Choice Restorative Medicine
8074 McIntyre Square Drive - Pittsburgh, PA 15237

Patient Name _____ **Date** _____

SS #/SIN _____ **DOB** _____ □ Male □ Female | **Cell Phone** _____

Patient's Address _____ **City** _____ **State** _____ **Zip** _____

Employer Name _____ **Job Title** _____

Whom may we thank for referring you? _____

Please provide your email address and cell phone number to receive statements, paper statements will no longer be mailed

Email Address: _____

_____ _____

Parent or Guardian **Date**

Responsible Party

Name of The Person responsible for this account _____ **Relationship to Patient** _____

Cell Phone _____ **Home Phone** _____

Emergency Contact

Person to contact in case of an emergency _____ **Phone** _____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Is the person currently a patient at our office? □ **Yes** □ **No**

Do you have any Medical insurance? □ **Yes** □ **No** **if yes, complete the following:**

Name of the insured _____ **Relationship to patient** _____

Auto Accident/ Work Injury Adjustor Name _____ **Phone** _____

Insurance Company _____ **Policy #** _____

Date of Accident _____ **Claim #** _____

Ins. Co. Address _____ **City** _____ **State** _____ **Zip** _____

Patient Name: _____ DOB: _____ Date: _____

Health History

Chief Complaint: _____

History of Present Illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example: normal vs abnormal color, activity, etc..)

Severity: _____ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____ (How long have you had this pain/ problem? When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ (What other associated problems have you been having?)

Date of Injury _____ □ work / □ auto / □ other__

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles	NO	YES	Anemia	NO	YES	Back Trouble	NO	YES	Hepatitis	NO	YES
Mumps	NO	YES	Bladder Infection	NO	YES	High Blood Pressure	NO	YES	Ulcer	NO	YES
Chicken Pox	NO	YES	Epilepsy	NO	YES	Low Blood Pressure	NO	YES	Kidney Disease	NO	YES
Whooping Cough	NO	YES	Migraine Headaches	NO	YES	Hemorrhoids	NO	YES	Thyroid Disease	NO	YES
Scarlet Fever	NO	YES	Tuberculosis	NO	YES	Date of Last Chest X-Ray_____			Any Other Disease	NO	YES
Diphtheria	NO	YES	Diabetes	NO	YES	Asthma	NO	YES	(Please List):		
Small pox	NO	YES	Cancer	NO	YES	Hives or Eczema	NO	YES	_____		
Pneumonia	NO	YES	Polio	NO	YES	AIDS & HIV	NO	YES			
Rheumatic Fever	NO	YES	Glaucoma	NO	YES	Infectious Mono	NO	YES	_____		
Arthritis	NO	YES	Hernia	NO	YES	Bronchitis	NO	YES			
Bleeding Tendency	NO	YES	Blood or Plasma			Mitral Valve Prolepses	NO	YES	_____		
Venereal Disease	NO	YES	Transfusion	NO	YES	Stroke	NO	YES			

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

_____ _____ _____

_____ _____ _____

Do you suffer from anxiety or depression? Yes / No If yes, are you under the care of any type of physician or therapist? Yes / No

Medication:

_____

_____

Have you ever taken Fen-Phen/Redux? NO YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

□ yes □ no if yes what type: _____

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: _____			
Excessive Exposure					
At home or at work to:	Fumes: _____	Dust: _____	Solvents: _____	Airborne Particles: _____	Noise: _____

Do you exercise? Yes / No If yes, how often and what type?

_____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

PATIENT NAME: _____ **DATE:** _____

CHOICE RESTORATIVE MEDICINEOFFICE POLICY

The following is an explanation of our payment and clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issues – regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

Patient Payment Policy

We require that you provide credit card information to Choice Restorative Medicine. You will not be treated without a credit card on file. The credit card provided will be debited **in the event you have any outstanding balance overdue by 90 days**. You will receive statements each month via mail and our office will attempt to contact you via phone and email address provided at least 24 hours prior to debiting the card. We will contact you one month prior to the expiration date indicated on the card to obtain updated information.

Credit Card Authorization

By providing the credit card below, I _____, authorize Choice Restorative Medicine to debit my credit card in the event I have an outstanding balance that is greater than 90 days.

Visa ___ Mastercard ___ American Express ___ Discover ___ Other ___

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Exp. __ __ / __ __ CVS __ __ __ Zip __ __ __ __ __

Signature _____ Date_____

Billing Policy

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation or auto injury claims. Payments need to be paid in accordance with the arrangements you have made with the front desk assistant. We do charge a 40% interest on all account balances over 90 days for delinquent accounts with a declined credit card. They are also forwarded to a collection agency at that time.

You will receive a monthly statement with all your charges itemized. Please review these and retain them for your records (taxes, etc.). For questions about your bill, please call 412-364-9699.

We will not submit claims for non-covered services to any insurance companies or third-party payors under any circumstances. This includes submissions with the intent of obtaining denials. This also refers to maintenance and cash-based services.

Confidentiality

Every employee of this company has been trained to maintain strict confidentiality regarding patient information. For a family member or friend to obtain general information such as your appointment time they must ask for you by first and last name and be able to prove their relationship status with you. If you do not wish any information to be shared, please make the front desk assistant aware.

Today most insurance policies do cover chiropractic care. We will be happy to file your primary insurance claim for you and do everything we can to ensure that you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover.

Appointments

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Incase of emergency you may contact the office for a special appointment at 412.364.9699 and emergency appointment fee will apply for after hours emergency.

HIPAA Acknowledgement Sheet

Acknowledgement of Receipt of notice of Privacy Practices for Protected Health Information

I acknowledge that I have received Choice Restorative Medicine's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____
Print Name

_____
Signature of patient/Personal Representative

Patient Rights and Responsibilities

I acknowledge that I received Choice Restorative Medicine's Patient Rights and Responsibilities information.

Date: _____ Name of Patient: _____
Print Name

_____
Signature of patient/Personal Representative

Do you know what an advance directive is?

Advance directives are a means for you to tell your health care givers about the care you wish to receive or not receive should you ever become unable to tell them of your wishes. There are two forms of advance directives, The first is a Living Will. The other is known as a "durable power of attorney for health decisions," or may also be called "durable appointment of a surrogate health care decision." Please discuss your advance directive choices with your Primary Care Physician."

Patient Signature: _____ Date: _____

CHOICE RESTORATIVE MEDICINE
CONSENT TO TREAT

I hereby consent to the performance of treatment rendered by any provider at Choice Restorative Medicine that **may** include various modes of physical medicine modalities, injections, examinations, procedures, and diagnostic testing, when warranted, on me (or on the patient named below, for whom I am legally responsible).

I have had an opportunity to discuss with the medical professional at Choice Restorative Medicine the nature and purpose of any recommended medical exam, injections, test, or other procedures. I understand that results are not guaranteed.

I understand and am informed that in the practice of medicine there are some risks to treatment and diagnostic services including but not limited to:

Examinations: increased pain or discomfort.

Injections/Procedures: increased pain and discomfort, swelling, infection, bleeding, bruising, burning, and allergic reaction.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the certified medical professional to be able to anticipate and explain all risks and complications, and I wish to rely upon the certified medical professional to exercise judgment during the procedure which the certified medical professional feels at the time, based upon the facts then known to him or her, is in my best interest. The certified medical professional named below has additionally explained the risks associated with my refusal of treatment.

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 the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date _____

Choice Restorative Medicine
P- (412) 364-9699 F- (412) 364-5172
8074 McIntyre Square Drive
Pittsburgh, PA 15202

*This form is for Medicare patients only- if you are not on Medicare, you do not need to fill it out

Patient Name:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare does not pay for **services/procedures listed below**, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have.

We expect Medicare may not pay for the services below.

Services/Procedures:	Reason Medicare May Not Pay:	Estimated Cost:
Trigger point injections, joint injections, tendon sheath injections.	Frequency, they allow 3 sessions in 3 months.	$60 per session
X-Rays	Performed/prescribed by a licensed Doctor of Chiropractic- **MEDICARE WILL NOT PAY**	$50 per body region
Exams	Performed/prescribed by a licensed Doctor of Chiropractic- **MEDICARE WILL NOT PAY**	$35 per exam
Modalities	Performed/prescribed by a licensed Doctor of Chiropractic- **MEDICARE WILL NOT PAY** *we will not prescribe	N/A

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 services/procedures 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 services/procedures 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 services/procedures 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 services/procedures 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 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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