



# **MARINO CHIROPRACTIC CLINIC**

**Dr. Michael Marino**

**Patient Information**

Date: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_ HomePhone: \_\_\_\_\_ CellPhone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  Male  Female

Check appropriate box:  Minor  Single  Married  Divorced  Widowed

Employer Name: \_\_\_\_\_ Spouse/Legal Representative's Name: \_\_\_\_\_

Please provide the name of your referral source: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

**Responsible Party**

Name of Person Responsible for Account: \_\_\_\_\_

**Current Medications -Include Non Prescription**

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**Allergies/Medication Allergies:**

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**Previous Hospitalizations/ Surgeries/ Serious Illnesses: When? Hospital, City, State?**

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**Patient Social History**

Marital Status:     Single  Married  Separated  Divorced  Widowed

Use of Alcohol:    Never  Rarely  Moderate  Daily

Use of Tobacco:   Never  Rarely  Moderate  Daily

Use of Drugs:     Never  Type/Frequency: \_\_\_\_\_

**Current/Past Medical Conditions**

**Muscular/Skeletal:**

**Neurological:**

**General:**

Muscle Aches	YES	NO	Headaches	YES	NO	Fatigue	YES	NO
Fibromyalgia	YES	NO	Migraines	YES	NO	Malaise	YES	NO
Arthritis	YES	NO	Dizziness	YES	NO	Weakness	YES	NO
Joint Pain	YES	NO	Numbness	YES	NO	Lightheaded	YES	NO
Knee Pain	YES	NO	Tingling	YES	NO	Irritability	YES	NO
Neck Pain	YES	NO	Pins/Needles	YES	NO	Constipation	YES	NO
Hand Pain	YES	NO	Burning	YES	NO	Diarrhea	YES	NO
Elbow Pain	YES	NO	Hypersensitivity	YES	NO	Feeling Foggy	YES	NO
Shoulder Pain	YES	NO	Difficulty with Balance	YES	NO	Forgetfulness	YES	NO
Hip Pain	YES	NO						
Foot Pain	YES	NO						
Low Back Pain	YES	NO						
Pain b/t Shoulder Blades	YES	NO						

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

\_\_\_\_\_  
Signature of the Patient, Parent, or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the Person Holding Power of Attorney for Patient

\_\_\_\_\_  
Date



## **ASSIGNMENT OF HEALTH BENEFITS AND RIGHTS AND APPOINTMENT AS PERSONAL REPRESENTATIVE AND BENEFICIARY**

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay Marino Chiropractic Clinic, as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider"), the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including but not limited to any plan or insurance contract governed by the Employee Retirement Income Security Act of 1974 (ERISA) or Patient Protection and Affordable Care Act (PPACA)) that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

I also designate and appoint a Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under, including but not limited to any plan or insurance contract governed by ERISA or PPACA. I also hereby appoint and designate Healthcare Provider to act on my/our behalf, as my/our Personal Representative, ERISA Authorized Representative, and PPACA Authorized Representative as to any claim determination; to request a relevant claim or plan information from the applicable health plan or insurer; to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider; and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Providers can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

I hereby authorize the release, in compliance with the Health Insurance Portability and Accountability Act of 1996, of any health status, conditions, symptoms, or treatment information contained in my/our Marino Chiropractic Clinic records that is needed to file and process any insurance or medical plan claim; to pursue appeals on any denied or partially paid claims; to legally pursue any unpaid or partially paid claims; or to pursue any other remedies necessary in connection with the same.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

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Patient Name

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Patient, Parent, or Legal Representative Signature

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Date



## CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby voluntarily request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by Dr. Michael Marino, D.C. and any other licensed doctors of chiropractic who now or in the future are employed by, contract with, or are otherwise affiliated with Marino Chiropractic Clinic.

I have had an opportunity to discuss with Marino Chiropractic Clinic's doctor or other personnel the nature and purpose of chiropractic adjustments and other procedures. I have been informed and understand that results are not guaranteed. I also have been informed and understand that in the practice of chiropractic, as in the practice of medicine, there are some potential risks to treatment and diagnostic services, including but not limited to:

- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and Procedures: additional pain and discomfort; increased risk of acute myocardial infarction (heart attack) resulting from endurance exercise in patients with known or possible cardiac conditions.
- Radiographs: harm to the fetus resulting from ionizing radiation for those who are pregnant or might be pregnant.

I do not expect Marino Chiropractic Clinic's doctor to be able to anticipate and explain all risks and complications of the offered services and treatment. I wish to rely upon the doctor to exercise judgment during the course of the treatment in a way that they believe, at the time and based upon the facts then known to them, is in my best interest. I understand that I also have the right at any time to pursue non-chiropractic treatment options, to receive a second opinion, and to refuse treatment. Marino Chiropractic Clinic's doctor will explain the risks and benefits associated with any of these treatment approaches.

By signing below, I acknowledge that I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to receive chiropractic treatment from Marino Chiropractic Clinic. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

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Patient Name

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Patient, Parent, or Legal Representative Signature

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Date



## PATIENT AGREEMENT

It has been our experience that those who understand and agree to the following guidelines can benefit the most from the care they receive at our office.

**Visits:** Our recommendations for your care are customized to your health goals and your body's needs. Please consider the following guidelines:

- Attend all appointments and arrange your other activities and responsibilities to accommodate these appointments.
- Call us as soon as possible if you have an emergency or unavoidable conflict so that we can reschedule your appointment.

**New Symptoms:** If you experience any new symptoms or other significant changes in your health, please let us know immediately.

**Payment of Bills:** We expect you to honor the financial agreement you make with our office. If you find that you cannot fulfill this financial obligation, tell our front office staff as soon as possible so that we can discuss available options. Your insurance company will be billed for services rendered if you have such insurance coverage. If you receive a check from your insurance company to pay for our services, it is your responsibility to bring it into our office within 3 days of receiving it, along with the "Explanation of Benefits" attached to the check. If you fail to bring in the insurance check and/or the "Explanation of Benefits," we reserve the right to bill you directly for those services. Available methods of payment include Visa, Mastercard, cash, check, and CareCredit.

**Questions or Concerns:** If you ever have any questions or concerns concerning your care in our office, please talk to a staff member immediately so we can help answer your questions and find you any assistance you may need.

I, the undersigned, fully understand, accept, and agree to adhere to these policies.

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Patient Name

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Patient, Parent, or Legal Representative Signature

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Date



## PROVIDER STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

### Patient Rights

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients have the right to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients have the right to access care easily and in a timely fashion.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about provider work history and training.
- Patients have the right to information about clinical guidelines used in providing and managing their care.
- Patients have the right to know about advocacy and community groups and prevention services.
- Patients have the right to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients have the right to know about laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process and to make recommendations regarding the organization's rights and responsibilities policy.
- Patients have the right to understand and help develop plans and goals to improve their health.

### Patient Responsibilities

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers the information they need in order to provide the best possible care.
- Patients have the responsibility to ask their providers questions about their care.
- Patients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to let their provider know about their insurance coverage and any changes to it.
- Patients have the responsibility to let their provider know about any problems paying fees.
- Patients have the responsibility not to take actions that could harm others.
- Patients have the responsibility to report fraud and abuse.
- Patients have the responsibility to openly report concerns about quality of care.
- Patients have the responsibility to let their provider know about any changes to their contact information (name, address, phone number, etc.).
- Patients have the responsibility to understand and help develop plans and goals to improve their health.

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Patient Name

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Patient, Parent, or Legal Representative Signature

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Date



## Advance Beneficiary Notice of Non-Coverage (ABN)

**\*FOR MEDICARE PATIENTS ONLY\***

**NOTE:** If Medicare doesn't pay for **D. Daily Therapy Services** below, you may have to pay. Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D. Daily Therapy Services** below.

D. Daily Therapy Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
<input type="checkbox"/> I. Laser Therapy <input type="checkbox"/> II. TDN (Needle Insertion(s) without injection(s)): 20560 (1 or 2 muscles) OR 20561 (3 or more muscles) <input type="checkbox"/> III. Iontophoresis - 97033 <input type="checkbox"/> IV. 97014 E-stim <input type="checkbox"/> V. 97124 Massage Therapy <input type="checkbox"/> VI. 97110 Ther Ex <input type="checkbox"/> VII. X-Rays <input type="checkbox"/> VIII. 97810 Acupuncture		<input type="checkbox"/> I. \$65 <input type="checkbox"/> II. \$40 <input type="checkbox"/> III. \$50 <input type="checkbox"/> IV. \$25 <input type="checkbox"/> V. \$25 <input type="checkbox"/> VI. \$25 <input type="checkbox"/> VII. \$25 <input type="checkbox"/> VIII. \$40

**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. Daily Therapy 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.

<p><b>G. OPTIONS: Check only one box. We cannot choose a box for you.</b></p> <p><input type="checkbox"/> <b>OPTION 1.</b> I want the <b>D. Daily Therapy Services</b> 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 copays or deductibles.</p> <p><input type="checkbox"/> <b>OPTION 2.</b> I want the <b>D. Daily Therapy Services</b> 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.</p> <p><input type="checkbox"/> <b>OPTION 3.</b> I don't want the <b>D. Daily Therapy Services</b> listed above. I understand with this choice I am <b>not</b> responsible for payment, and I cannot appeal to see if Medicare would pay.</p>
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**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 also receive a copy.

<b>I. Signature:</b>	<b>J. Date:</b>
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