NorthEast
SPINE and SPORTS MEDICINE

Patient Intake

PATIENT NAME:		SOCIAL SECURITY #:
SEX: M F	DATE OF BIRTH:	AGE:
MAILING ADDRESS:	CITY: STATE:	ZIP:
EMAIL ADDRESS:		
HOME PHONE #:	CELL PHONE #:	WORK PHONE #:
EMPLOYER:		
OCCUPATION:		
NUMBER OF BIOLOGIAL CHILDREN:		MARITAL STATUS: S / M / D / W

Insurance Information

PRIMARY INSURANCE CO. NAME:		TYPE: (CIRCLE ONE) MEDICAL / AUTO / OTHER	
COMPANY ADDRESS:			
ID #:	GROUP #:	CLAIM #:	SUBSCRIBER SSN:
SUBSCRIBER NAME:	SUBSCRIBER DOB:	RELATION TO SUBSCRIBER:	
COVERAGE EFFECTIVE DATE:		DATE OF INJURY:	

Secondary Insurance Information

SECONDARY INSURANCE:	ID #:	GROUP #:	SUBSCRIBER SSN:
COMPANY ADDRESS:		RELATION TO SUBSCRIBER:	
SUBSCRIBER NAME:		SUBSCRIBER DOB:	COVERAGE EFFECTIVE DATE:

IN CASE OF EMERGENCY NOTIFY: (Name & Phone):

HOW WERE YOU REFERRED TO OUR OFFICE?

Newspaper/Magazine _____ Internet _____

Family/Friend _____ Physician _____

Other _____

NorthEast
SPINE and SPORTS MEDICINE

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____ Date of Birth: _____

Name of Referring Doctor: _____ Name of Family Doctor: _____

Reason for Today's Visit: _____

How long have you had this problem? (days, weeks, months, etc.)_____

What makes your problem better or worse? (i.e. positions, activities and/or treatments)
Symptoms better with: _____
Symptoms worse with: _____

What other treatments did you have for this problem? (meds, physical therapy, chiropractic, acupuncture, injections, etc.)

_____

Rate the Pain (0 = No Pain, 10 = worst imaginable pain) On average _____ At worst _____

Are you allergic to Latex? _____ Are you allergic to Iodine or Contrast dye? _____

Are you allergic to any drugs? (circle one) YES or NO If yes, please list those drugs below:

DRUG	REACTION	DRUG	REACTION

List your current medications, vitamins and supplements:

Are you currently enrolled in the Medicinal Marijuana Program/ MMP? (circle one) YES or NO

PAST MEDICAL HISTORY (Please **circle** all that apply)		Diabetes	Kidney Disease
High Blood Pressure	Heart disease or heart attack	Congestive heart failure	Vascular disease
Multiple Sclerosis	Seizures	Scoliosis	Lyme disease
Asthma	COPD	Emphysema	Depression
Gastric reflux	Stomach ulcers	Enlarged prostate	Thyroid disease
Liver disease	Hepatitis	Bleeding disorder	Cancer
Osteoarthritis	Rheumatoid arthritis	Gout	Shingles

Please list any other medical conditions you may have that were not mentioned above:

_____

FAMILY HISTORY (Please **circle** all that apply to members of your family):			
Bleeding disorder	Coronary artery disease	Hepatitis	Cancer
Heart Disease/Attacks	Seizures	Lung disease	Rheumatoid arthritis
Kidney disease	Malignant hyperthermia	Scoliosis	Asthma

Please list any medical conditions that a member of your family may have that were not mentioned above:

_____

NorthEast
SPINE and SPORTS MEDICINE

PATIENT MEDICAL HISTORY QUESTIONNAIRE (continued)

PAST SURGICAL HISTORY (Please **circle** all that apply to you and list the date of surgery)			
Surgery	Date	Surgery	Date
Spine surgery – cervical spine		Shoulder Arthroscopy (right/left)	
Spine surgery – thoracic spine		Knee Arthroscopy (right/left)	
Spine surgery – lumbar spine		Joint replacement (right/left)	
Coronary artery bypass graft		Laparoscopy	
Cardiac catheterization		Thyroid surgery	
Pacemaker or Defibrillator		Hysterectomy	
Peripheral bypass surgery		Hernia repair	
Eye surgery			

Please list any other surgeries you had that were not mentioned above: _____
_____

Do you Smoke? ___ Current Smoker ___ Former Smoker ___ Never Smoked ___ Pipe Smoker ___ Cigar Smoker
If yes, how much do you smoke? ___3 cigarettes or less per day ___1/2 a pack per day ___ More than a pack per day

Do you drink alcohol? (circle one) YES or NO
If yes, how frequent? ___ Social only ____Several times per week ____Everyday

Do you have a history of substance abuse? (circle one) YES or NO
If yes, what kind? ___ IV Drugs ____ Pills ___ Marijuana ____ Alcohol ____ Other

Do you currently use illicit drugs? (circle one) YES or NO
If yes, what kind? ___ IV Drugs ____ Pills ___ Marijuana ____ Other

Occupation: _____

Do you exercise or participate in sports? (circle one) YES or NO If yes, please give details: _____
_____

Please **circle** any of the following symptoms that you've experienced recently:			
Constitutional	Fever	Night Sweats	Weight loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pain	Palpations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomiting	Diarrhea
Genitourinary	Burning w/ urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have related to the problems circled above: _____
_____

Patient Signature: _____ Date: _____
Reviewed by Provider: _____ Date: _____

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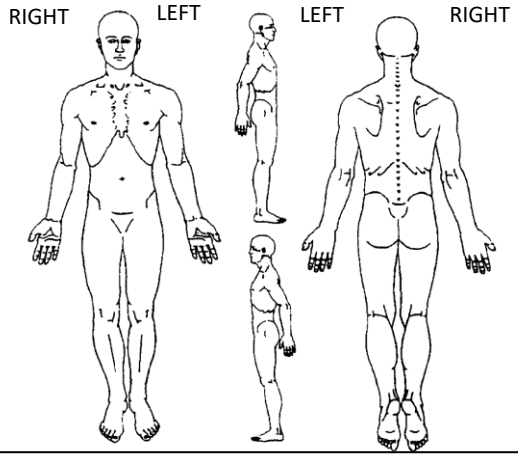
PAIN DIAGRAM

NAME: _____ DATE: ____/____/____

PLEASE COMPLETE THE FOLLOWING "**PAIN DIAGRAM**" BY CIRCLING THE AREAS YOU'RE EXPERIENCING PAIN ON THE DIAGRAM WITH A CIRCLE AND ANSWERING ALL THE QUESTIONS. Note: If you have more than one area of complaint please number each in the circle from most to least severe and indicate below in the blank spaces provided



What is your current complaint? (why are you seeking treatment?) _____

_____

How severe is this problem?
□ Mild
□Mild to Moderate
□Moderate
□Moderately Severe
□Severe

How Frequently?
□ Constant
□ Occasional
□ Intermittent
□ Frequent

On a 1-10 scale, how would you rate your pain? (10=most painful, 1=least painful)
□ 1 □ 5 □ 9
□2 □ 6 □ 10
□3 □ 7
□4 □ 8

Improvement (%)
□ 10% □ 60%
□ 20% □ 70%
□ 30% □ 80%
□ 40% □ 90%
□ 50% □ 100%

When was the onset of this problem?
□ gradual □ about a day ago □ several months ago
□ sudden □ several days ago □ about a year ago
□ insidious □ about a week ago □ several years ago
□ several weeks ago
□ about a month ago

Select each choice that applies to you

Movement
□ Cramps
□ Inflexibility
□ Restricted Movement
□ Spasm

Sensation
□ Crawling □ Prickly
□ Dead □ Tingling
□ Numb
□ Pins & Needle

What are you doing for exercise now?_____
Number of alcoholic beverages per week? _____
Number of caffeinated beverages per day? _____
Living Situation _____ Typical Breakfast _____
How many meals daily? _____

Select the type of pain that best describes your complaint
□ Achy □ Numb ache □ Shooting
□ Burning □ Pounding □ Stabbing
□ Dull □ Pulsating □ Stinging
□ Excruciating □ Sharp □ Throbbing

Please indicate everything that makes you feel better
□ Usually better in the morning □ Usually better during the day □ Usually better at night

_____
_____
_____

Please indicate everything that makes you feel worse or aggravates your condition
□ Usually worse in the morning □ Usually worse during the day □ Usually worse at night

_____
_____
_____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____ **DOB:** _____/_____/_____

NorthEast
SPINE and SPORTS MEDICINE

FINANCIAL POLICY AGREEMENT / ASSIGNMENT OF BENEFITS

Thank you for choosing NorthEast Spine and Sports Medicine as your health care provider. We are committed to providing excellent care to all of our patients and we will always do our best to achieve this goal, whether it is in office or at the surgery center.

NorthEast Spine and Sports Medicine are private professional entities and are *not* contracted with *any* insurance plans other that Medicare. Even though we do not participate in your insurance plan's provider network, we pledge to help you understand and manage the financial aspects associated with providing you the very best care and attention you deserve.

Most insurance plans allow patients to select their own treating physician even if the physician they prefer is not in their insurance plan's network. To help you understand your responsibilities, we will inquire as to your plan's out-of-network benefits, and explain what, if any, financial obligations you will have for our services.

Our independence is a hallmark trait of our practice. As an out-of-network provider, the course of treatment we provide will not be limited to what an insurance plan representative will approve, but will instead be solely upon the state-of-the-art care that your board certified physician recommends.

All charges will be submitted to your insurance carrier on behalf as an out-of-network provider. You may be responsible for your deductible and co-insurance on allowed payments up to your out-of-pocket maximum according to your out-of-network insurance policy. Most insurance plans allow reasonable and customary payment for our services in which case you will not receive any bills. In few cases however, a particular plan may not provide reasonable and customary payment in which case you may be responsible for some of the difference between what is billed and what your insurance plan allows for payment.

In addition, the Horizon Blue Cross Blue Shield insurance company may send payment for our services directly to you. You agree to relinquish all payments that you receive form your insurance company for our services to NorthEast Spine and Sports Medicine. Failure to do so will result in legal action.

By signing below, you attest that you completely understand and agree with our financial policy as described above for the services provided by NorthEast Spine and Sports Medicine and its professionals.

ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

I irrevocably assign to NORTHEAST SPINE AND SPORTS MEDICINE all of my rights and benefits under any insurance contracts for payment for services rendered to me by NORTHEAST SPINE AND SPORTS MEDICINE. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by NORTHEAST SPINE AND SPORTS MEDICINE to be released to NORTHEAST SPINE AND SPORTS MEDICINE. I irrevocably authorize NORTHEAST SPINE AND SPORTS MEDICINE to file insurance claims on behalf for services rendered to me. I irrevocably direct that all such payments go directly to NORTHEAST SPINE AND SPORTS MEDICINE. I irrevocably authorize NORTHEAST SPINE AND SPORTS MEDICINE to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

X_____

Patient Signature

_____ _____

Patient Name (printed) Date

NorthEast
SPINE and SPORTS MEDICINE

HIPAA AUTHORIZATION

For use or disclosure of health care information

By signing this form I, _____, authorize the use and disclosure of my health information as described below

You can disclose my health information as described below:

- ☐ Leave message on my answering machine
- ☐ Leave message with spouse
- ☐ Leave message with anyone who answers the phone
- ☐ Can fax information to my home
- ☐ Can fax information to my work
- ☐ Can mail information to my home
- ☐ Can mail information to my work place
- ☐ Can request your Medicare information for prior facilities/physicians

You can leave messages confirming my appointments as described below:

- ☐ Leave message on my answering machine
- ☐ Leave message with my spouse
- ☐ Leave message with anyone who answers the phone

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization I must do so in writing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

An Accounting of Disclosures: You have the right to request an accounting of our disclosures of medical information about you except for certain circumstances, including disclosures for treatment, payment, health care operations or where you specifically authorized a disclosure. NorthEast Spine and Sports Medicine will provide the first accounting to you in any 12-month period will be the practice complies with state records release laws.

We ask that you submit these requests in writing.

Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we do not share or disclose information about a procedure that you had. We ask that you submit these requests in writing.

Except under Specific circumstances, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment or is required by law. We must agree to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations (as defined by HIPPA) if the information pertains solely to a health care item or service for which we have been paid by you out-of-pocket, and in full.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will agree to the request to the extent that it is reasonable for us to do so. For example, you can ask that we use an alternate address for billing purposes. We ask that you submit your request in writing.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

To exercise any of your rights, please obtain the required forms from the Privacy Officer and submit your request in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us by calling the office at which you are treated or by contacting the Secretary of the Federal Department of Health and Human Services. All complaints must also be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of the care that we provided you.

I acknowledge having received a copy of the practice's Notice of Privacy Policies.

Patient Name (Print):_____

Patient Signature:_____**Date:**_____

Health Insurance Profitability and Accountability Act of 1996

Notice of Privacy Practices

Effective August 1st 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at the number listed at the end of this Notice.

Our Responsibilities

NorthEast Spine and Sports Medicine is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. The current Notice will be posted on the practice website at www.NorthEastSpineAndSports.com and in our waiting room. The notice will include the effective date. In addition, we will make our best effort to provide you with a copy of this notice and we request that you acknowledge receipt with your signature.

We are required by law to abide by the terms of this Notice and notify you if we make any changes to this Notice, which may be at any time. Changes of this notice will apply to your medical information that we already maintain as well as new information received after the change occurs. If we change our Notice, it will be made available to anyone who asks for it, and be posted on the practice website at www.NorthEastSpineAndSports.com and in the office waiting room. You may also request that the revised Notice will be sent to you in the mail or you may ask for one at your next appointment or appropriate visit. This Notice will also serve as to your rights with regard for your medical information.

How We May Use and Disclose Medical Information About You

The following categories describe examples of the way we use and disclose medical information:

For Treatment: We may use medical information about you to provide, coordinate and manage your treatment or services. We may disclose medical information about you to other- doctors, nurses, technicians (e.g. clinical laboratories or imaging companies), medical students or other personnel who are involved in your care. We may communicate your information either orally or in writing by mail or facsimile.

We may also provide a subsequent healthcare provider with copies of various reports that should assist him or her in treating you. For example, your medical information may be provided to a physician to whom you have been referred so as to ensure that the physician has appropriate information regarding your previous treatment and diagnosis.

For Payment: We may use and disclose medical information about your treatment and services to bill and collect payment from you, your insurance company or a third-party payer. For example, we may need to give your insurance company information before it approves or pays for the health care services, we recommend for you.

For Healthcare Operations: We may use or disclose, as needed, your health information in order to support our business activities. These activities may include, but are not limited to quality assessment activities, employee review activities, licensing, legal advice, accounting support, information systems support and conduction or arranging for other business activities. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment by telephone or reminder card.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include collections and software support. If their services are contracted, we may disclose your health information to our business associate so that they can perform the job that we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information through a written contract. In addition, business associates are individually required to abide by the HIPPA rules.

NorthEast
SPINE and SPORTS MEDICINE

Informed Consent to Chiropractic, Physical Therapy & Occupational Therapy Treatment

Medical doctors, chiropractic doctors, osteopaths, Physical Therapists, and Occupational Therapists that perform manipulation are required to obtain your informed consent before starting treatment.

I, _____, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, traction, ultrasound, hot packs, TENS unit, exercises, laser, and other therapeutic modalities may also be used.

Soreness: I am aware that, like exercises, it is common to experience muscle soreness in the first few treatments.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of complications from treatment, and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available
Reasonable alternative to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

_____ _____
DATE PATIENT SIGNATURE

_____ _____
DATE WITNESS

Consent to evaluate and treatments of a minor child (if applicable)

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care and/or physical therapy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ _____
DATE PARENT/GUARDIAN SIGNATURE

NorthEast
SPINE and SPORTS MEDICINE

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which my physician may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date: _____

If Patient is a Minor

I am the parent or legal representative of _____, who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor which my physician may consider necessary or advisable.

Signed _____ Date: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and my physician has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

I am not pregnant due to the following:

_____ Post-Menopausal > 1 year

_____ Hysterectomy

_____ Active menstrual cycle: Date of last menstrual cycle: _____

Signed _____ Date: _____

NorthEast
SPINE and SPORTS MEDICINE

Informed Consent to Treatment

I consent to acupuncture and other procedures associated with Traditional Chinese Medicine by a Licensed Acupuncturist. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine, and nutritional counseling

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including slight bleeding, bruising and numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Burns and /or scarring are a potential risk of moxibustion. I understand that while this document describes major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have unpleasant smell or taste. I will immediately notify the acupuncturist of unanticipated or unpleasant side effects associated with the consumption of herbal teas. I will notify the Clinic Staff member who is caring for me if I am to become pregnant.

I understand that there is no guarantee concerning the effect of treatment provided to me and that I am free to discontinue treatment at any time. By voluntarily signing below, I show that I have read, and understand this consent of treatment about the risks and benefits of acupuncture and other procedures and have an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition.

Print Patient Name: _____

Signature of Patient: _____

Minor Patient Representative: _____

Witness: _____

Date: _____/_____/_____

NorthEast
SPINE and SPORTS MEDICINE

Medical Records Request

Patient Name: _____ Date of Birth: _____

Provider(s) FROM whom medical records are requested: 1). 2). 3).	Phone Fax 1). 2). 3).
Provider to WHOM records are to be forwarded:	NorthEast Spine & Sports Medicine Attn: Please fax records to the office checked: [ ] Aberdeen 732-583-4704 [ ] Point Pleasant 732-714-0188 [ ] Barnegat 609-660-0003 [ ] Rahway 732-388-4380 [ ] Freehold 732-780-7139 [ ] Tinton Falls 848-217-7463 [ ] Jackson 732-415-1403 [ ] Toms River 732-504-7676 [ ] Lincroft 732-530-3561 [ ] Wall 732-529-2866 [ ] Manchester 732-350-0252

Records Authorized to be Released:

[ ] Hospital records _____ **[ ]** NCV/EMG reports _____

[ ] Most recent office note _____ **[ ]** Other diagnostic tests _____

[ ] Lab reports _____ **[ ]** Procedure and/or OP notes _____

[ ] Radiology reports _____ **[ ]** Other _____

This information will be used for the purpose of providing additional medical care for the patient listed above.

I understand that I can revoke this authorization at any time by writing to the health care provider or to NorthEast Spine & Sports Medicine, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am entitled to receive a copy of this authorization
- A copy of this authorization may be utilized with the same effectiveness as an original.
- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal

_____
Signature of Patient or Representative Date

_____
Name of Patient or Representative (print)

_____
Relationship to Patient

A. Notifier: NorthEast Spine and Sports Medicine

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Chiropractic Exam/Adj 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.** Chiropractic Exam/Adj below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Exam/Adj	Medicare does not cover examinations when performed by a chiropractor, or the x-ray which we use to develop your treatment plan. Depending on your diagnosis, Medicare may choose to deny chiropractic manipulation which will be forwarded to your secondary insurance.	$50 - $110 which will be billed to the secondary insurance.

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 **D.** Chiropractic Exam/Adj 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.** Chiropractic Exam/Adj 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.** _____ 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.** _____ 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 also receive a copy.

I. Signature:	J. 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.

Interventional Pain

Sports Medicine

Orthopedic Surgery

Spinal Rehab

Chiropractic

Acupuncture & Oriental Medicine

Physical Therapy

ABERDEEN

BARNEGAT

FREEHOLD

JACKSON

LINCROFT

MANCHESTER

POINT PLEASANT

RAHWAY

TINTON FALLS

TOMS RIVER

WALL

NorthEast SPINE and SPORTS MEDICINE

DISCLOSURE FINANCIAL INTEREST IN AMBULATORY SURGERY CENTER/MEDICAL PRACTICE

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist, and all other licensees of the Board of Medical Examiners inform patient of any significant financial interest held in a health care service. Accordingly, please take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred:

1. NorthEast Surgi-Care, LLC the provider of the Ambulatory Surgery Center procedures you are scheduled to undergo.
2. NorthEast Surgery Associates, LLC the provider of certain healthcare items/service your physician/other provider has recommended to/ordered for you.

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Additionally, please be advised that the procedure(s) you are scheduled to undergo at the foregoing entities will be considered to be "out-of-network" services and reimbursed at an "out-of-network" level by your insurance carrier.

Please sign below to acknowledge that I have informed you of the ownership interest in the above entities prior to or at the time I referred you to the above entities.

_____ _____

PATIENT'S NAME (Please print) DATE

_____

PATIENT'S Signature

AUTHORIZATION AND CONSENT TO USE IMAGE

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I hereby certify that I am the parent and/or guardian of

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A child under the age of 18 years, and I hereby consent that any Images (as defined above) may be used for any purpose set forth in this Authorization and Release above.

Signature of Parent/or Guardian: _____

Witness: _____

Date:_____