

Medicare

INITIAL HEALTH STATUS

Chiropractic

E-Mail _____ Height _____ Weight _____
Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Emergency Contact: Name _____ Phone #: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

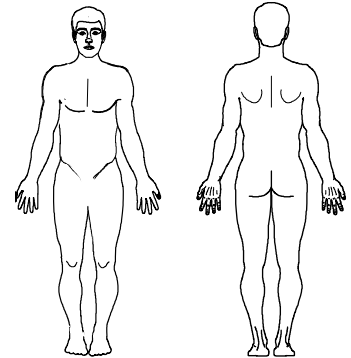
☐ Other _____

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began _____

How Problem Began

Current complaint (how you feel today):										
0	1	2	3	4	5	6	7	8	9	10
No Pain						Unbearable Pain				



How often are your symptoms present?

(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry
on any activities

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes

Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

- | | |
|---|--|
| ☐ Alcohol/Drug Dependence | ☐ Prostate Problems |
| ☐ Recent Fever | ☐ Menstrual Problems |
| ☐ Diabetes | ☐ Urinary Problems |
| ☐ High Blood Pressure | ☐ Currently Pregnant, # Weeks _____ |
| ☐ Stroke (Date) _____ | ☐ Abnormal Weight ☐ Gain ☐ Loss |
| ☐ Corticosteroid Use (Cortisone, Prednisone, etc.) | ☐ Marked Morning Pain/Stiffness |
| ☐ Taking Birth Control Pills | ☐ Pain Unrelieved by Position or Rest |
| ☐ Dizziness/Fainting | ☐ Pain at Night |
| ☐ Numbness in Groin/Buttocks | ☐ Visual Disturbances |
| ☐ Cancer/Tumor (Explain) _____ | ☐ Surgeries _____ |
| ☐ _____ | ☐ _____ |
| ☐ Osteoporosis | ☐ Tobacco Use - Type _____ |
| ☐ Epilepsy/Seizures | Frequency _____/Day |
| ☐ Other Health Problems (Explain) _____ | ☐ Medications _____ |

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature _____ Date _____

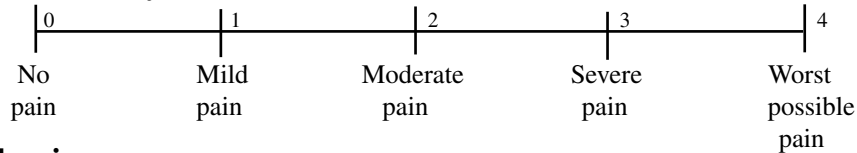
Functional Rating Index

For use with Neck and/or Back Problems only.

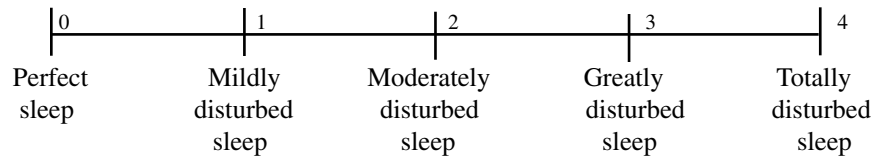
In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.

For each item below, **please circle the number which most closely describes your condition right now.**

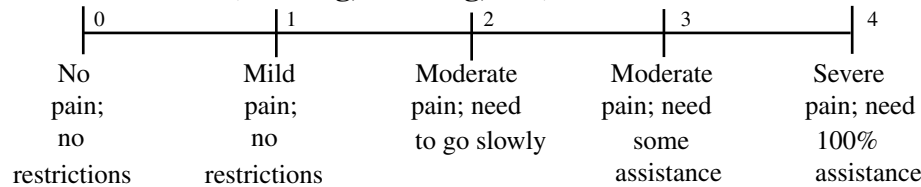
1. Pain Intensity



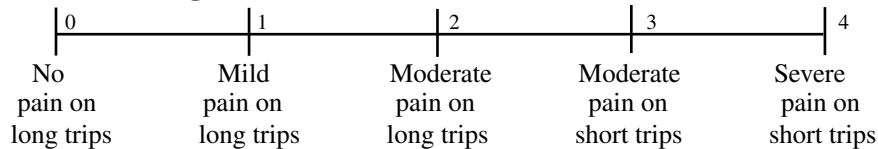
2. Sleeping



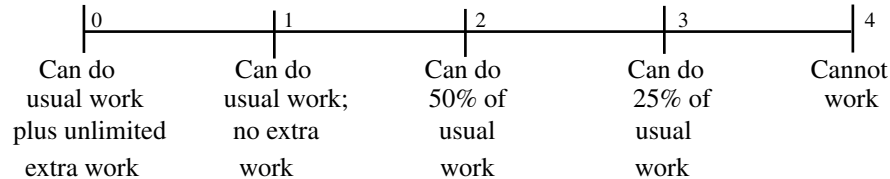
3. Personal Care (washing, dressing, etc.)



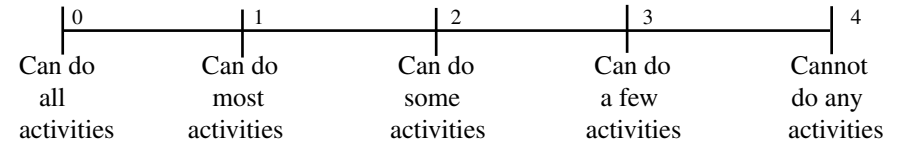
4. Travel (driving, etc.)



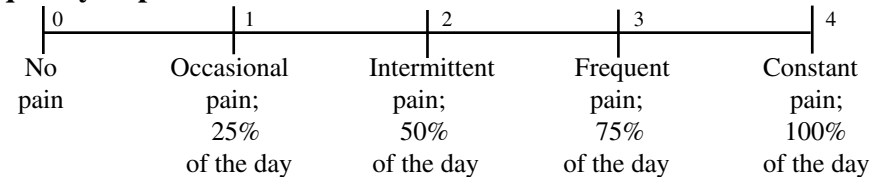
5. Work



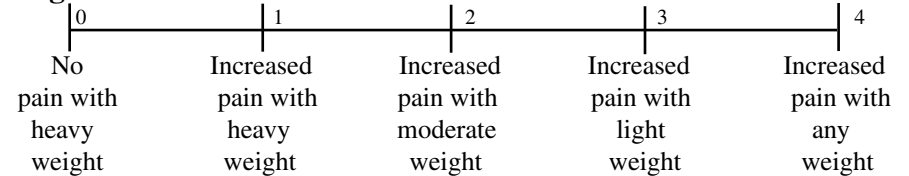
6. Recreation



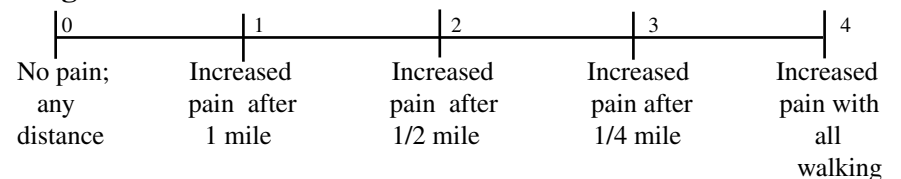
7. Frequency of pain



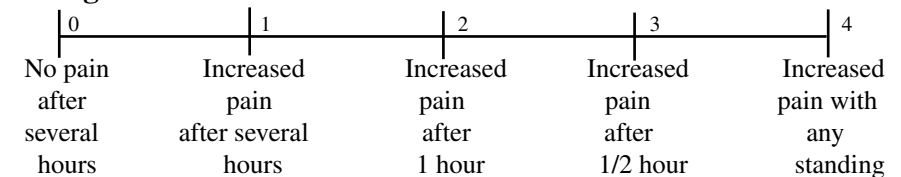
8. Lifting



9. Walking



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature

Date

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For office use only : Total ÷ 40x100 = %

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various mode of physical therapy and diagnostic x-ray, on me, (or the patient named below), for whom I am legally responsible)) by the Doctor of Chiropractic named below and/or other licenses Doctor of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other or clinic.

I have had an opportunity to discuss with the Doctor of chiropractic named below and /or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which to doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by sighing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by Patient:

Print patient's Name

Signature of patient

Date

As: _____
Relationship or authority of patient' Representative

Print name(s) of Doctor(s) treating this patient:

Dr. Kenneth Greenberg DC

To be completed by patient representative, if
Necessary, e.g., If patient is a minor or
Physically or legally incapacitated

Print name of patient

Print name of patient's representative

Signature of patient's representative

**To be completed by doctor or
staff name and address of
clinic/office**

San Diego Chiropractic

8312 Lake Murray Blvd Suite O

San Diego, CA 92119

Witness to Patient signature:

Translated By _____

IMPORTANT INFORMATION FOR OUR MEDICARE PATIENTS EXPLANATION OR NON-COVERED CHIROPRACTIC SERVICES

Patient's name

Medicare Number

DEDUCTIBLE

Medicare requires that you pay a yearly deductible of \$183 toward your Part B medical expenses before they will begin paying for covered services. If you have already been treated by other doctors this year, you may apply those bills towards your deductible.

MEDICARE COVERAGE

Medicare in a chiropractic office only covers manual manipulation of the spine (commonly referred to as spinal adjustment or CMT). Medicare pays 80% of the services and the patient is liable for 20% after deductible is met. All other services other than spinal manipulation are your responsibility and outlined below in detail.

EXAMINATIONS

In order to determine the extent of your condition, as well as the type of treatment you will need, the doctor will examine you prior to the initiation of treatment, and periodically thereafter. Medicare will not reimburse for examination charges; and therefore, payment must be made by you.

X-RAYS

Medicare does not require x-rays in order to be reimbursed for chiropractic treatment. Your doctor may determine x-rays are necessary to assess your condition. If x-rays are taken or ordered by your Chiropractor, they are not covered by Medicare and therefore you are fully liable for the charges for x-rays.

PHYSICAL MEDICINE, SUPPLEMENTS AND SUPPORTS

During the course of your treatment in this office, the doctor may determine that certain physical therapy modalities or procedures, Vitamin supplements or orthopedic supports may be necessary to assist in the treatment of your condition. Medicare will not reimburse for any of these services, and therefore, payment must be made by you.

I understand that although the Chiropractic services listed above may be required for treatment of my condition, these charges are not covered by Medicare and I will be personally responsible for payment of these charges.

Patient's Signature

Date

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, and ask us any question you may have, and then sign in the space provides. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact you insurance company with any questions you may have regarding you coverage.

2. Co-Payments and Deductibles. All co-payments and deductibles must be paid at the time of services. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payment and deductibles from patients can be considered fraud. Please help us in upholding the law by paying you copayment at each visit. We accept payment in the form of **CASH**, or **CHECK**.

3. NON-covered services. Please be aware that some- and perhaps all - of the services you receive may not be covered or considered necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of Insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefits are a contract between you and your insurance company: we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. NON Payment. If your account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your account in full, partial payments will not be accepted unless otherwise negotiated. Interest will be accrued at a rate of 18%. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. **There is a \$25 fee for the return of any personal checks!**

8. Missed appointments. Our policy is to charge \$30 for missed appointments, not canceled within 24 hours of scheduled appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping our regularly scheduled appointment.

Our practice is committed to providing the best to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

X _____
Signature of patient or responsible party

X _____
Date

COVID-19 Compliance

COVID-19 Pre-Visit Screening Survey

As essential healthcare workers, **SAN DIEGO CHIROPRACTIC** has been able to continue to serve our community with necessary chiropractic care. As such, we must do everything possible to mitigate risk to our staff and other members of the community so it is vitally important to you complete this form accurately prior to each visit.

Name: _____ Today's Date: _____

Have you been exposed to COVID-19 or do you believe that you have? ☐ Yes ☐ No

Please check any of the following symptoms you (or other members of your family that also have an appointment) are currently expressing:

- | | | |
|--|---|---|
| ☐ Shortness of breath | ☐ Productive Cough | ☐ Non-Productive Cough |
| ☐ Bronchitis | ☐ Respiratory infection | ☐ Sore throat |
| ☐ Fever | ☐ Nausea | ☐ Vomiting |
| ☐ Diarrhea | ☐ Severe fatigue (not related with travel) | |
| ☐ None of the above | | |

Other: _____

Have you traveled to or from a high-risk geographic area in the past 14 days? ☐ Yes ☐ No

If you are visiting **SAN DIEGO CHIROPRACTIC** with other family members, please list their names and which symptoms listed above (if any) they are currently experiencing:

By signing here, you are attesting that everything you stated above is truthful and accurate to the best of your knowledge.

Signed

Date