(for use by participating providers)

TO: Medicare Patients

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. **WE WILL FILE ALL MEDICARE CLAIMS.**

2. **WE WILL FILE ALL MEDICARE SECONDARY/SUPPLEMENTAL INSURANCE.**

3. **WE ARE PARTICIPATING PROVIDERS WITH MEDICARE WHICH MEANS THAT MEDICARE PAYS US DIRECTLY, HOWEVER, MEDICARE PATIENTS MUST MEET AN ANNUAL $131 DEDUCTIBLE, WHICH WE ARE REQUIRED TO COLLECT AT THE BEGINNING OF SERVICES FOR EACH CALENDAR YEAR. SUPPLEMENTAL COVERAGE MAY PAY THE DEDUCTIBLE BUT IF NO SUCH COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE FOR THE DEDUCTIBLE.**

4. **MEDICARE PAYS FOR 80% OF ALLOWED CHARGES. SUPPLEMENTAL COVERAGE MAY PAY THE 20%, BUT IF NO COVERAGE IS AVAILABLE, THE PATIENT IS RESPONSIBLE.**

5. **MEDICARE DOES NOT PAY FOR MAINTENANCE CARE. THIS WILL BE YOUR RESPONSIBILITY.**

6. **MEDICARE DOES NOT PAY FOR ALL OF YOUR HEALTH CARE COSTS. THE FACT THAT MEDICARE DOES NOT PAY FOR A PARTICULAR ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT.**

MEDICARE PAYS FOR:	**MEDICARE DOES NOT PAY FOR:**
Manual manipulation of the spine	**-Examinations**
-IF SUPPORTED BY X-RAY AND/OR EXAMINATION	**-Physical therapy**
-After the deductible is met	**-X-rays**
-Depending upon the condition	**-Nutritional supplements**
	-Orthopedic supplies
	-Maintenance care
	-Rehab

If you have questions regarding these guidelines, please ask, we are here to help you!

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for the payment of non-covered services if I choose to receive those services.

Signature of patient or person acting on patient's behalf **Date**

(for use by non-participating providers)

TO: Medicare Patients

To make dealing with Medicare as simple as possible, we have established the following guidelines. Keep in mind that Medicare regulations change frequently and therefore, these guidelines may have to be updated.

1. **WE WILL FILE ALL MEDICARE CLAIMS.**

2. **WE WILL FILE ALL MEDICARE SECONDARY/SUPPLEMENTAL INSURANCE.**

3. **MEDICARE DOES NOT PAY FOR MAINTENANCE CARE.**

4. **AFTER YOU HAVE REACHED AN ANNUAL DEDUCTIBLE OF $131, MEDICARE WILL PARTIALLYREIMBURSE YOU FOR THE COVERED CHARGES (SPINAL ADJUSTMENTS) YOU INCUR IN OUROFFICE IF MEDICARE DEEMS THOSE SERVICES TO BE MEDICALLY NECESSARY.**

5. **MEDICARE DOES NOT PAY FOR ALL OF YOUR HEALTH CARE COSTS. THE FACT THAT MEDICARE DOES NOT PAY FOR AN ITEM OR SERVICE DOES NOT MEAN THAT YOU SHOULD NOT RECEIVE IT.**

MEDICARE PAYS FOR:	**MEDICARE DOES NOT PAY FOR:**
Manual manipulation of the spine	**-Examinations**
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-After the deductible is met	**-X-rays**
-Depending upon the condition	**-Nutritional supplements**
	-Orthopedic supplies
	-Maintenance care

I have read and understand the limitations of my Medicare coverage and agree to be personally responsible for payment of non-covered Medicare services if I choose to receive those services.

Signature of patient or person acting on patient's behalf **Date**

Patient Information

First Name: _____ **MI:** _____ **Last Name:** _____

Street: _____**Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security #:_____ **Marital Status: S M W D Spouse:**_____

DOB:_____**Home Phone:** _____ **Work Phone:**_____

Cell Phone: _____**Carrier**_____ **email:** _____

Emergency Contact:_____

Whom may we thank for referring you to our office? _____

Occupation: _____ **Employer:** _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ **M.I.** _____ **Last Name:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ **M.I.** _____ **Last Name:** _____

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____

Policy Holder's Employer: _____

Assignment & Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____