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 _____

Gender: ☐ Male ☐ Female Do you prefer to go by a **nickname**? ☐ No ☐ Yes _____

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 ☐ Student Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

COVERAGE INFORMATION

Complete below, providing your Medicare and additional coverage, if any, in full. Sign where indicated, then provide your insurance card(s) to reception.

SECTION A: **Medicare Beneficiary Identifier** (MBI #) _____

If you have additional coverage, complete either Section B -OR- Section C, but not both, depending on your type of additional coverage.

SECTION B: **Medicare *Supplemental* Insurance Plan**

Supplemental Insurance _____ Policy # _____ Plan: A B C F G K L N
(circle one)

OR

SECTION C: **Secondary and, if applicable, *Tertiary* Group Health Plan**

Secondary Insurance _____ Policy # _____ Insured: ☐ Self ☐ Spouse

Insured, if not self: Full Name _____ Phone # _____ Date of Birth _____

Social Security Number _____ - _____ - _____ Employer _____

Tertiary Insurance _____ Policy # _____ Insured: ☐ Self ☐ Spouse

Insured, if not self: Full Name _____ Phone # _____ Date of Birth _____

Social Security Number _____ - _____ - _____ Employer _____

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, all 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.

ACKNOWLEDGEMENT OF UPDATED OFFICE POLICY & PROCEDURES

All policies and procedures are available on our website for reference at any time. Office policies and procedures are updated regularly. Your signature below indicates you have read, understand, and agree to the updated office policies.

Financial Policy & Procedures

Payment We accept cash, personal check, debit, and Visa, MasterCard and Discover. There is a minimum fee of $35 charged for returned checks. A surcharge of 3% is imposed on all brands of credit card transactions, that is not greater than our cost of acceptance.

Insured By request, as a courtesy to our patients, we will submit your medical claim to your insurance carrier. Patient balances are billed immediately upon receipt of your carriers EOB. Your remittance is due immediately upon receipt of our bill.

Self-Pay We offer a pay-at-time-of-service discount for all patients. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee.

Delinquent Accounts Unpaid balances are past due at 30 days. Balances left unpaid may receive a second and third notice prior to final notice, mailed at 30-day intervals. The Back Alley utilizes an outside collection agency. Balances over 120 days past due may be submitted to our collection agency.

Medicare We accept Medicare assignment. As a Medicare patient you are responsible for your deductible and co-insurance. If you have secondary or supplemental insurance we will bill it for you. Medicare non-covered services are due at the time of service.

Workers Compensation If you are here as a result of a work related injury; we will require information regarding your health insurance and your employers Workers Compensation insurance.

Personal Injury Claims We bill third party insurance carriers ***only*** on a lien basis. Please notify our staff of your personal injury immediately. You will be asked to complete forms specific to personal injury as well as a consent and notice for medical lien.

Patient Billing Protocol

While our standard office policy is to require payment at the time of service, there are times when insurance companies must be billed in advance of collecting payment from the patient. In addition, errors can happen during the verification process that may leave a patient with a balance or a credit.

Why do we have a Patient Billing Protocol? We have created this policy to establish a non-discriminatory procedure for our patients.

How do we bill patients? Patient billing is an on-site office process, with patient bills printed on paper, and mailed at 30-day intervals.

What happens to delinquent accounts? Our office utilizes an outside collection agency for patient accounts that are uncollectible.

What happens if a patient has a credit? A credit will remain on a patient's account until it is either refunded or applied to future dates of service. A patient with a credit may request a refund of said credit at any time, by telephone or in writing by mail.

Patient Billing Procedure:

- Patient billing is processed every 30 days at approximately the 15th day of the month
- Unpaid balances are past due at 30 days of EOB/835 processing
- The patient will receive a FIRST notice indicating the balance due is **copay**, **deductible**, or explanation of **other** reason
- The patient will receive a SECOND notice if balance is left unpaid at the next billing cycle
- The patient will receive a third and FINAL notice to remit payment within 10 days, if balance is left unpaid at the next billing cycle
- If a balance is left unpaid after FINAL notice, the patient is referred to our collection agency for further collection activity

We do not write-off any charges as a standard procedure. Uncollectable accounts should be referred to our collection agency for further collection activity. Samples of acceptable write-offs:

- Allowed amounts by contractual obligation
- Timely filing by contractual obligation
- Medicare QMB eligible members are not responsible for deductible, coinsurance, or copay. This eligibility is verified during the verification process.
- Hardship cases. This eligibility is determined through application process.

Claims Billing Protocol

Claims billing is a process that begins at the Front Desk, with proper collection of information and data entry. It is equally important to collect the information as it is to verify the information received before the patient is rendered payable services. Benefits should NEVER be guessed at.

Why do we have a billing protocol? For our biller to properly submit claims, we must be sure data is entered timely as well as accurately. We must also be sure that patient insurance policies are verified properly.

Who is our biller? At this time we handle all billing in house.

How are claims submitted? We submit claims electronically through a clearinghouse.

How do we verify benefits? Our office utilizes an all in one online access to verify most insurance policies, including Medicare and AHCCCS (Medicaid), as well as many supplemental policies. When necessary, we can utilize online provider portals or provider services by telephone.

Claims Billing Procedure:

- Patient provides identification and insurance information to our office
- Staff contacts insurance company to verify Eligibility and Benefits
- Services are rendered at the time of patient's appointment
- After services are rendered, the provider identifies CPT codes and ICD-10 codes for diagnosis
- Office Staff enters patient's data and demographics
    - Demographics must include patient's full name, address, phone number, date of birth, and policy holder full name, address, phone number, date of birth and employer. IT IS IMPERATIVE this info is entered accurately to avoid claim denials.
    - Other data that is required includes ICD-10 diagnosis codes, onset date for Medicare policies, insurance policy information, and CPT codes for services rendered
- The biller creates insurance claims using the patient's data. The biller then converts the claim into an electronic file that is submitted to the clearinghouse, which then forwards the claim to the insurance company.
- The insurance company processes the claim and either accepts it or rejects it. The insurance company sends the status decision to the clearinghouse. If the claim is valid, the insurance company will reimburse for services based on network status contracted rates. If the claim is rejected, the insurance company will provide the clearinghouse with a detailed description of why the claim was denied.
- Rejected claims must be promptly corrected and refiled so that timely filing limits are adhered to.
- EOBs and ERAs should be processed timely so that AR records and patient ledgers are continually up to date
- Following the processing of EOBs and ERAs, the patient should be billed for any outstanding balances. Likewise, credits may be refunded by check if requested by patient (see patient billing protocol for more information).

Current Fee Schedule

	CPT Code	Description	Professional Fee	Prompt Pay Fee*
E/M	99202	NP OV 15-29 min	$146.20	$35.00
	99203	NP OV 30-44 min	$226.44	Not available
	99204	NP OV 45-59 min	$335.92	Not available
	99205	NP OV 60-74 min	$443.36	Not available
	99212	EP OV 10-19 min	$114.24	$35.00
	99213	EP OV 20-29 min	$182.24	Not available
	99214	EP OV 30-39 min	$257.72	Not available
	99215	EP OV 40-54 min	$361.08	Not available
CMT	98940	CMT Spinal 1-2 Region	$50.00	Not available
	98941	CMT Spinal 3-4 Region	$80.24	$50.00
	98942	CMT Spinal 5 Regions	$104.04	Not available
	98943	CMT Extraspinal 1+ Regions	$53.04	$10.00
THERAPY	97014	Electrical Stimulation	$25.16	$10.00
	G0283	Electrical Stimulation	$25.16	$10.00
	97110	Therapeutic Exercises	$59.84	$10.00
	97140	Manual Therapy	$55.08	$10.00
OTHER	99080	Special Reports	$100.00	Not available
	S9981	Medical Records Copy Fee	$75.00	$75.00
	97124	Massage Therapy	$25.00 per unit	$25.00 per unit

*We offer a Prompt Pay fee discount for all patients by request, in lieu of insurance coverage. Insurance ***cannot*** be used when opting for a Prompt Pay Fee service discount. If you fail to provide payment at the time services are rendered, you will be responsible for and billed for 100% of the professional fee. Questions regarding this fee schedule may be directed to our office at (520) 877-2666.

What is a CPT® code? CPT is designated by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA) as a national coding set for physician and other health care professional services and procedures, CPT's evidence-based codes accurately encompass the full range of health care services.

What are E/M codes? E/M services represent a category of CPT codes called Evaluation and Management. E/M services are a type of patient encounter between a physician and a patient seeking medical advice and care for symptoms, conditions, illnesses, or injuries. Commonly, E/M services are face-to-face encounters between the provider and patient. There are different levels of E/M codes, which are determined by the complexity of a patient visit and documentation requirements.

What are CMT codes? As explained by CPT guidelines, Chiropractic Manipulative Treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. CMT services are represented by a category of CPT codes used to indicate the number of spinal regions manipulated. Spinal regions as defined by CPT are: Cervical, Thoracic, Lumbar, Sacral, and Pelvic. Extraspinal (non-spinal) regions as defined by CPT are: Head, Upper extremities, Rib cage, Abdomen, and Lower extremities.

What is Therapy? Therapeutic procedures are modalities (specific types of treatment) that can be used in conjunction with CMT to assist with a variety of conditions or injuries.

Massage Policy

Your well-being is very important to us. Our goal is to provide quality health care to all our patients in a timely manner. We do understand that sometimes unexpected delays or emergencies can occur. Please be aware of our policy regarding missed appointments. As a necessary business practice this policy is enforced.

Why do we have a Massage Therapy Policy? No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients.

What can I do? In order to be respectful of your fellow patients, please call our office at (520) 877-2666 as soon as you know you will not be able to make your appointment.

Cancellation Policy Cancellation is free up to ***24 hours*** in advance. Appointments are in high demand and your advanced notice will allow another patient access to that appointment time. N*ew clients and/or first appointments that result in a no show or late cancellation will be charged* ***100%*** *of the scheduled fee;* otherwise, for existing clients *after* 24 hours a **50%** late cancellation fee will be charged. Cancellation fee is based on the current fee schedule at the time cancellation occurs. Cancellations are payable by client only and due at the time of late cancellation/no show.

Late Cancellations/No-Shows A cancellation is considered late when the appointment is cancelled less than ***24 hours*** before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, you will be responsible for a cancellation fee as outlined above.

How to Cancel Your Appointment If you need to cancel or reschedule your appointment time, please call us at (520) 877-2666. If necessary, you may leave a voicemail message. Cancellation by text message is available by following the instructions on your original text reminder or by replying with a detailed text message. Cancellations by email *cannot* be accepted.

Prompt Pay Massage Fees 30 minutes $50.00 60 minutes $80.00 90 minutes $115.00 120 minutes $150.00

Prompt pay massage fees apply only to payments made at the time of service for massage appointments of 4+ units, any balance left unpaid, regardless of reason, is subject to the full professional fee of $25.00 per massage unit (15-minute interval). This policy applies to all pre-arranged non-pay at time of service agreements, i.e. third party payment, personal injury, MEDPAY, etc.

Appointment Reminders As an added convenience, our office offers text message reminders. If you would like to sign up for this service, ask any member of our front desk to opt-in. In addition to this convenience, you can easily cancel an appointment by text message by following the instructions on your original text. *Remember, a 24-hour notice is always required for any cancellations or appointment changes*.

Records Request & Release

The are many reasons medical records may be requested. A patient has a legal right to view and/or request a copy of their medical records. The following policy was put into effect for our office to abide by HIPAA requirements as well as to allow the patient to assert their rights.

How may a patient view their records? A patient may request to schedule an appointment to view their records at any time. A member of the staff must be present with the patient at all times to ensure records are not tampered with or removed.

How may a patient request a copy of their records? A patient may request a copy of their medical records at any time by completing an Authorization for Protected Health Information form. The form must be completed with no blank spaces.

Is there a charge to copy records? Arizona law allows physicians to charge a reasonable amount for the cost of copying and mailing records.

How long does it take to process a request for medical records? Arizona law states we must process requests for records within 30 days of the request. Records may be faxed, mailed, or picked up.

Who else may request medical records? Other physicians, insurance companies, insurance carriers, and attorneys may request records at any time.

Is there a charge when other physicians, insurance companies, insurance carriers, and attorneys request records? Records requested by other physicians for continuing care can not be charged. Insurance companies, insurance carriers and attorneys may be charged per request, payable in advance. In some cases, health insurance companies which we are in network with can not be charged for records, or the patient is liable for the fee.

How can others request medical records? A signed request on letterhead or other office form from the requesting physician or facility, a Medical Authorization form signed by the patient, Subpoena of the court, Record's Retrieval service.

Can a patient request records be sent to someone else? A patient may complete an Authorization for Protected Health Information with the name of the receiver on the request. Charges do not apply if the receiver is a physician, doctor office or hospital, and for the purposes of continuing care.

I, _____, have received and reviewed a copy of this office's updated Office Policy and procedures including, but not limited to :

- Financial Policy
- Fee Schedule
- Billing Procedures
- Claims Billing protocol and procedures
- Financial Agreement
- Massage Therapy policy
- Records Request & Release protocol

Patient or Parent/Guardian Signature _____ Date _____