Confidential Patient Information

Name _____ Address _____

City _____ State _____ Zip _____ Home phn _____ Cell phn _____

Drivers Lic# _____ Email Home: _____ Email Work: _____

SSN _____ Date of Birth _____ Age _____ Height _____ Weight _____

Male _ Female _ Single _ Married _ Divorced _ # of children _ Name of spouse (or parent) _____

Employer _____ Address _____

City _____ State _____ Zip _____ Wk phn _____ Occupation _____

Who referred you to this office: _____

What is the name of your family physician? _____ What city are they located in? _____

Have you ever had Chiropractic care before? ___ If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck pain, low back pain, etc), health problems, symptoms, and/or complaints, please list in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting worse or staying the same? _____

Currently or in the past have you ever experienced any of these complaints while working? ____ If yes, please describe what activities at work may be causing you to experience these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____If yes, please explain: _____

Have you at any time in the past ever suffered a work injury? _____ If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury? _ Yes _No Name of attorney_____

Have you been involved in an auto accident in the last 12 months? _ Yes _ No If yes, what is the date of accident? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: 1._____ 2._____

If due to an auto accident, what is the name of your auto insurance company? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any current or past injuries and illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking: _ Aspirin/Tylenol _ Pain killers _ Muscle Relaxers _ Insulin _ Birth Control Pills _ Sleeping pills _ Anti-depressants _ Others _____

Health Insurance Co. Name _____ Policyholder _____

Name of Spouse's health insurance (If applicable) _____ Policyholder_____

Spouse's Health Insurance Claims address _____

Policy number _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing)/ In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. **0** means no disability at all and a score of **10** means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

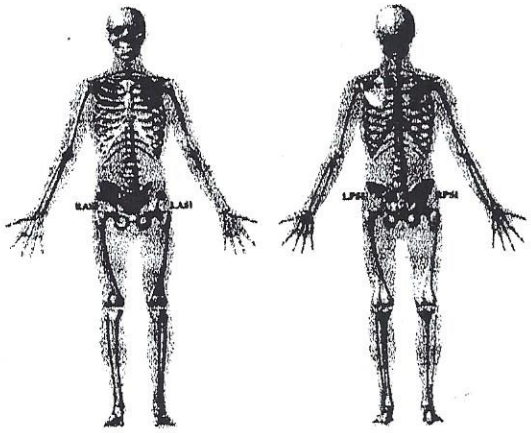
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — **Totally unable to function**

1. **FAMILY/HOME RESPONSIBILITIES**: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc. _____
2. **RECREATION**: hobbies, sports, and other similar leisure time activities. _____
3. **SOCIAL ACTIVITY**: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. **OCCUPATION**: activities that are a part of directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. **SELF CARE**: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. **LIFE SUPPORT ACTIVITY**: basic life behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location on the diagram below. Also describe the type of frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: _CASH _CHECK _CREDIT CARD _OTHER_____

NOTICE: NOT ALL PATIENTS REQUIRE XRAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOU'RE EXAMINATION WARRANTS X-RAYS ANALYSIS THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays. The film itself is the property of this office. Films may be loaned to another facility with authorization only.

Patient Signature_____ Date _____

RONALD WILLIAMS CHIROPRACTIC CLINIC, INC.
RONALD B. WILLIAMS, D.C.
P.O. Box 4422 • Vallejo, CA 94590
Phone: (707) 643-3768 • Fax: (707) 643-4029
Email: ronwilliamschiropractic@hotmail.com
Website: williamschiropractic-vallejo.com

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed 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 office of 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 that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including by 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 I wish to rely on the doctor to exercise judgment during the course of the procedure which the 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 signing 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.

Print patients name	Relationship to patient
Signature of patient	Name of patient rep.
Date signed	Signature of patient rep.
	Date signed

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

WILLIAMS CHIROPRACTIC CLINIC
541B CURTOLA PARKWAY
VALLEJO, CA 94590
(707) 643-3768

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain 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 of disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

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

Date: _____ Initials: _____

Reasons: _____

RONALD B. WILLIAMS, D.C.
Williams Chiropractic Clinic

Phone: (707) 643-3768
Email: ronwilliamschiropractic@hotmail.com

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient Name _____

Employer _____

Claim/Group # _____

SS#/ID# _____

I hereby instruct and direct the _____Insurance Company to pay by check made out to and mailed directly to:

Williams Chiropractic Clinic
2441 Imola Ave. W.
Napa, CA 94558

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

C/O: **Williams Chiropractic Clinic**
2441 Imola Ave. W
Napa, CA 94558

For professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POILICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information to may case to any insurance company, adjuster, or attorney involved in this claim.

Dated at _____County, this _____day of _____20_____.

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

WILLIAMS CHIROPRACTIC CLINIC
2441 Imola Avenue West
Napa, CA 94558
(707) 643-3768

PATIENT NAME: _____ IDENTIFICATION NUMBER: _____

ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

Note: If Medicare doesn't pay for services listed in the box 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 service listed or checked below:

Items or Services	Reason Medicare May Not Pay	Estimated Cost
Manual Manipulation of the spine	Medicare NEVER pays for maintenance care	$46.41

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 checked items listed in the first box 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.

Options: Check only one space. We cannot choose a box for you.

__ OPTIONS 1. I want the services listed above. You may be asked 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 services listed above, but do not bill Medicare. You may be asked 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 services listed above. I understand with this choice **I am not responsible for payment** and I cannot appeal to see if Medicare would pay.

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** (I-800-633-4227/TTY: 1-877-486-2048)

Signing below means that you have received and understand this notice. You also receive a copy.

Signature: _____ Date: _____

QUESTIONS & ANSWERS

Q: How do I meet the $ 147.00 deductible for Medicare?

A: Beginning on January 1 of each year, you may use the first $147.00 of all your "allowable" medical charges to meet your yearly Medicare deductible. (You may include charges from other doctors to meet your deductible.) You must meet this deductible before Medicare will reimburse you for any other charges.

Q: I have a supplemental insurance policy, what do I do?

A: Each Medicare supplemental insurance policy pays different percentages of your doctor's bill. In order to bill your supplemental insurance company, simply submit a copy of the **"Explanation of Medicare Benefits (EOMB)"** form which accompanies your Medicare payment to your supplemental insurance company.

Q: What is the difference between Medicare Part A and Part B?

A: The Medicare program is divided into two parts: Part A (Basic) coverage is for hospital services and related care. Part B (Supplemental Medical Insurance) covers medical services by physicians, chiropractors, out-patient hospital services, out-patient physical therapy services, ambulance services, durable medical equipment and independent laboratory services. You MUST have Part B coverage if you seek reimbursement for chiropractic services.

Q: How do I submit my bills to Medicare for reimbursement?

A: As of September 1, 1990, you no longer have to handle the necessary paperwork for Medicare reimbursement. The physician that treated you MUST submit his/her charges directly to Medicare for you on an approved claim form in order for you or your physician to receive reimbursement for covered services.

If you have additional questions about Medicare, please feel free to contact our office.

IMPORTANT INFORMATION FOR OUR MEDICARE PATIENTS

EXPLANATION OF NON-COVERED CHIROPRACTIC SERVICES

DEDUCTIBLE:

Medicare requires you to pay a yearly deductible of $147.00 toward your medical expenses. (If you have already been treated by other doctors this year, you may apply those bills to your deductible.)

WHAT MEDICARE WILL PAY FOR:

After you have met your yearly deductible, Medicare will reimburse 80% of "allowable treatment charges". (The only "allowable treatment charges" by a chiropractor is "manual manipulation of the spine").

Once Medicare has determined that further manipulative treatment is not "reasonable or necessary" to restore your condition, you will then be responsible to pay for all your treatment charges.

EXAMINATIONS:

In order to determine the extent of your condition, as well as the type of treatment you need, the doctor will examine you prior to the initiation of treatment. Medicare WILL NOT REIMBURSE you for this examination, however, and payment must be made by you.

PHYSICAL THERAPY, SUPPLEMENTS AND SUPPORTS:

During the course of your treatment in this office, the doctor may determine that certain physical therapy, vitamin supplements and/or orthopedic supports are necessary to assist in the treatment of your condition. Medicare WILL NOT REIMBURSE you for any of these services, however, and 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*

_____ _____

Patient's Name Medicare CL#

ADVANCE NOTICE OF NON-COVERED SERVICES

(Required Language)

PHYSICIAN NOTICE

In accordance with the Medicare Act, Section 1842(i), this letter is to advise you that Medicare will only pay for services that determines to be "reasonable and necessary" under Section 1862(a)(i)of the Medicare Act. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary," under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment for:

Procedure description: *Exam, x-rays and modalities*

Treatment plan (or dates of service):

_____

_____

_____

The reason(s) for this denial is: *Not deemed a medical necessity*

BENEFICIARY AGREEMENT

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Beneficiary's Signature Date

_____ _____

Witness Signature Date