

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, lumbar, 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.

<p>G. OPTIONS: Check only one box. We cannot choose a box for you.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> 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.</p>

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: _____
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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.

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.



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

Pre-Existing Patient Information

Name: _____ Date: _____

Address: _____
(Street) (City) (State) (Zip)

Patient Contact #: (Home)_(____)____-____(Cell)_(____)____-____ Preferred (H | C)

Email Address: _____

Sex:_(Male | Female | Other:_____) Date Of Birth: ____/____/____

Emergency Contact

Name: _____ Relationship: _____

Phone #:_(____)____ Work #:_(____)____

Medical History

Primary Care Physician: _____ Phone: _____

Office Name: _____

Are you being seen by other specialists? _____

Medication List: _____

Allergies To Medication: _____

Insurance Update Information 2026

Insurance Company: _____

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

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

Relationship to Policy Holder: Self | Spouse | Child

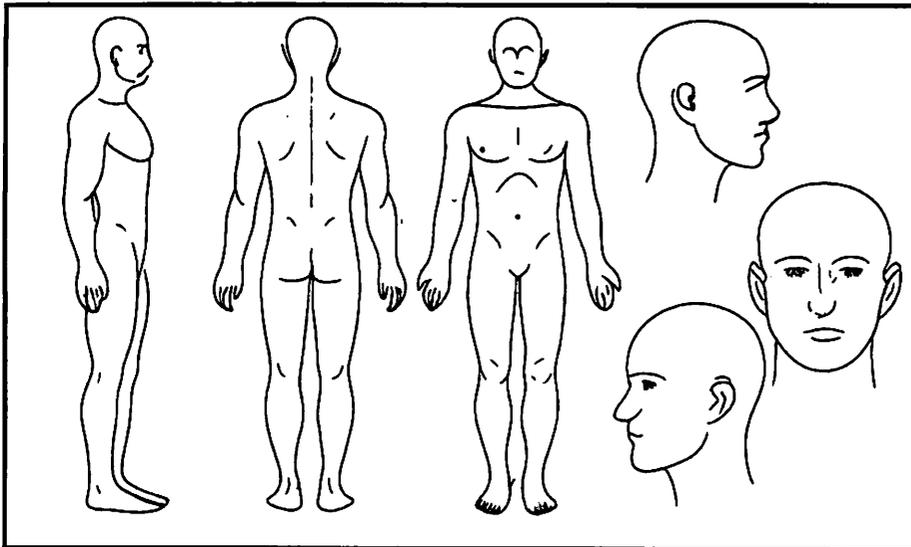


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Patient Name: _____ **Date:** _____

Regular
 Worker's Comp
 No-Fault



On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:

SHARP/ STABBING ++++
DULL/ ACHY VVVV
PINS / NEEDLES 0000
NUMBNESS /////
OTHER XXXX

Type of discomfort (choose all that apply):

___Sharp ___Dull ___Aching Burning ___Numbness ___Tightness ___Throbbing
 ___Diffuse ___Shooting ___Tingling ___Other: _____

Frequency of Pain:

___Constant ___Frequent ___Intermittent ___Occasional
 (100%-75%) (75%-50%) (50%-25%) (25%-0%)

Discomfort increases with:

___Movement ___Applying Pressure ___Sitting ___Standing ___Coughing
 ___Other: _____

Discomfort decreases with:

___Rest ___Movement ___Medication ___Ice ___Heat ___Chiropractic Care
 ___Other: _____

Region	At WORST	At BEST	TODAY
NECK	012345678910	012345678910	012345678910
MID/UPPER BACK	012345678910	012345678910	012345678910
LOW BACK	012345678910	012345678910	012345678910
Other _____	012345678910	012345678910	012345678910

Office Financial Agreement 2026

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

INDIVIDUAL POLICY

___ **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.

PLEASE READ & INITIAL OUR NEW OFFICE POLICIES

___ **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