holder Name:_____ **D.O.B.:**_____/_____/_____

Policy Number:_____ **Group # (If Applicable):**_____

Relationship to Policy Holder: Self | Spouse | Child

INDIVIDUAL POLICY

Insurance policies are individualized per each patients benefit. Please read and initial next to your benefit plan.

_____ **Excellus BC/BS, Aetna and United:** Deductibles: Referral may be needed. Until your annual deductible is met, the insurance fee schedule will be procedure-dependent. Once the deductible is met, you will be responsible for the co-insurance policy dependent. Your co-pay is due at the time of service and will range from $0-$70, depending upon your contract. Insurance covers acute care and not maintenance care. Supplements are not covered and are the patient's responsibility.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United:** Authorization may be required. Some insurances set a number of visits allowed. Some costs are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care, not maintenance care.

_____ **Medicare:** No referral needed. Until your annual deductible of $283.00 is met, the insurance fee schedule is $50-$100.00. You will be responsible for any usual and customary fee (ABN). Your insurance covers acute care and no maintenance care.

_____ **MVP/Cigna/Other:** The doctors in this office are out of network providers. Payment follows the Usual and Customary Fee shown below.

_____ **Usual & Customary Fees:** First visit for consultation, history and examination is $100.00. Subsequent visits thereafter are $50.00.

_____ **Maintenance Care:** Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. This is a service not covered as per your insurance company policy, and you will be responsible for the office fee of $50. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre-complaint status or plateaued in improvement.

I understand that I am financially responsible for all charges, whether paid by insurance or self-pay.

_____

Responsible Party Signature Date

_____

Printed Name

Office Financial Agreement 2026

Please read and initial next to each of the office policies to indicate your agreement and understanding of each section.

OFFICE POLICY

_____ **New Patient Appointment Fee: $50**
All new patients will be charged a $50 appointment holding fee that will be credited towards your total bill.

_____ **Consultation Fee: $50**
No treatment | 15 Minute Appointment

_____ **Missed/ Cancelled Visit w/in 24 Hrs : $50**
All patients are subject to adhere to a $50 charge without notice of a missed or cancelled appointment.

_____ **No Insurance | Self Pay: $100 | $50**
Each visit will be $50 for all current patients. If you are a New Patient, your initial evaluation will be $100, then $50 thereafter per visit.

_____ **Our office does not allow a personal balance over $100. Should your account become 30 days delinquent, a $10 charge per week will be assessed to the outstanding balance.**

_____ **Payment is due at the time of service. Payment in the form of cash, credit or check is accepted. All major credit cards are accepted.**

_____ **Returned checks will have a $25 service charge.**

I understand that I am financially responsible for all charges, whether paid by insurance or self-pay.

_____

Responsible Party Signature Date

_____

Printed Name

CHIROPRACTIC ASSOCIATES OF ROCHESTER

Tina Shores, D.C.
Colby Shores, D.C., CCSP

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroroc.com

www.chiroROC.com

AUTHORIZATION FOR RELEASE OF INFORMATION:

OFFICE USE ONLY

TO: _____

_____

_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____

_____X-Rays and / or report of findings, CT scans, MRI's

_____ Consult reports from specialists

_____ Test Results

_____Billing Records

_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____Date of Birth: _____

Signature of Patient _____Date: _____

If under age 18 Signature of Guardian: _____Date: _____

Relationship to Patient: _____