THE BACK ALLEY
CHIROPRACTIC & MASSAGE

MEDICARE PATIENT UPDATE

Please take the time to complete these forms to the best of your ability. If you have any questions, we will be glad to help you.

First Name _____ **Middle** Initial _____ **Last** Name _____

Home Address _____

City _____ State _____ Zip Code _____

Billing Address (*if different*) _____

City _____ State _____ Zip Code _____

Email Address* _____

Cell Phone _____ Would you like to receive text reminders? ☐ Yes ☐ No

Home Phone _____ **Work** Phone _____

Emergency Contact Name _____ Phone # _____

Primary Care Physician _____ Phone # _____

Date of Birth _____ / _____ / _____ Social Security Number _____ - _____ - _____

Employment Status: ☐ Employed ☐ Not Employed ☐ Retired Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

MEDICARE INFORMATION ON NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any
- more improvement.
- Wellness Care - to promote better health.

SYMPTOMS

List and describe your ***chief complaint*** *and answer all questions following. If you need more space, please ask for an additional page.*

Chief complaint _____ How long ago? #____ Days #____ Weeks #____ Months #____ Years

How did this begin? ☐ job related injury ☐ auto accident ☐ illness ☐ injury ☐ unknown ☐ gradual onset ☐ sudden onset

This occurs? ☐ seldom ☐ repeatedly ☐ frequently ☐ constant Severity: 0 1 2 3 4 5 6 7 8 9 10

How often? ☐ 0-25% ☐ 25-50% ☐ 50-75% ☐ 75-100% ☐ in the afternoon ☐ in the evening Intensity: ☐ light ☐ extreme

Condition is: ***Aggravated*** by_____ ***Improved*** by_____

To the best of my ability, the information I have supplied is complete and truthful. At any time, I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and may be released. I grant permission to be called or emailed to confirm or reschedule an appointment and to be sent occasional cards, letters, or emails as an extension of my care in this office. *Providing an email is explicit consent and agree to receive communication and marketing emails (see our HIPAA notice for more details).

Patient Signature _____ Date _____

A. Notifier: Donald K Shiflet DC, 2060 E Tangerine Rd #182, Oro Valley AZ 85755, (520) 877-2666

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. Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
OFFICE VISIT	According to existing Medicare law, the services listed on the left are NON-COVERED	$35 per visit
REPORT OF FINDINGS (ROF)		$35 per visit
PHYSIOTHERAPY such as manual therapy, electrical stimulation, physical therapy, decompression		$10 per therapy

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.

☐ **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.

☐ **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.

☐ **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:

n/a

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:

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.