Chart Number _____

Date ____/____/_____

GENTNER Chiropractic & Wellness CENTER LLC

13708 MADISON AVENUE• LAKEWOOD, OHIO 44107 • 216,221.2008• FAX 216.221.6446• www.gentnerchiro.com

Confidential Patient Information

Last Name _____ First Name _____ Mi. Initial _____

Address _____ City _____ State _____ Zip _____

Email _____ Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____

D.O.B (MM/DD/YYYY) _____/_____/_____ Male / Female

Social Security Number _____-_____-_____ Occupation _____ Employer _____

Emergency Contact Name _____ Relationship _____ Phone (_____)_____-_____

Ethnicity:

___ Hispanic or Latino
___ Not Hispanic or Latino
___ Declined

Race:

___ American Indian/Alaska Native
___ Asian
___ Black or African American
___ Native Hawaiian or Pacific Islander
___White
___ Other
___ Declined

Preferred Language:

___ English
___ Spanish
Other: _____

Insurance Information

Insurance Company _____ ID Number _____ Group Number _____

Policy Holder Name _____ Policy Holder Employer _____ Policy Holder D.O.B. (MM/DD/YYYY) _____/_____/_____

Assignment of Benefits and Release of Medical and Plan Documents

I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign to Gentner Chiropractic Center all medical benefits and/or insurance reimbursement for services rendered. I understand that I am responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including, but not limited to, my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

_____ _____

Signature of Patient or Parent/Guardian Date

_____
Name

_____/_____/_____
Date

Has your address or insurance changed? **Y / N**

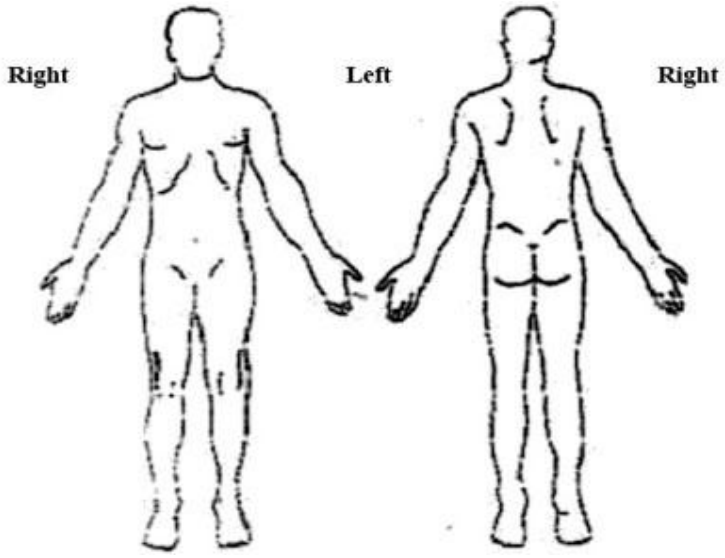
Confidential Patient History

Please list your current complaints in order of severity

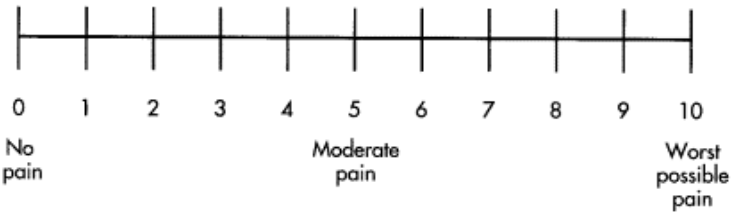
Main complaint	How long have you had this problem?	This episode?
Second complaint	How long have you had this problem?	This episode?
Third complaint	How long have you had this problem?	This episode?

Use letters below to indicate type of symptoms and location:

A- Ache **B-** Burning **S-** Stabbing
N- Numbing **P-** Pins & Needles **O-** Other



Please circle the severity of your main complaint (at its worst):



Have you had any tests done in the past (X-Rays, MRIs, CT Scans, bloodwork, etc.)? If yes, when?

_____

Have you ever suffered from:

____ Dizziness ____ Arthritis
____ Diabetes ____ Sinus Trouble
____ Backaches ____ Neck Pain
____ Heart Trouble ____ Nervousness
____ Digestive Disorder ____ Headaches

How often do you experience these symptoms?

Constantly Frequently Occasionally Intermittently

Have you previously been treated for this condition?

Y / N If yes, when?

_____

What are these conditions due to?

Auto Accident Work Injury Falling

Other _____

What makes it feel better?

Rest Heat/Ice Chiropractic Standing

Other _____

What makes it feel worse?

Sitting Bending Lifting Twisting Activity

Other_____

_____
Name

_____/_____/_____
Date

_____

Whom may we thank for referring you?

_____

Please list any medications

_____

Please list any allergies to medications

_____

Please list any surgeries you've had and their approximate dates

Does anyone in your family have a history of cancer, diabetes, heart disease, osteoporosis or strokes? Y / N If yes, please list relationship and which condition.

_____

Have you ever smoked? Y / N Do you currently smoke? Y / N How much _____

When is the last time you had a screening for colorectal cancer (Colonoscopy)? _____

When is the last time you had a screening for breast cancer (Mammogram)? _____

When is the last time you had a screening for cervical cancer (Pap test)? _____

Have you had an Influenza vaccine this season? Y / N Approximate date: _____

Have you had a pneumococcal vaccine? Y / N Approximate date: _____

Over the past two weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
	0	1	2	3
Little interest or pleasure in doing things				
	0	1	2	3
Feeling down, depressed, or hopeless				

Email: _____

Office use only

_____ _____ _____ _____/_____
Height Weight Pulse BP

Mother's maiden name: _____

_____
Chart Number

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Insurance: Most insurance policies cover chiropractic services, but the amount they pay varies per policy. As a courtesy we will verify your insurance benefits for you and review them with you. THIS DOES NOT GUARANTEE PAYMENT. Payment is subject to benefit limits and member eligibility at the time the claim is processed. If your insurance places a limit on the number of visits they will cover, you will be considered a cash patient once your limit is reached. Please read the "Cash" area below. Please note that it is your responsibility to track your visits. It must be fully understood that the type and number of covered services is defined by your insurance company, and that you are responsible for services not covered by your insurance. You will receive a monthly statement and we appreciate prompt payment of any balance due. Copays are due at the time of service.

Cash: If you do not have insurance, we request that you come prepared to pay in full for your first visit at the time of service. Subsequent appointment fees will reflect services rendered during each visit. Self-pay fees that are paid in full *at the time of service* will be offered a 20% discount.

Worker's Compensation: If you are injured on the job, your employer's Worker's Compensation insurance will pay for care that is APPROVED by the Bureau of Worker's Compensation. If your claim for treatment is denied, you are responsible for payment, either through your medical insurance or personally. **IMPORTANT:** You must report your injury to your employer prior to your first visit.

Personal Injury/Auto Accident: If you have medical coverage on your auto insurance policy, we will bill them directly for payment for your care. If you do not have med-pay on your policy, or you are waiting for a settlement with another party such as an attorney, you will be expected to sign a lien which covers the doctor's services through your settlement. **Regardless of any settlement, you, as the patient, are responsible for all medical bills. Responsibility for payment is not contingent on any settlement.**

All Patients Please Read: As stated above, insurance copays and cash patient payments are expected on the day of service. To accommodate you, we accept cash, personal check, money order, VISA and Mastercard in the office. For your convenience, we also offer a secure on-line system through which to pay bills and store credit cards and on-line signatures.

NOTE: There will be a $25.00 fee for any returned checks.

I have read and understand the office financial policy. This is an agreement between the doctor's office and myself and failure to abide by this agreement could result in my account being turned over to an outside collection agency.

_____ _____

Patient or Parent/Guardian Signature Date

Gentner Chiropractic & Wellness Center LLC

13708 Madison Ave. Lakewood, Ohio 44107 - 216-221-2008

Patient Name:

Advance Beneficiary Notice of Noncoverage (ABN)

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

Service:	Reason Medicare May Not Pay:	Estimated Cost
Exam 99202 - 99203		$50 - $100
X-Rays 72040 - 73100		$40 - $126.50
E Stim 97014	Non- Covered Services	$15
Exercise 97110		$40
Mechanical Traction 97012		$20
Active Therapy 97530		$45

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 service(s) 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.

OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the service(s) 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 service (s) 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 service (s) 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 ABN form is only for non-covered Medicare services. Medicare never pays for such services. The only reason for using Option 1 above is when you have secondary insurance that might reimburse you.

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.

Signature:	**Date:**

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