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PRE EXISTING PATIENTS – PERSONAL INFORMATION UPDATE

NAME: ____DATE: ___________

ADDRESS: ____

EMAIL:____

PHONE NUMBER: (_____)_________-____________ CELL NUMBER (______)_________-__________

INSURANCE INFORMATION:

INSURANCE COMPANY: ____

SUBSCRIBER ID#:____

MAIN POLICY HOLDER NAME:__________________________ DOB :____/____/__

RELATIONSHIP TO POLICY HOLDER: SELF / SPOUSE / CHILD

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I have insurance coverage with the above insurance company and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature Date

HEALTH HISTORY:

PRIMARY CARE PHYSICIAN: _________________________________PHONE____________

ARE YOU SEEING ANY OTHER SPECIALISTS? _______________________________________

MEDICATIONS:____

PLEASE DESCRIBE YOUR PRIMARY COMPLAINT:

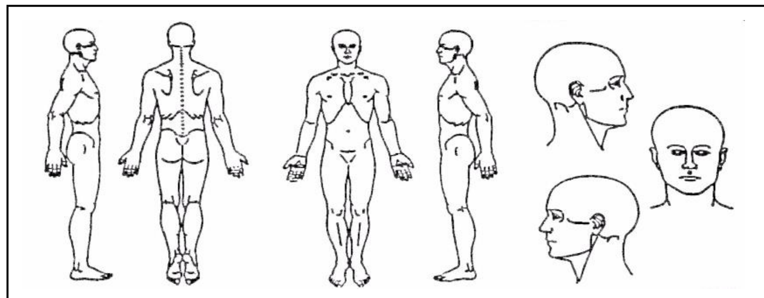
____

____

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: ____ Sharp _____ Dull _____ Aching ______ Burning ______Numbness
(choose all that apply) ______ 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______Coughing

Discomfort decrease with: ______Rest________Movement ________Medication ________Ice________Heat
______ Chiropractic Care

Region	At WORST	At BEST	TODAY
NECK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
MID/UPPER BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
LOW BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Other_______________	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Scale: 0=no pain or discomfort 10=most intense pain

~For office use only~

Notes:
____
____
____
____

	Cervical ROM	Lumbar ROM
Flexion	(90)	(90)
Ext	(70)	(35)
LLF	(40)	(25)
RLF	(40)	(25)
Lrot	(70)	(30)
Rrot	(70)	(30)

OFFICE FINANCIAL AGREEMENT-2023

It is your responsibility to know what your insurance policy covers. Insurance covers acute, medically necessary care. If your insurance denies payment for our services at any time, you agree to take full financial responsibility. Some insurance companies will not allow multiple family members to be treated on the same day in the same office.

Please sign and initial designated insurance line.

_____**Excellus BC/BS, Aetna and United**
Deduct- Referral may be needed. Until your annual deductible is met the office fee will be procedure dependent. Fee is due at time of service. Once the deductible is met, you will be responsible for co-insurance policy dependent. Supplements, orthotics, supports, etc. are not covered.
Co-Pay- Your co-pay is due at the time of service and will range from $10-$70 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsibility. Blues cover **acute care** and not maintenance care.

_____ **Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United**
Authorization is required on some Ins. Your insurance sets number of visits allowed. There are some costs that 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 estimated Deductible of $226.00 is met the office fee is $40.00 - $80.00. You will be responsible for any usual and customary fee (ABN)

_____**MVP/CIGNA/OTHER***:* The doctors in this office are out of network providers. Initial consultation fee, history and examination is $80.00. Subsequent visits thereafter are $40.00. Depending on your contract you may have out of **network coverage**. We will supply you with a claim form so that you can submit to your insurance company.

____**Usual & Customary Office Fees:** First visit for consultation, history and examination is $80.00. Subsequent visits thereafter are $40.00. Initial Spinal scan fee included in $80.00 charge.

Rock Tape (Kinesio Tape):
__ Option 1: Free application with purchase of roll (for life of roll)
__ Option 2: $5.00 charge per region application

_____**Worker's Compensation:** If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered. **Mileage sheets will be available for $20.**

_____**Auto Accidents/No Fault Insurance**: If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered. **Mileage sheets will be available for $20.00**

______ **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. Treatment intervals are at regular intervals (example: 1 time a week, every 2 weeks, every 4 weeks, etc.) Benefits of maintenance care include enhanced quality of life, improved health, prevention of future injury. This is a service not covered by the insurance company and you will be responsible for the office fee of $40. 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.

There may be additional services/products needed to supplement your care.

I, the undersigned certify that I (or my dependent) have insurance coverage with ____________________ and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

- **Please note that our office does not allow a personal balance over $100 (unless other financial arrangements have been made in writing). Should your account become 60 days delinquent a $10 charge per month will be assessed to the outstanding balance.**
- **Payment is due at the time of service. Payment in the form of cash, check, HSA, Credit Card is accepted.**
- **Returned Checks will have a $25 service charge.**

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Responsible Party Signature **Date**