Welcome to Mack Chiropractic Health Center

Date _____

Patient Name _____
First Last MI

Home
Address _____ City _____ State _____

Zip _____ E-mail _____

Billing
Address (if diff) _____ City _____ State _____

Zip _____

Home Phone _____ Cell Phone _____

Sex M / F Age _____ Birthdate _____

__ Married __ Widowed __ Single __ Minor __ Separated __ Divorced __ Partnered for _____ yrs

Occupation _____

Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Primary Care Physician _____ Phone _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home # _____ Cell # _____ Work # _____

INSURANCE (SUBSCRIBER'S INFORMATION):

Name _____ Relationship to Patient _____ Birthdate _____

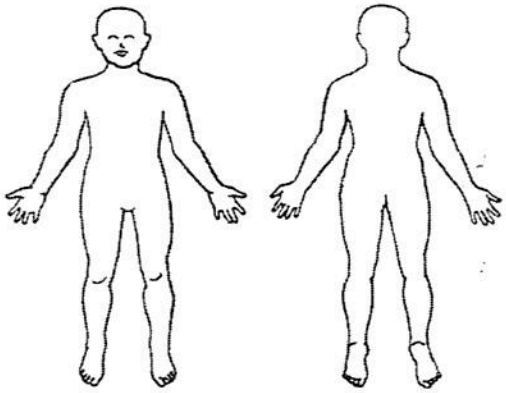
ID# _____

Is patient covered by **additional** insurance? Y / N

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ ID# _____

Please mark and **X** on the body diagram pertaining to area(s) where you continue to have pain and where it travels to:



Complaint area(s) _____

When did symptoms appear? (approx date) _____How?_____

Is it getting progressively worse? __ yes __ no __ unknown -- Pain is: __ constant __ comes & goes

***Rate the severity of your pain on a scale of 1-10, and 10 being the worst _____ ***

Type of pain: __ sharp __ dull __ throbbing __numbness __aching __shooring __ burning

__ tingling __ cramping __ stiffness __swelling __ other:_____

How often do you have the pain? (times a day/week, etc...) _____

Does the pain interfere with?: __ work __ sleep __ daily routines __ recreation

Activities/movements that are painful to perform: __ sitting __standing __ walking __ bending

__ lying down __ exercising *Other:*_____

How would you say your overall health is right now is: __ excellent __ very good __ good __ poor

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Chicken Pox	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____
		Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	_____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Family History

Please tell us if any close blood relative has/had the following medical conditions:
Mark all that all that apply.

_____Heart Disease _____Stroke _____Cancer

_____Diabetes _____Lung Disease _____Bone Disease

_____Rheumatoid Arthritis _____Multiple Sclerosis _____Autoimmune Disease

Father: Living_____ Deceased_____ Age_____

Mother: Living_____ Deceased_____ Age_____

Sisters: # Living_____ #Deceased_____ Age_____

Brothers: # Living_____ # Deceased_____ Age_____

Assignments And Releases

Consent To Treat A Minor: I (we) being parent, guardian or custodian of the minor being _____Age_____, do hereby authorize Mack Chiropractic, assistants and or staff to administer chiropractic care/ treatment deemed necessary to the minor named above.

Pregnancy Statement: Please check appropriate statement

The doctor/associates/staff have my permission to perform diagnostic testing using X-ray equipment. **I am not pregnant**. _____

I am currently pregnant_____ Weeks_____
I have been advised that x-rays may be hazardous to an unborn child. X-rays **will not** be taken when pregnant.

Consent To Treat: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic testing procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s). I understand there are risks involved with any medical services and have informed the doctor of any health related conditions that may affect my care.

_____Date_____
Signature of Patient/ Guardian

Assignments and Releases

Health Insurance/Medicare Assignment Of Benefits: I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, or billing agents for the processing of medical claims. I assign the benefits payable for medical services received directly to Dr. Patrick Mack/Mack Chiropractic and I acknowledge I am financially responsible for my deductable and coinsurance. Regarding commercial policies, I certify that I and /or my dependents have insurance coverage with the insurance presented and I directly assign to Mack Chiropractic all insurance benefits that would be payable to me for services rendered. I understand that the insurance policy is a contract between the insured and the insurance company and that I am financially responsible for all charges whether or not the claim is paid by my insurance carrier. It is my responsibility to know the requirements pertaining to my policy. I authorize the use and disclosures of my medical records for the purpose of treatment, payment or healthcare operations. I authorize the use of my signature on all insurance submissions. In the event of out-of-network benefits, we ask that you bring or mail any checks, with a copy of any EOB's (Explanation of Benefits), to our office in a timely manner.

Notice Of privacy Practices: I_____(your name) acknowledge that I may request a complete copy of the Notice Of Privacy Practices, written in plain language, from Mack Chiropractic. It is also visibly displayed in the office waiting room. The notice provides in detail the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights and the practice's legal duties to protect my PHI. The practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all PHI that it maintains. I may request a copy at any time.

_____

Print Name

_____ Date _____

Signature of patient or legal representative

MACK CHIROPRACTIC
Contact Release Form

I understand that it is important that Mack Chiropractic be able to contact me by phone/email in regard to appointments, scheduling, and or closing.

I,_____, do hereby authorize Mack Chiropractic to contact me by phone, voicemail and/or email to confirm/reschedule appointments, release results of diagnostic tests or to relay messages from Dr. Mack. By leaving your contact information implied consent is given to leave a general message with limited information.

In my absence, I authorize the information to be released to the following:

- ○ **Spouse** Name_____
- ○ **Daughter** Name_____
- ○ **Son** Name_____
- ○ **Other** Name_____
- ○ **Email - Please provide email address below.**

_____

This authorization will remain in effect until I revoke it in writing.

Signature_____ **Date**_____

Mack Chiropractic
269 Rt. 31 S. Suite 5
Washington NJ 07882

Billing/Patient Acknowledgement

The purpose of this form is for the patient to acknowledge responsibility of payment for services rendered when insurance denies coverage, the reasons for this are not limited to but include:

- Maxed visits
- Insurance deeming treatment as not medically necessary
- Insurance deeming treatment as supportive/maintenance
- Insurance deeming treatment as preventative/wellness care
- The service, product, or supply is not a covered benefit
- The service is covered, however a deductible applies

The services, products and supplies generally being billed to the insurance:

- Spinal 1-2 Region ($56)
- Spinal 3-4 ($78)
- Spinal 5 ($99)
- Spinal Extra ($66)
- Manual Traction ($66)
- Mechanical Traction ($35)
- Electric Stimulation ($42)
- Neuromuscular Re-education ($74)
- Ultrasound ($27)
- X-RAYS ($80 - $240)
- DME (durable medical equipment), orthotics, braces, portable tens units, etc. ($170 - $400)

I _____, **(Please print first & last name)**
Acknowledge that I have been told in advance by this office that the services, products and or supplies listed above may not be covered by my insurance plan due to the reasons stated above. I agree to pay for these non-covered services, products and or supplies at the time of service, when I am billed, or when product or supply is provided.

I understand that insurance is not a guarantee of payment and I will be notified by the office if the insurance I have presented is not covering my treatment services.

My complete understanding of this Acknowledgement is that in the event my insurance doesn't cover my treatment, I am responsible for all charges as determined by my insurance company.

X _____ Date: _____
Patient or Legal Representative

_____
(Legal Rep.) Print first & last name Relationship

Medicare Patients Only

A. Notifier: Mack Chiropractic (Dr. Patrick C. Mack DC,PC)

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____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._____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Spinal Manipulation	Charges are paid at discretion of Medicare Part B and are based on their interpretation of medical necessity	$28.87 - $49.91
X-rays, Electric Stimulation, Traction, Ultrasound	Not Covered by Medicare	$35 - $240
Ancillary Products: Orthotics, Pillows, Personal Devices, Durable Medical Devices	Not Covered by Medicare	$26 - $352

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._____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._____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:

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