ASH
Chiropractic & Wellness

Massage Client Registration

Name_____ Phone (____) _____ DOB _____

Address_____ City _____ State ____ Zip _____

E-Mail_____

Referred By _____ Phone (_____) _____

Occupation _____ ☐Male ☐Female Physician _____

Health Insurance Carrier _____

In Case of Emergency _____ Phone (_____) _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced professional massage or bodywork? ☐Yes ☐No How recently? _____

What are your massage/bodywork goals? _____

What kind of pressure do you prefer? ☐Light ☐Medium ☐Firm
Additional Comments_____
_____

If you answer "Yes" to any of the following questions, please explain as clearly as possible

☐Yes ☐No Do you frequently suffer from stress?

☐Yes ☐No Do you have diabetes?

☐Yes ☐No Do you experience frequent headaches?

☐Yes ☐No Are you pregnant?

☐Yes ☐No Do you suffer from arthritis?

☐Yes ☐No Are you wearing contact lenses?

☐Yes ☐No Are you wearing dentures?

☐Yes ☐No Do you have high blood pressure?

☐Yes ☐No Do you suffer from epilepsy or seizures?

☐Yes ☐No Do you suffer from joint swelling?

☐Yes ☐No Do you have varicose veins?

☐Yes ☐No Do you have any contagious diseases?

☐Yes ☐No Do you have osteoporosis?

☐Yes ☐No Do you have allergies? Please specify_____

☐Yes ☐No Do you bruise easily?

☐Yes ☐No Any injuries in the last two years?

☐Yes ☐No Do you have tension or soreness in a specific area? Please specify_____

☐Yes ☐No Do you have cardiac or circulatory problems?

☐Yes ☐No Do you have numbness or stabbing pains? Please specify _____

☐Yes ☐No Are you sensitive to touch or pressure in any area? Please specify_____

☐Yes ☐No Have you had surgery in the last two years? Please specify_____

☐Yes ☐No Are there any other medical conditions the practitioner should be aware of?

☐Yes ☐No Are you taking any medications? Please specify_____

I understand that the massage/bodywork I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Financial Policy

SELF PAY PATIENTS

We request that 100% of the visit be paid at the time of the services. We accept your check, Cash, Master Card, Visa, Discover. Unless prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent.

____ INITIAL

CHIROHEALTH USA

For a $49 annual fee, you and your immediate family can receive a 20% discount on all chiropractic care and 10% discount on massage. Please inquire at the front desk for more information.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

We accept PI insurance cases on a case by case basis. We must have verification from your insurance carrier and a signed assignment of benefits on file prior to treatment. Notify our office immediately if an attorney is representing you. Once the claim is settled or if you suspend or terminate care prior to release, any fees for services are due immediately. ***We also require you to sign a credit card guarantee for any unpaid balances remaining after six months.***

____ INITIAL

PATIENTS WITH GROUP OR INDIVIDUAL COVERAGE

Ash Chiropractic and Wellness will provide insurance billing services for you with insurance companies that we are contracted with. ***Remember that you are ultimately responsible for any charges incurred in this office***. When possible, we will call to verify benefits on your insurance. However, the benefits quoted to us by your insurance company **are not** a guarantee of payment. Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. ***Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.***

____ INITIAL

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover, which for Chiropractors, is ***ONLY manual manipulation of the spine (adjustments)***. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay deductible and the remaining 20% ***as well as any non-covered services***. Our office completes and files the forms for Medicare at no charge. Please inform us of any secondary insurance that you may have.

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. (below)** you may have to pay.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Rollerbed	**Medicare states that these are all non-covered services.**	**$20**
Electric Stimulation		**$20**
Physical Therapy Exercises		**$20-$30**
Spinal Decompression		**$55**
Massage		**$35-$65**

Choose an option below about whether to receive the **D. (listed services above)**.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. services listed above.** I may asked to pay 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. I may be asked to pay 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.**

Signing below means that you have received and understand this notice. You may also receive a copy.

Signature (Medicare Patients only)	**Date**

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). According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850. Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Missed appointments or appointments cancelled without 24 hour notice

I understand that as of July 1, 2014 all existing and new patients may be charged a cancellation fee for missed appointments or appointments that are cancelled with less than 24 hour notice. Patients must be on-time to their appointment. If you are not here at your scheduled time, the doctor may not be able to see you, and you may be charged a cancellation fee.

____ INITIAL

Authorization to treat a minor

I, _____ , the undersigned parent or legal guardian of, _____ (Minor child), hereby give my permission to the staff of Ash Chiropractic and Wellness to treat said minor.

Guardian Signature	**Date**

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, assign payments to go directly to Ash Chiropractic & Wellness. I hereby authorize the doctor to release all medical information necessary to process all claims. I hereby authorize any plan administer or fiduciary, insurance and my attorney to release to such doctor and clinic and all plan documents, insurance policy and/ or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments.

Signature	**Date**

These signatures will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.