

Back N' Balance
Charting Your Way Back To Good Health

Patricia L. Snair, D.C.
Director

CONFIDENTIAL NEW PATIENT INFORMATION

Date: _____
Legal Name: _____ SS#: _____
Name I prefer to be called: _____ Phone #: _____
Cell#: _____ Driver's License #: _____
E-mail Address: _____
Gender: M F Age: _____ Date of Birth: ____/____/____
Marital Status: Single Married Other Spouse Name: _____
Local Address: _____
City: _____ State: _____ Zip Code: _____
Employment Status: _____
Employer Name

Work Address/ City/ State/ Zip

Type of Work: _____ Work #: _____

In Event of Emergency:

Contact Name: _____ Relationship: _____
Home #: _____ Work #: _____
How did you hear about our office?: _____

Please answer the following questions so that we may better care for you.

- I have a problem/symptom (circle one) and I am ONLY interested in help with this specific problem.
 I have a problem/symptom (circle one) and I am interested in help with this problem and in learning how to prevent it in the future.
 I have a problem/ symptom (circle one) and I am interested in help with this problem in addition I am interested in learning about health potential and the role of Chiropractic care in improving my health and my family's health as well.
 I have no special problem, I understand the role of Chiropractic care in my general healthcare.

Who is your primary care physician? _____
Name

Address: _____ City/State/Zip: _____

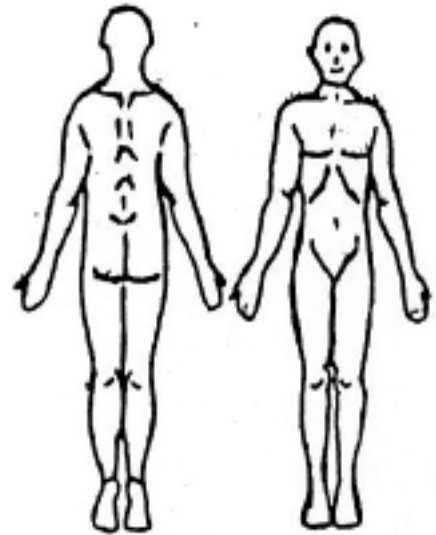
Do you want us to forward initial visit information to your Primary Care Physician? No Yes

Previous Chiropractic History

Have you ever been to a Doctor of Chiropractic before? No Yes
If yes, when was the approximate date of your last adjustment? _____
Doctor's name and address: _____
Have you had Therapeutic Massage before? No Yes

MAJOR AREA OF COMPLAINT: (Circle areas of discomfort)

Describer Symptoms: _____



Do you know what may have caused this complaint?
 Auto Work Fall Unknown

Has it been bothering you for more than a couple of days?
 No Yes How long? _____

Do you smoke tobacco? No Yes If yes, how much? _____

Do you drink alcohol? If yes, how often?
 Never Very Seldom Social 1 drink/day 2-5 drinks/day

Do you have any allergies to medications? (Prescription and/or OTC) If yes, what?

Do you have any other allergies or adverse reactions? _____

Please write any other information you might feel is pertinent to today's visit: _____

Office Policy:

1. All fees are due at the time of services rendered unless other arrangements have been made.
2. Each patient is responsible for payment of our fees.
3. In case of any new injury, please notify the office of injury/accident prior to making an appointment.
4. Patients are scheduled by appointments. If you are late you have missed your appointment time and will be worked in the schedule as best as we can.
5. Any payment plans are to be discussed with the Office Manager.

Release and Assignment:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctors' office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

MEDICARE & YOU!!!!

Medicare Coverage Information – Chiropractic Care

Medicare & Railroad Medicare Part B does cover chiropractic care, but, it has it's limitations. It allows a limited number of spinal manipulations per 12 months. Since we do not accept payment directly from Medicare, a claim will be filed to Medicare in your behalf and they will respond directly to you.

Medicare fee schedules for the year **2008** are as follows:

Spinal manipulation 1-2 regions fee: \$25.84

Spinal manipulation 3-4 regions fee: \$35.65

Spinal manipulation 5 regions fee: \$46.92

(Medicare limiting charge)

Medicare allowance:

Reimbursement made at 80% of allowance:

If you have any questions, please feel free to ask us!

Date: _____

Patient signature: _____

PATRICIA L. SNAIR, D.C.

PROVIDER NOTICE TO BENEFICIARY REGARDING SERVICES THAT ARE LIKELY TO BE DENIED BY MEDICARE PART B AS THEY ARE NOT A BENEFIT UNDER THE MEDICARE PART B PROGRAM.

THIS IS PART OF THE PATIENT'S PERMANENT FILE

CURRENTLY, THERE IS LIMITED COVERAGE UNDER THE MEDICARE PROGRAM FOR SERVICES PROVIDED BY CHIROPRACTIC PHYSICIANS.

MANUAL ADJUSTMENT OF THE SPINE 98940, 98941, AND 98942 ARE **THE ONLY COVERED CHIROPRACTIC SERVICES** ALLOWED BY LAW TO BE REIMBURSED BY THE MEDICARE PROGRAM.

NOTICE TO THE MEDICARE B PATIENT:

MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE "REASONABLE AND NECESSARY" UNDER SECTION 1862 (a)(1) OF THE MEDICARE LAW. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH IT WOULD OTHERWISE BE COVERED, IS "NOT REASONABLE AND NECESSARY" UNDER THE MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE. I BELIEVE THAT, IN YOUR CASE, MEDICARE IS LIKELY TO DENY PAYMENT FOR YOUR OFFICE VISITS, ANY X-RAYS TAKEN, MASSAGES, AND THERAPIES DONE AT OUR FACILITY.

POSSIBLE REASONS FOR DENIAL OF CHIROPRACTIC SPINAL ADJUSTMENT:

(NOTE - PHYSICIAN MUST CHECK THE APPROPRIATE BLOCK THAT BEST DESCRIBES THE PATIENT'S SITUATION)

THE NUMBER OF SPINAL ADJUSTMENTS YOU HAVE RECEIVED BASED ON YOUR MEDICAL CONDITION HAS EXCEEDED THE ACCEPTED STANDARDS OF MEDICAL PRACTICE AS DETERMINED BY MEDICARE PART B OF FLORIDA AND IS LIKELY TO BE DENIED BY THE MEDICARE PROGRAM.

MANUAL SPINAL ADJUSTMENTS ARE ONLY COVERED UNDER THE MEDICARE PROGRAM FOR "MEDICALLY NECESSARY" CONDITIONS. UPON REVIEW OF YOUR PHYSICIAN'S DOCUMENTATION, THE CARRIER MAY DETERMINE YOUR SERVICES DO NOT MEET MEDICAL NECESSITY.

PATIENT'S ACCEPTANCE OF FINANCIAL RESPONSIBILITY

PATIENT'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____

**Back N' Balance, Inc.
PATRICIA L. SNAIR, D.C.
DUNEDIN, FL 34698**

(727) 733-6501

Tax ID 01-0738196

Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Back N' Balance, Inc. all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Back N' Balance, Inc.

Furthermore, I hereby **IRREVOCABLY ASSIGN** to Back N' Balance, Inc. the rights and benefits under any policy if insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Back N' Balance, Inc.

Authorization To Release Medical Record Information:

Back N' Balance, Inc. is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payment of services rendered by Back N' Balance, Inc. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Back N' Balance, Inc.

The undersigned certifies that He/She has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of witness: _____

Signature of patient or responsible party: _____

MASSAGE, PHYSICAL THERAPY & NUTRITIONAL COUNSELING POLICY

Our clinic offers massage, physical therapy and nutritional counseling services, which have been recommended for you by your doctor, who feels it is clinically necessary for your care and treatment. Our policies are outlined here and we ask that you read this carefully and sign it, as this will become part of your permanent record. If you have any questions, please feel free to ask them before signing this form. **You are fully responsible for the bill from services received. Services will be paid for at the time of your appointment.**

INSURANCE BILLING

Our massage therapists are under contract with our naturopaths and chiropractors; therefore billings are submitted under his or her name and license. If you are unsure of your policy benefits we advise you to contact your insurance company. All policies are different and we do not guarantee coverage. Generally, if your policy states that services provided are **“under the direct supervision of a covered physician”** those services should be covered. For massage, the procedural codes we are required to use for these services are listed as **“Therapeutic Procedures”** classified under physical medicine/ rehabilitation and broken down into timed increments of 15-minutes each for a total of 60 or 30 minute massages. As a courtesy, we will bill your insurance plan for massage or physical therapy sessions. Nutritional counseling services are not billable to insurance plans. Payments for nutritional counseling are required at the time services are rendered.

**MASSAGES, PHYSICAL THERAPY AND NUTRITIONAL COUNSELING CANCELLATION/
NO-SHOW/ LATE FEE POLICY**

When you make a massage, physical therapy or nutritional counseling appointment, that time is set-aside specifically for you by our therapists. Because we often have a waiting list for these appointments, we ask that you give 24 hours cancellation notice so that someone else can be scheduled for that time slot. In the event of a no-show or cancellation without 24 hours notice, you will be charged 50% of your appointment fee. Massage and nutritional counseling appointments will not be scheduled until the fee is paid. If you arrive more than 15 minutes late for an appointment, you will be billed directly for 50% of the charges. **The appointment session will be shortened to compensate. We will not bill your insurance company for any cancellation or late fees.**

Thank you for your time and attention, please sign and date in the spaces provided below.

Patient Signature

Date

Print Name

Witness Signature

Date

Back N' Balance

As a courtesy to our patients we file insurance claim forms for you.

It is however your responsibility to give us your insurance information. This includes a copy of your most recent insurance card and a claim number if auto related. We can not provide service without this information

Please know that verification of benefits is not a guarantee of payment. Claims are paid in accordance to the written terms of your contract. It is important that you know your insurance policy.

Date: _____/_____/20____

Signature: _____

Print Name: _____



**RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN
ACKNOWLEDGEMENT FORM**

Back N' Balance, Inc.

I, _____ have reviewed/ received a copy of Back N' Balance's Notice of Patient Privacy Practices.

Signature of Patient or Parent or Legal Guardian

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:

Initials:

Reason:

NOTICE THESE FORMS ARE AVAILABLE UPON REQUEST

- | | |
|--|----------|
| 1. Notice of Privacy Practices Hand-outs | #HIPAA01 |
| 2. Patient Authorization for Use and Disclosure of Protected Health Information to Third Parties | #HIPAA40 |
| 3. Request for Limitations and Restrictions of Protected Health Information | #HIPAA33 |
| 4. Request to Inspect and Copy Protected Health Information | #HIPAA38 |
| 5. Request for Correction/ Amendment of Protected Health Information | #HIPAA36 |
| 6. Request for an Accounting of Certain Disclosures of Protected Health Information | #HIPAA42 |
| 7. Patient Complaint Form | #HIPAA18 |

Back N' Balance

Terms Of acceptance

When a patient seeks chiropractic health care, and when a chiropractor accepts a patient for such care, it is essential that they are both seeking and working for the same goal.

Chiropractic has only one goal. It is therefore important that the patient understands the goal and the means that will be used to attain it. This will ensure that there is no confusion, misunderstanding or disappointment. The goal of chiropractic is to correct vertebral subluxations for the purpose of restoring the proper transmission of nerve energy over nerve pathways so that every part of the body may have proper nerve supply at all times. This allows the innate healing ability of the body to work at a maximum efficiency.

Patients usually want to get rid of whatever ailments or conditions are bothering them. This, however, is not the goal of chiropractic.

The purpose of chiropractic is to restore and maintain the mechanical integrity of the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by, the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. They come from many causes and prevent various organs, glands and muscles from working properly. By means of chiropractic adjustments, subluxations are corrected, thus restoring normal nerve functions. With proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower and in a few, it is only partial or not at all.

Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it. Nor do they offer advice regarding the treatment of the disease. Their only goal is to allow the body to do its job. Their only means is the correction of the vertebral subluxations. They do not promise a cure from other diseases, nor offer treatment for other diseases.

I, _____ have read the above, understand it fully and undertake chiropractic care on this basis.

Signed _____ Date _____

Parental Release Form

I, _____ being parent/legal guardian (circle one) of _____, do hereby grant permission for him/her to receive care from a doctor at Back N' Balance. This shall include when necessary standard analysis, including X-rays and corrective spinal adjustments.

Patient Privacy Questionnaire

1. Please print the address of where you would like your billing statements, appointment reminders, test results, and/or correspondence from our office to be sent.

2. Please indicate if you would mind being in one of the rooms with the door open.

No, I do not mind _____ **Yes, I would like a private room only** _____

3. Please print the telephone numbers where you would want to receive calls about your appointment reminders, follow-up, test results or other health care information:

Phone Number: _____ Back-up: _____

*** I am fully aware that a cell phone is not a secure and private line**

4. Please list the names of any family and/or significant others whom we may inform about your medical condition and diagnosis. (Treatment, payment and health care operations) and in case of an emergency.

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

5. Can confidential messages (appointment reminders, etc.) be left on your telephone answering machine or voicemail?

Yes _____ **No** _____

Patient Name: _____
(Guardian if under 18 years)

Social Security Number: _____ - _____ - _____

Patient Signature: _____

Parent/ Guardian Signature: _____

Date: _____

Back N' Balance
1059 Broadway Unit C
Dunedin, FL 34698
Ph: 727-733-6501 Fax: 727-733-6701
www.backnbalance.com



Name: _____

Date: _____ / _____ / _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. Please check the symptoms you have experienced in either (or both) of the chronic (recurrent symptoms) or acute (symptoms you have now). Leave the question blank if neither acute or chronic symptoms are present.

<p>Part 1: Gastrointestinal</p> <p>Acute Chronic</p> <p>_____ Digestive complaints</p> <p>_____ Stomach complaints</p> <p>_____ Ulcers</p> <p>_____ Frequent Heartburn</p> <p>_____ Nausea</p> <p>_____ Frequent Diarrhea</p> <p>_____ Frequent Constipation</p> <p>_____ Irritable Bowel</p> <p>_____ Hemorrhoids</p> <p>_____ Frequent Vomiting</p> <p>_____ Colitis/ diverticulitis</p> <p>_____ Black or bloody stool</p> <p>_____ Gallbladder trouble</p> <p>_____ Frequent burping/ belching</p>	<p>Part 4: Cardiovascular</p> <p>Acute Chronic</p> <p>_____ Irregular heartbeat</p> <p>_____ Heart murmur/palpitations</p> <p>_____ High or low blood pressure</p> <p>_____ Chest pain</p> <p>_____ Previous heart trouble</p> <p>_____ Poor circulation</p> <p>_____ Previous heart surgery</p> <p>_____ Varicose or spider veins</p> <p>_____ Hands or feet cold all the time</p>	<p>Part 8: For Men Only</p> <p>Acute Chronic</p> <p>_____ Prostate Trouble</p> <p>_____ Urination problems</p> <p>_____ Reproductive problems</p>
<p>Part 2: Immune Response</p> <p>Acute Chronic</p> <p>_____ Frequently sick</p> <p>_____ Frequent swollen glands</p> <p>_____ Frequent sore throats</p> <p>_____ Depression and/ or anxiety</p> <p>_____ Achy joints/ muscle pain</p> <p>_____ Headaches/ migraines</p> <p>_____ Recurrent digestive complaints</p> <p>_____ Chronic fatigue</p> <p>_____ Food allergies</p> <p>_____ Eczema or hives</p> <p>_____ Allergies:mild/moderate/severe</p>	<p>Part 5: Respiratory</p> <p>Acute Chronic</p> <p>_____ Chronic cough</p> <p>_____ Asthma</p> <p>_____ Emphysema</p> <p>_____ Recurrent head colds</p> <p>_____ Recurrent sinus infections</p> <p>_____ Recurrent bronchitis</p> <p>_____ Smoker</p>	<p>Part 9: For Women Only</p> <p>Acute Chronic</p> <p>_____ Recurrent urinary tract inf</p> <p>_____ Yeast infections</p> <p>_____ Vaginal Discharge</p> <p>_____ Menstrual irregularity</p> <p>_____ Cramping</p> <p>_____ Mood swings</p> <p>_____ Depression</p> <p>_____ PMS</p> <p>_____ Infertility</p> <p>_____ Hot flashes</p> <p>_____ Currently taking hormone medication</p> <p>_____ Currently taking birth control pills</p> <p>_____ Lumps in breast</p> <p>_____ Uterine or ovarian cysts</p> <p>_____ Bladder leaks easily</p> <p>_____ Endometriosis</p>
<p>Part 3: Structural/ Neurological</p> <p>Acute Chronic</p> <p>_____ Headaches</p> <p>_____ Muscle cramps/ muscle spasm</p> <p>_____ Neck pain</p> <p>_____ Jaw pain</p> <p>_____ Dizziness</p> <p>_____ Back pain</p> <p>_____ Shoulder/ elbow/ wrist pain</p> <p>_____ Numbness/ Tingling</p> <p>_____ Tremors in hand or feet</p> <p>_____ Knee or hip pain</p> <p>_____ Joint pain or loss of function</p> <p>_____ Osteoporosis/ osteomalacia</p> <p>_____ Current bone fracture or injury</p> <p>_____ Tendonitis/ Bursitis</p>	<p>Part 6: Genito- Urinary</p> <p>Acute Chronic</p> <p>_____ Too frequent urination</p> <p>_____ Discolored or foul smelling</p> <p>_____ Blood in urine</p> <p>_____ Recurrent kidney infections</p> <p>_____ Recurrent bladder infections</p> <p>_____ Kidney stones</p> <p>_____ Bedwetting</p> <p>_____ Inability to control bladder</p>	<p>Part 10: Endocrine (Glandular)</p> <p>Acute Chronic</p> <p>_____ Cold hands and feet</p> <p>_____ Low blood pressure</p> <p>_____ Weight problems (over or under)</p> <p>_____ Thyroid problems</p> <p>_____ Diabetes</p> <p>_____ Irritable if meals are Missed</p> <p>_____ Anxiety/ nervousness/ Irritability</p> <p>_____ Dizzy upon standing</p> <p>_____ Too quickly</p> <p>_____ Weak and shaky</p> <p>_____ Hyperactive behavior</p> <p>_____ Depression</p> <p>_____ Very susceptible to Infections</p> <p>_____ Frequent headaches</p> <p>_____ Digestive complaints</p>