Advanced SPINE REHAB & Athletics

Patient Information:

Full Name: _____ Sex: M F

Date of Birth: _____ Social Security #: _____ Marital Status: S M D W

Address: _____ City, State, Zip _____

Cell Phone: _____ Home or Work Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Health Insurance Information:

Primary Insurance: _____
Member ID #: _____ Group #: _____ Relationship to Insured: _____
Policyholder Name: _____ DOB: _____ SSN: _____

Secondary Insurance: _____
Member ID #: _____ Group #: _____ Relationship to Insured: _____
Policyholder Name: _____ DOB: _____ SSN: _____

Appointment Reminders:
As a convenience to our patients, we offer appointment reminders through emails and text messages. Would you like automatic reminders? □ Email □ Text - Cell Phone Provider: _____

Accident Information:
Is this visit due to an accident? □ Yes □ No Type? □ Auto □ Work □ Other Date of Accident: _____
Has the accident been reported? □ Yes □ No To Whom? _____

Whom may we thank for referring you to our office? _____

Patient/Guardian Signature: _____ **Date:** _____

Treatment of a Minor Child:
I authorize Advanced Spine Rehab and Athletics to examine and provide necessary treatment and adjustments to my minor child _____.

Parent/Guardian Signature _____ **Date:** _____

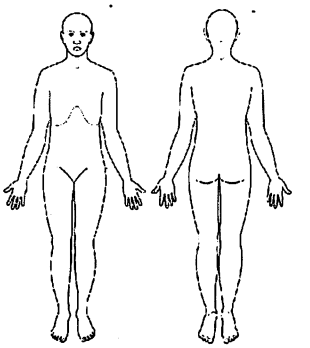
Patient Condition and Health History

Reason for your visit:

□ Neck Pain/Stiffness	□ Jaw Problems	□ Headaches/Migraines	□ Dizziness
□ Mid Back Pain/Stiffness	□ Shoulder Pain	□ Elbow Pain	□ Wrist/Hand Pain
□ Low Back Pain/Stiffness	□ Hip Pain	□ Knee Pain	□ Ankle/Foot Pain
□ Pins/Needles in Arms	□ Pins/Needles in Legs		

□ Other _____

Mark an "X" on the picture where you are experiencing symptoms:



When did your symptoms appear? _____

Is your condition/Symptoms: □ Getting Worse □ Getting Better □ Staying the Same

Do the symptoms interfere with: □ Daily Routine □ Recreation □ Sleep □ Work

What treatment have you already received for your condition? □ Physical Therapy □ Medications □ Chiropractic □ Surgery □ Other: _____

Have you had: □ X-Rays □ MRI/CT Scan □ Other: _____ When? _____

Are you currently Pregnant? □ Yes □ No If yes, when is your due date? _____

Dominant Hand? □ Right □ Left

Are you currently on any blood thinners? □ Yes □ No

Do your work activities mostly involve: □ Sitting □ Standing □ Light Labor □ Heavy Labor

Please check to indicate if you have ever had any of the following:

□ Aids/HIV	□ Chest Pain	□ Heart Disease	□ Mononucleosis	□ Sleeping Difficulties
□ Alcoholism	□ Chicken Pox	□ Hepatitis	□ Multiple Sclerosis	□ Stomach Problems
□ Allergies/Allergy Shots	□ Cold Feet	□ Hernia	□ Mumps	□ Stroke
□ Anemia	□ Constipation	□ Herniated Disc	□ Nervousness	□ Sudden Weight Loss
□ Anorexia	□ Depression	□ Herpes	□ Night Pain	□ Thyroid Disorder
□ Appendicitis	□ Diabetes	□ High Blood Pressure	□ Osteoporosis	□ Tonsillitis
□ Arthritis	□ Eczema	□ High Cholesterol	□ Parkinson's Disease	□ Tuberculosis
□ Asthma	□ Emphysema	□ Kidney Disease	□ Pinched Nerve	□ Tumors/Growths
□ Bleeding Disorders	□ Epilepsy	□ Light Bothers Eyes	□ Pneumonia	□ Typhoid Fever
□ Blurred Vision	□ Fainting	□ Liver Disease	□ Polio	□ Ulcers
□ Bowel/Bladder Changes	□ Fatigue	□ Loss of Memory	□ Prostate Problems	□ Unintentional Weight Loss
□ Breast Lump	□ Fractures	□ Loss of Smell	□ Prosthesis	□ Vaginal Infections
□ Bronchitis	□ Glaucoma/Cataracts	□ Loss of Taste	□ Rheumatoid Arthritis	□ Venereal Disease
□ Bulimia	□ Goiter	□ Measles	□ Rheumatic Fever	□ Other: _____
□ Cancer	□ Gonorrhea	□ Migraines	□ Scarlet Fever	_____
□ Chemical Dependency	□ Gout	□ Miscarriage	□ Shortness of Breath	_____

Contraindications: **Certain procedures should be avoided if patients have certain conditions. Please answer the following:**

Do you have a Pacemaker? □ Yes □ No

Do you suffer from blood clots? □ Yes □ No

Do you have a knee or hip replacement? □ Yes □ No

Do you have a local or systemic infection? □ Yes □ No

Family History (Indicate which family member and type):

□ Heart Disease _____

□ Diabetes _____

□ Cancer _____

□ Arthritis _____

□ Other _____

Medications/Supplements:

_____

_____

_____

Surgeries/Hospitalizations:

_____

_____

_____

Allergies:

_____

_____

_____

Exercise

□ None Activities: _____

□ Moderate _____

□ Daily _____

□ Heavy _____

Habits

□ Smoking Packs per Day _____

□ Alcohol Drinks per Week _____

□ Caffeine Cups per Day _____

□ Energy Drinks Drinks per Day _____

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Patient or Guardian Signature: _____ **Date:** _____

Consent to Treatment

I understand that Advanced Spine Rehab and Athletics will attempt to diagnose and treat any symptoms I am experiencing through diagnostic testing, chiropractic care, active/passive rehabilitation, physical therapy and/or massage therapy. I will be referred to an appropriate physician should there be a condition or symptom present that is out of the Doctor's scope of practice. I am also aware that any treatment provided is meant to help my condition, but in certain cases due to underlying physical defects, pathologies or deformities there may be an increase in the risk for injury. I am responsible to inform the doctor of any conditions (illnesses, deformities, etc.). I also clearly understand that if I do not follow the Doctor's specific recommendations that I will not receive the full benefit from the treatment and/or program.

Financial Policy

I understand that I am financially responsible and agree to ensure full payment for any and all fees incurred for any services/treatment provided to me regardless of any health insurance coverage that may provide payment on my behalf. Payment is due at the time of service unless other payment arrangements have been agreed upon by all parties. If I terminate my care prematurely, all fees incurred are immediately due and payable at that time and any discounts will not apply. I am aware that there will be a $20 fee charged for any returned checks.
*Insurance Patients: I understand and agree that health/accident insurance policies are an arrangement between the insurance carrier and myself. If this office chooses to bill any service to my health insurance carrier, it is strictly as a convenience to me. The office will provide any necessary reports or required information to my insurance carrier, but I am responsible for any unpaid balances due to denied claims.

Insurance Authorization and Assignment

I authorize Advanced Spine Rehab and Athletics to release any medical information necessary to process any insurance claims. Upon receipt of written request, I authorize any fiduciary or plan administrator, my attorney or insurer to release any and all insurance policies, settlement information or plan documents to Advanced Spine Rehab and Athletics and its representatives for the purpose of medical benefits and reimbursement. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I authorize the assignment of all insurance benefits to be directed to the Doctor and/or Physician for all services rendered.

I certify that I have read and fully understand this assignment and authorize this assignment to remain in effect until revoked by me in writing. A copy of this assignment is as valid as the original.

Name of Guarantor (person responsible for guaranteeing payment of all services) _____

Patient or Guardian Signature: _____ **Date:** _____

X-Ray Consent

I understand that the Doctor may recommend x-rays to accurately diagnose and analyze my condition. By signing below, I do hereby consent and will allow Advanced Spine Rehab and Athletics to take x-rays of my spine and/or extremities.

Females Only: I also hereby declare that to my knowledge, I am not pregnant. _____ (initial)

Patient or Guardian Signature: _____ **Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby confirm that I have received a copy of Dr. Gina Infantino, D.C., M.S. and Dr. Christopher McDonough, D.C., M.S.'s **Notice of Privacy Practices**. I understand that it is my responsibility to familiarize myself with the contents of this Notice.

Patient or Guardian Signature: _____ **Date:** _____

Advanced SPINE REHAB & Athletics

Insurance Company Payment(s) Policy

I _____ have been advised that the doctors and therapists at Advanced Spine Rehab & Athletics, will bill my insurance company directly for my treatment. I have been further advised that the payment may be sent to me by my insurance company. By signing below, I affirm and attest that I am in no way entitled to this reimbursement for my treatment, and I understand that this money is intended to pay the above mentioned companies and physicians.
Accordingly, it is hereby understood and agreed to again that I have no right, implied or otherwise to said funds as they do not belong to me, and/or the insured party and are intended to pay for my medical care and procedure(s) performed with my informed consent.
Furthermore, in the event I receive a check or checks from the responsible insurance company as payment for my treatment/procedure(s) or the insured's procedure(s), I will immediately or within forty eight hours contact the appropriate party (the office or the billing department) about the check and return these funds to the appropriate party.
I understand that I am ultimately responsible for all medical bills if my insurance company fails to pay, and I will assist Advanced Spine, Rehab & Athletics with the collection of any funds.
In the event that a check or multiple checks are made payable to me or the insured and is received by Advanced Spine, Rehab & Athletics or its physicians, I hereby grant the facility and above provider(s) the express permission and limited power of attorney solely and exclusively for the purpose of endorsing said check(s), so that I do not need to return to the facility with the express intent to endorse the funds to the facility / provider(s).
If either party defaults in the performance of any of the terms, provisions, covenants and conditions and by reason thereof, the other party employs the services of an attorney to enforce performance of the covenants, or to perform any service based upon defaults, regardless of initiation of court proceedings, there in any of said events, the prevailing party shall be entitled to recover from the non-prevailing party all of the prevailing party's reasonable attorney's fees and all expenses and costs incurred by the prevailing party pertaining thereto (including costs and fees relating to any appeal) and in the enforcement of any remedy. By signing below, I agree that the sole and exclusive venue for any litigation arising from or related to this Lease shall be in the state courts in Licking County.

Patient Printed Name: _____

Signature: _____ **Date:** _____

Massage Cancellation Policy

I understand that if I am scheduled for a massage appointment that I must cancel at least 2 hours prior to my scheduled time. I also understand that if I do not give at least 2 hours notice and the office is not able to fill my massage time, that I will be responsible for a $25 cancellation fee.
I understand that if I am late for my massage that the time I missed will not be made up. If I am more than 10 minutes late and I do not call, the office may give my appointment to another patient.
I understand that if I fail to call or show up to my appointment and the office is not able to fill the appointment, I will be responsible for a $25 missed appointment fee.

I have read and fully understand the above.

Signature: _____ **Date:** _____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay ____(Advanced Spine Rehab and Athletics LLC, Dr. Gina Infantino, Dr. Christopher McDonough, Pinnacle Chiropractic and Physical Therapy LLC. _____, 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; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

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 ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any 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 with 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 Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

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, test, 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.

Signed this _____ day of _____, 20____.

X _____ (SEAL)
(Patient Signature)

_____
(Please Print Patient Name)

X _____(SEAL)
(Signature of Guardian if applicable)

Advanced SPINE REHAB & Athletics

Dr. Christopher McDonough
Dr. Gina Infantino
Chiropractic Physicians

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Etna, Ohio 43062
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ASRAhealth.com

Dr. Christopher McDonough and the team here at Advanced Spine Rehab & Athletics are committed to providing you with the best healthcare possible; our goal is to help you reach your optimal health and function. With that in mind, we always make recommendations based on your health condition and not on what your insurance will cover. The decision to proceed with care is always up to you, as the patient, since your healthcare choices are personal decisions. With that in mind, this notice is intended to help you understand what is covered by Medicare in a chiropractic office and what may be your financial responsibility.

Medicare covers spinal adjustments ONLY if the treatment meets Medicare's guidelines for medical necessity. Medicare **does not pay for maintenance care**. Medicare (CMS) defines maintenance care as follows: "Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment **becomes supportive rather than corrective in nature**, the treatment is then considered maintenance therapy." While being treated for a chronic condition, you may elect to receive care beyond that which is determined to be medically necessary. You may also choose to receive maintenance care once maximum benefit from treatment has been reached.

Since Medicare only covers medically necessary spinal adjustments, **all other services** that we deliver here in our office **are excluded by Medicare** because they are ordered or rendered by a Doctor of Chiropractic. This includes the items listed below:

- ☐ X-rays
- ☐ E/M services (examinations)
- ☐ Adjustments to areas other than the spine, such as the shoulder, arm, hand, leg, ankle, and foot.
- ☐ Physical therapy modalities and procedures, such as traction, electric muscle stimulation, decompression, massage, IASTM, Kinesiotape and exercises
- ☐ Durable medical equipment, such as pillows, braces, supports and exercise tools for home use
- ☐ Dry Needling

It is our office policy to never deny care to any patient due to financial circumstances. We offer many options to assist you with your financial responsibility and will discuss each of these options with you in detail. We are happy to have you as a part of our practice family. Please let

us know if you have any questions related to your treatment here at Advanced Spine Rehab & Athletics.

I _____ acknowledge that I have been told in advance by
PRINT NAME

my provider that the services/products listed above are not covered by my Medicare plan.

_____ _____

Patient Signature **Date**