

NEW PATIENT INFORMATION

REFERRED BY _____

NAME _____ Age: _____ Birthdate _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE # _____ CELL# _____ SS # _____

E-MAIL _____ RELATIVE'S PHONE #: _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE _____

INSURED'S NAME _____ INSURED'S BIRTHDATE _____

INSURED'S ID # _____ RELATIONSHIP _____

GROUP # _____ INSURED'S EMPLOYER _____

INFORMED CONSENT FOR 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 Dr. Wasserman. I will have the opportunity to discuss with Dr. Wasserman 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 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 I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest. I have read, or have had read to me, the above consent. I will have 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) or which I seek treatment here at this office.

I ALSO GIVE MY FULL AND COMPLETE PERMISSION FOR THIS MEDICAL GROUP TO TREAT MYSELF OR MY MINOR CHILD. I ACCEPT FULL FINANCIAL RESPONSIBILITY, AND **ASSIGN ALL MY PAYMENTS DUE TO THE DOCTOR.** I HEREBY AUTHORIZE THE GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT REQUIRED FOR THE PURPOSE OF BILLING. A PHOTOCOPY OF THIS ASSIGNMENT WILL BE AS VALID AS THE ORIGINAL.

THIS COMPLAINT OF _____ WAS **NOT** CAUSED BY AN AUTOMOBILE ACCIDENT, RELATED TO EMPLOYMENT, OR OCCUR ON COMMERCIAL PROPERTY.

SIGNATURE _____ DATE _____

Initial Symptom History

Please state your primary complaint of why you are here today: _____

What caused this and how long have you had it: _____

Have you had this condition in the past? _____

Please put a check that applies to your present condition:

Frequency: ___rare ___occasional ___frequent ___constant

Symptoms: ___pain ___stiffness ___spasms

Intensity: 0 (none)- 10 (severe) = ___neck ___mid ___low back ___extremity

Quality: ___sharp ___dull ___stabbing

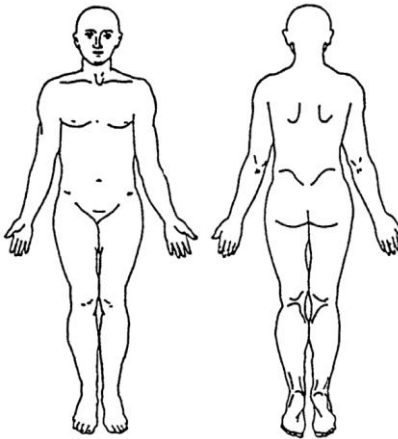
Assoc. Symptoms: ___weakness ___limited ranges of motion

radiating pain into _____ numb/tingling of _____

Aggravated by prolonged: ___sitting ___standing ___walking ___lying down ___driving

Relieved by: ___rest ___movement ___stretching ___Rx ___ice ___heat

Please mark the areas where your current complaints are located:



Signature _____ Date _____

INITIAL HEALTH HISTORY

Allergies: _____

Medications/Supplements _____

Cholesterol Lowering Drugs: _____

Surgeries/Hospitalizations: _____

Pace Maker/Metal /Breast Implants _____

Cancer: _____

Diabetes: _____

Heart Disease: _____

Stomach/Colon: _____

Etc. _____

Spinal Injuries/Accidents: _____

Previous Chiropractic Care: _____

Last Menstrual Period: _____ PREGNANT? () YES () NO

Previous MRI, CT Scans; X-Rays: _____

Exercise/Sports Activities: _____ times per week: 1 2 3 4 5 6 7

Average Daily Emotional Stress Level: ()very high ()high ()medium ()minimal

Patient Signature _____ **Date** _____

Comments:

STEVEN WASSERMAN, R.N., D.C.
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LOS ALAMITOS CA 90720
(562) 430-4949

MEDICARE FINANCIAL POLICY

Dear New Patient,

Please be advised that our financial policies take into account the requirements of the Insurance Companies, California Insurance Commission, and the ever-changing needs of this practice.

Payment in full at time of service. We will bill Medicare for you; we do not bill secondary insurances. Please remember, Medicare or your secondary insurance may or may not pay for services. Therefore, we require that you the patient be responsible for knowing your benefits and policy limits.

- a. Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits.
- b. When you receive an item or service that is not a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Ask us to explain, if you don't understand why Medicare won't pay.

Medicare will pay for an adjustment only for subluxation of the spine; however, Medicare may not feel chiropractic care is medically necessary. Medicare will not pay for: Exam, consultation, extremity adjusting, x-rays, physical therapy, supplies, or maintenance care because it is not a covered Medicare benefit.

FEES

Initial consultation, exam, adjustment, and physical therapy: \$175.00

Initial consultation and exam only: \$125.00

Adjustment and physical therapy: \$65.00

Adjustment/thermal pack: \$45.00

Patient not seen in over 6 months from last visit date; consultation, re-exam, adjustment, with or without physical therapy: \$100.00

Supplies: separate charge per item

Physical Therapy= electrical stimulation, manual traction, laser, ultrasound, thermal pack

I have read the above, and agree to the terms of this office's policy.

Signature _____ Date: _____

***PLEASE READ**

SIMPLIFIED MEDICARE FINANCIAL

DEDUCTIBLE

Medicare requires that you pay a yearly deductible of \$183, etc., towards 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 service 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.

1. **What is my responsibility each visit for Chiropractic care?** Payment in full for all services rendered that day. (see Medicare Financial Policy)
2. **Who bills Medicare for my services?** We will bill Medicare for you, even though we are an out-of-network provider.
3. **If I have a secondary insurance, who bills them?** Medicare will send Chiropractic charges to your secondary insurance; our office does not bill secondary insurances.
4. **Will my secondary insurance pay for care?** Your secondary insurance may or may not pay for services.
5. **What does Medicare cover for Chiropractic care?** Medicare will pay for an adjustment only; however, Medicare may feel chiropractic care is not medically necessary. It also depends on if your Medicare deductible has been met.
6. **What Medicare will not cover?** Medicare will not pay for: Exam,

consultation, x-rays, physical therapy, supplies, or maintenance care because it is not covered under Medicare guidelines.

7. **What will Medicare reimburse me?** Approximately \$23.00 for the adjustment only. Physical therapy is not a covered Medicare benefit.
8. **What will my secondary reimburse me?** They may or may not reimburse you for the adjustment; it depends on your individual secondary insurance benefit policy. It also depends on if your secondary deductible has been met.