

A. Chiropractic Associates of Rochester

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Services 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. services** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New patient exam:	This is not a covered service under Medicare / Medicare Advantage Plans	\$40.00
Maintenance Care (once a month)	This is not a covered service under Medicare / Medicare Advantage Plans	\$40.00
Extremity Manipulation:	This is not a covered service under Medicare / Medicare Advantage Plans	\$10.00
Soft Tissue (ART, GRASTON, etc)	This is not a covered service under Medicare / Medicare Advantage Plans	\$10.00
Any Supplies (pillows, lumbar, biofreeze)	This is not a covered service under Medicare / Medicare Advantage Plans	Prices Vary

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. services 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.
<input type="checkbox"/> OPTION 1. I want the D. Services 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.	
<input type="checkbox"/> OPTION 2. I want the D. Services 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.	
<input type="checkbox"/> OPTION 3. I don't want the D. Services 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 may ask to receive a copy.

I. Signature:	J. Date:
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You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



Tina Shores, D.C.
Colby Shores, D.C., CCSP
Kevin O'Hagan., D.C.

Welcome to our office.

190 Perrin Drive
Rochester, New York 14622
Phone (585) 544-1540
Fax (585) 544-1580
doctors@chiroROC.com

www.chiroROC.com

Patient Information

Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Email Address: _____

Sex M F Age _____ Date of Birth ____/____/____

Single Married Widowed Separated Divorced

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Family (Parents, Siblings) Health History _____

Contact Numbers

Home (____) _____ Cell (____) _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home # _____ Work # _____

Insurance Information

Insurance Co. _____

Policy Number: _____

Policy Holders Name: _____

Policy Holders Date of Birth: _____

How are you related to Policy Holder: Self / Spouse / Child

Lifestyle

Glasses of water per day _____

Kind of Shoes you wear most often _____

Do you wear orthotics? _____

How old is your mattress? _____

Sleep Position: (back) (side L / R) (stomach) (couch)

Accident Information

Is condition due to the accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Work Comp. Other

Attorney Name (if applicable) _____

Patient Condition

Reason for your Visit? _____

When did it begin? _____ What do you think was the cause? _____ Make's it better? _____ Worse? _____

Rate the severity of the pain on a scale of 0 (no pain) to 10 (excruciating pain) 0 1 2 3 4 5 6 7 8 9 10

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramping Stiffness Swelling Other

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does the pain interfere with your Work Sleep Daily Routine Hobby/Recreation

Previous history of primary complaint? _____

Health History



Name: _____

Date: _____

Primary Care Physician? _____ Office Phone() _____ Address: _____

Are you being seen by other specialists? _____ Who is your OB/GYN Physician?(Female Only) _____

What treatment have you already received for your condition? Medications (list) _____

Have you seen a Chiropractor in the past? Who _____ Date of last adjustment _____ None

Date of Last: Physical Exam _____ Blood Test _____ Urine Test _____

Spinal Exam _____ Spinal X-ray _____ Chest X-ray _____

MRI, CT, Scan _____ DEXA (Bone density) _____ Prostate Exam _____

AIDS/HIV	Y N	Emphysema	Y N	Parkinson's	Y N	Other: _____
Allergy	Y N	Epilepsy	Y N	Disease		_____
Anemia	Y N	Fainting	Y N	Pneumonia	Y N	_____
Appendicitis	Y N	Fractures	Y N	Polio	Y N	_____
Arthritis	Y N	Glaucoma	Y N	Prostate Issues	Y N	
Asthma	Y N	Gout	Y N	Psychiatric	Y N	
Bleeding disorder	Y N	Hernia	Y N	Care		
Breast Lump	Y N	Herniated Disc	Y N	Rheumatoid	Y N	
Bronchitis	Y N	High/Low	Y N	Arthritis		
Cancer	Y N	Blood Pressure		Scarlet Fever	Y N	
Cataracts	Y N	High Cholesterol	Y N	Stroke	Y N	
Chemical	Y N	Kidney Disease	Y N	Thyroid Problem	Y N	
Dependency		Liver Disease	Y N	Tuberculosis	Y N	
Chicken Pox	Y N	Migraine	Y N	Tumor/Growth	Y N	
Diabetes	Y N	Headaches		Ulcer/Colitis	Y N	
Depression	Y N	Multiple	Y N	Whopping	Y N	
Difficulty breathing	Y N	Sclerosis		Cough		
		Osteoporosis	Y N	Heart Attack	Y N	
		Pacemaker	Y N			

Exercise

Never
Seldom
Frequent
Daily

Work Activity

Sitting (desk)
Computer
Standing
Light Labor
Heavy Labor

Habits

Smoking
Alcohol
Caffeine
High Stress

Packs/Day _____ For _____ Yrs.
Drinks/Week _____
Cups/Day _____
Reason _____

Women Only

Are you pregnant? Y N
Number of pregnancies? _____
How many deliveries? _____
Vaginal C-section
Birth Control Pills? Y N

Injuries/Surgeries you have had: Please indicate actual dates or year.

Motor Vehicle Accidents _____

Broken Bones/Fractures _____

Spinal Injuries (Neck, Back, Low Back, Pelvis) _____

Head Injuries/Concussions _____

Surgeries (include all, i.e. Tonsillectomy) _____

Medications

Anti-inflammatory _____
Muscle Relaxants _____
Pain Killer/Analgesic _____
Heart Medication _____ Coumadin _____
Other _____

Vitamin/Herb/Mineral

Multivitamin _____
Multimineral _____
Herbs _____
Other _____



Patient Name _____

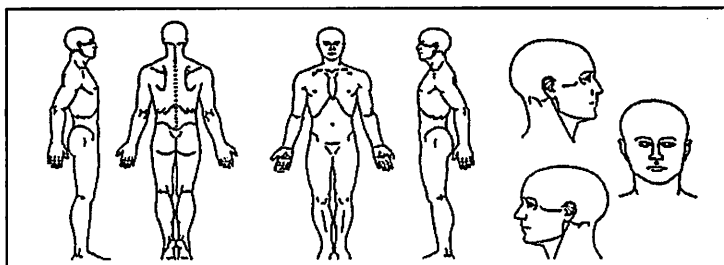
Date _____

☐ Regular

☐ Worker's Comp

☐ No Fault

On the diagram, please indicate the location of pain and the symbol that best describes what you are currently experiencing:



SHARP/STABBING +++
DULL/ACHY VVVV
PINS/NEEDLES 0000
NUMBNESS ////
OTHER XXXX

Type of discomfort: _____ Sharp _____ Dull _____ Aching _____ Burning _____ Numbness
(choose all that apply) _____ Tightness _____ Throbbing _____ Diffuse _____ Shooting _____ Tingling
_____ Other

Frequency of Pain: _____ Constant _____ Frequent _____ Intermittent _____ Occasional
(100%-75%) (75%-50%) (50%-25%) (25%-0%)

Discomfort increases with: _____ Movement _____ Applying Pressure _____ Sitting _____ Coughing

Discomfort decrease with: _____ Rest _____ Movement _____ Medication _____ Ice _____ Heat
_____ Chiropractic Care

Region	At WORST	At BEST	TODAY
NECK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
MID/UPPER BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
LOW BACK	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Other _____	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Scale: 0=no pain or discomfort 10=most intense pain

-For office use only-

Notes:

	Cervical ROM	Lumbar ROM
Flexion	(90)	(90)
Ext	(70)	(35)
LLF	(40)	(25)
RLF	(40)	(25)
Lrot	(70)	(30)
Rrot	(70)	(30)

Chiropractic Associates of Rochester

Patient's Name _____

Date _____

OVERALL HEALTH HISTORY

Do you have vertigo (dizziness)?	YES _____	NO _____
Do you pass out easily (faint, loss of consciousness)?	YES _____	NO _____
Do you have double vision or have you lost sight in one eye?	YES _____	NO _____
Do you have any slurred speech or difficulty in arranging words properly?	YES _____	NO _____
Have you had any difficulty walking, with coordination or falling to one side?	YES _____	NO _____
Do you have any nausea or vomiting?	YES _____	NO _____
Do you have numbness on one side of you face or body?	YES _____	NO _____
Do you have any visual disturbances or rapid eye movement?	YES _____	NO _____
Do you have a headache or head pain that is unlike any you have had before?	YES _____	NO _____
Do you have headaches for hours or days?	YES _____	NO _____
Do you have history of stroke in the family?	YES _____	NO _____
Do you have chest pain?	YES _____	NO _____
Do you have any change in bowel or bladder habits?	YES _____	NO _____
Do you have a sore that does not heal?	YES _____	NO _____
Do you have any unusual bleeding or discharge?	YES _____	NO _____
Do you have any thickening in your breasts or elsewhere?	YES _____	NO _____
Do you have indigestion or difficulty swallowing?	YES _____	NO _____
Do you have a change in any wart or mole?	YES _____	NO _____
Do you have a nagging cough or hoarseness?	YES _____	NO _____
Do you have night sweats?	YES _____	NO _____
Do you have pain in the neck, jaw or face?	YES _____	NO _____
Do you have a drooping eyelid or changes in your pupils?	YES _____	NO _____
Do you have any ringing in your ears?	YES _____	NO _____
Do you take birth control pills?	YES _____	NO _____

PROBLEM SPECIFIC

Head: headaches y / n location _____
Neck: difficulty with: turning L—R—forward—backward—tilt right—tilt left
Midback: pain with cough, sneeze or bowel movement
Low Back: pain down the buttock—legs pain with cough sneeze or bowel movement
Shoulder: _____
Elbow: _____
Wrist: _____
Hand/Fingers: _____
Hip: _____
Knee: _____
Ankle: _____
Foot/Toes: _____

Bournemouth Questionnaire

Back Pain (BQ-back)

Name:

Date:

Please circle **ONE** number for each of the following statements that best describes your neck pain and how it is affecting you **NOW**.
Please read each question carefully before answering:

1. Over the past few days, on average, how would you rate your back pain?	No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain
2. Over the past few days, on average, how has your back pain interfered with your daily activities (housework, washing, dressing, lifting, reading, driving, sleeping)?	No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry-on with normal day-to-day activities
3. Over the past few days, on average, how has your back pain interfered with your normal social routine including recreational, social, and family activities?	No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to participate in any social and recreational activities
4. Over the past few days, on average, how anxious (uptight, tense, irritable, difficulty in relaxing/concentrating) have you been feeling?	Not Anxious At All 0 1 2 3 4 5 6 7 8 9 10 Extremely Anxious
5. Over the past few days, on average, how depressed (down-in-the-dumps, sad, in low spirits, pessimistic, lethargic) have you been feeling?	Not Depressed At All 0 1 2 3 4 5 6 7 8 9 10 Extremely Depressed
6. Over the past few days, how do you think your work (both inside the home and/or employed work) has affected your back pain?	Makes It No Worse 0 1 2 3 4 5 6 7 8 9 10 Makes It Very Much Worse
7. Over the past few days, on average, how much have you been able to control (help/reduce) and cope with your back pain on your own?	I Can Control My Pain Completely 0 1 2 3 4 5 6 7 8 9 10 I Have No Control Whatsoever

THANK YOU VERY MUCH FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Chiropractic Associates of Rochester

190 Perrin Drive
Rochester, NY 14622

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** pick your response to the following questions:

	Disagree 0	Agree 1
1 My back pain has spread down my leg(s) at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 I have had pain in the shoulder or neck at some time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 I have only walked short distances because of my back pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of back pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all

☐

0

Slightly

☐

0

Moderately

☐

0

Very much

☐

1

Extremely

☐

1

Total score (all 9): _____ **Sub Score (Q5-9):** _____

CARE PLAN GOALS:

1. Pain Reduction by _____
2. TX Duration _____
3. Improve ROM _____
4. Resume ADL _____
5. Resume Work _____
6. Other GOALS _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care, spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years that have been demonstrated to be a highly effective treatment for spinal pain, headaches and other symptoms. Maintaining spinal alignment through chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical treatment, medications and procedures given for the same condition.

I acknowledge that I have received information regarding my condition and proposed chiropractic treatment as well as alternative courses of care, the benefits, the risks, the side effects of treatment and the consequences of not having the proposed treatment.

I understand and am informed that, as in all health care, in the practice of chiropractic there are some risks to treatment, including but not limited to: muscle strains & sprains, fractures, dislocations, disc injuries and strokes. I wish to rely on the doctor to exercise judgment during the course of the treatment that he feels at the time based upon the facts then known, is in my best interests.

My doctor has responded to all of my requests for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content. I intend this consent to apply to all my present and future chiropractic care in this office.

Patient Signature _____ Date _____

Witness _____ Date _____



Tina Shores, D.C.
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PATIENT ACKNOWLEDGEMENT & CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 whom may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change the Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address above to obtain a 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 or disclosed to carry out treatment, payment or healthcare options. I also understand the practice is not required to agree to my requested restrictions, but if the practice does agree then it is bound to abide by such restrictions.

This notice is in effect as of the date signed below. By signing below, I certify that I have received this notice and all of my questions have been answered to my satisfaction with language that I can understand.

Patient Name _____
Relationship to Patient _____
Signature: _____
Date: _____

OFFICE USE ONLY

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

Date	Initials	Reason



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OFFICE FINANCIAL AGREEMENT-2024

It is your responsibility to know what your insurance policy covers. Insurance covers acute, medically necessary care. If your insurance denies payment for our services at any time, you agree to take full financial responsibility. Some insurance companies will not allow multiple family members to be treated on the same day in the same office.

Please sign and initial designated insurance line.

Excellus BC/BS, Aetna and United

Deduct- Referral may be needed. Until your annual deductible is met the office fee will be procedure dependent. Fee is due at time of service. Once the deductible is met, you will be responsible for co-insurance policy dependent. Supplements, orthotics, supports, etc. are not covered.
Co-Pay- Your co-pay is due at the time of service and will range from \$10-\$70 depending upon your contract. Supplements, orthotics, cushion are not covered and are the patient's responsibility. Blues cover acute care and not maintenance care.

Medicare Advantage Plans: Aetna/BCBS/MVP Gold/United

Authorization is required on some Ins. Your insurance sets number of visits allowed. There are some costs that are out of pocket per Medicare. Please refer to the ABN agreement. Your insurance covers acute care not maintenance care.

Medicare: No referral needed. Until your annual estimated Deductible of \$226.00 is met the office fee is \$40.00 - \$80.00. You will be responsible for any usual and customary fee (ABN)

MVP/CIGNA/OTHER: The doctors in this office are out of network providers. Initial consultation fee, history and examination is \$80.00. Subsequent visits thereafter are \$40.00. Depending on your contract you may have out of network coverage. We will supply you with a claim form so that you can submit to your insurance company.

Usual & Customary Office Fees: First visit for consultation, history and examination is \$80.00. Subsequent visits thereafter are \$40.00. Initial Spinal scan fee included in \$80.00 charge.

Rock Tape (Kinesio Tape):

- Option 1: Free application with purchase of roll (for life of roll)
- Option 2: \$5.00 charge per region application

Worker's Compensation: If you require treatment for an injury that occurred while performing your normal employment, you may be eligible for 100% coverage by your employer's worker's compensation insurance. In such cases, to ensure your coverage, it is your responsibility to report your injury to your employer in writing and fill out the appropriate reports. Failure to do so will jeopardize your coverage. Should your case be denied you would become liable for services rendered. Mileage sheets will be available for \$20.

Auto Accidents/No Fault Insurance: If you are seeking treatment because of an auto accident, you may be eligible for 100% coverage by your No-Fault Insurance. Some companies have a deductible that must be met first. It is your responsibility to contact your insurance company and fill out the appropriate reports. Should your insurance decline to pay for your case, you would become liable for all services rendered. Mileage sheets will be available for \$20.00

Maintenance Care: Elective healthcare defined as patient has achieved and maintained pre-complaint status, plateaued in improvement, and/or chronic symptoms show no progression in reduction or remain stable. Treatment intervals are at regular intervals (example: 1 time a week, every 2 weeks, every 4 weeks, etc.) Benefits of maintenance care include enhanced quality of life, improved health, prevention of future injury. This is a service not covered by the insurance company and you will be responsible for the office fee of \$40. If you sustain a future incident or injury, your chiropractic care would again meet the criteria for acute care and would be covered by your health plan until that condition has achieved pre complaint status or plateaued in improvement.

There may be additional services/products needed to supplement your care.

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Chiropractic Associates of Rochester all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

- Please note that our office does not allow a personal balance over \$100 (unless other financial arrangements have been made in writing). Should your account become 60 days delinquent a \$10 charge per month will be assessed to the outstanding balance.
- Payment is due at the time of service. Payment in the form of cash, check, HSA, Credit Card is accepted.
- Returned Checks will have a \$25 service charge.

Responsible Party Signature

Date



Tina Shores, D.C.
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AUTHORIZATION FOR RELEASE OF INFORMATION:

TO: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

_____ Medical Records regarding _____
_____ X-Rays and / or report of findings, CT Scans, MRI's
_____ Consult reports from specialists
_____ Test Results
_____ Billing Records
_____ Other _____

I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

Initials _____

I understand that this authorization is voluntary and that I may revoke it at anytime by submitting my revocation in writing to the entity providing the information. The revocation will only be effective from the date the written revocation is provided and will not apply retroactively.

Initials _____

I understand that this authorization will expire one (1) year from the date of the original signature indicated below.

Initials _____

Patient Name: _____

Date of Birth: _____

Signature of Patient _____ Date: _____

If under age 18 Signature of Guardian: _____ Date: _____

Relationship to Patient: _____