

# Welcome to Church Street Chiropractic

## About You

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Hm Phone: \_\_\_\_\_

Date of Birth: / / • Age: \_\_\_\_\_

Male •  Female

Ht: \_\_\_\_\_ • Wt: \_\_\_\_\_

SS#: \_\_\_\_\_

Married •  Single •  Divorced

Widowed •  Separated

# of children

Employer: \_\_\_\_\_

Job title: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Supervisor: \_\_\_\_\_

## In An Emergency

Whom should we contact?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Hm Phone: \_\_\_\_\_

Wk Phone: \_\_\_\_\_

## Insurance

Person ultimately responsible for your  
account: you and:

Personal Health Insurance

Worker's Comp

Attorney: Name: \_\_\_\_\_

Medicare

MassHealth

Ecuare

## Current Health Condition today's date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Date pain began: / /

Type of onset:  slow/gradual •  sudden

Related to accident or injury:  yes  no

Please list other doctors seen: \_\_\_\_\_

Was any therapy instituted?  yes  no

Medications: \_\_\_\_\_

Physical Therapy:  yes  no

Please circle tests performed: X-Ray • MRI • CT  
Bloodwork • NCV/EMG • Other: \_\_\_\_\_

Any prior history of a similar complaint?  yes  no  
If so, when? / /

## Please outline areas of discomfort

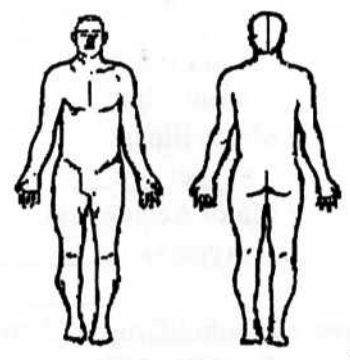
Mark areas of:

pain - xxx

stiffness - ///

numbness - 000

other:  
(specify)



## Rate your daily pain on this scale (circle)

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (very severe pain)

The pain is best described as:

- constant •  comes and goes
- sharp •  dull ache •  tightness •  burning
- remains localized •  radiates into arm or leg
- getting better •  getting worse •  no change

## Concurrent Medical Conditions

Who is your primary physician? \_\_\_\_\_

Are you currently treating with a doctor for any other  
medical condition?  yes  no

If yes, what condition(s)? \_\_\_\_\_  
\_\_\_\_\_

Dr. Peter May  
73 Church Street

413-664-9050



**AUTHORIZATION & ASSIGNMENT**

In consideration of Dr. Peter May undertaking to treat me, I agree to the following:

**RELEASE**

I authorize my insurance company, attorney or any other holder of medical or billing information about me to release directly to Dr. Peter May any information needed to determine my insurance benefits or the benefits payable for services provided by Dr. May.

I authorize all medical personnel to provide medical history information, examination and test results as it may relate to my care with Dr. May.

I authorize Dr. May to release all medical PHI and billing information as necessary, as it pertains to my care in his office, to attorneys, my other treating physicians, diagnostic facilities and/or insurance companies or their representatives, including: utilization review companies.

**ASSIGNMENT OF BENEFITS**

I request that payment of authorized Medicare and/or other Private Insurance benefits or proceeds from any legal claim relevant to treatment in this office, as secured by an Attorney, be paid directly to Peter D. May, DC for any/all services provided by him, as my chiropractor, to me. If not possible, and the check is made in my name, I request that the check be mailed directly to Dr. May and, furthermore, I authorize Dr. May to cash the check in my name as payment on my account.

I acknowledge that my insurance may not cover all or part of the services of health products (orthotics, supplements, missed appointments, etc) provided and that I am financially responsible to Peter D. May, DC for all charges incurred, to the extent allowed by law. Should the need arise, I authorize Dr. May to file a complaint with the Insurance Commissioner on my behalf.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Witnessed: \_\_\_\_\_

**PRIVACY NOTICE**

I acknowledge that I have received a copy of the Practice's Privacy Notice that has an effective date of April 14, 2003.

Print Name: \_\_\_\_\_ Signed : \_\_\_\_\_ Dated: \_\_\_\_\_

I authorize Dr. May to contact and release my name to:

\_\_\_ My emergency contact: \_\_\_\_\_

\_\_\_ The person who referred me to this office: \_\_\_\_\_

\_\_\_ My immediate family: \_\_\_\_\_ other: \_\_\_\_\_

\_\_\_ Office newsletter

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# FINANCIAL POLICY

## Insurance Patients:

Filing insurance is a courtesy that we are willing to extend to you as our patient.

**Ultimately, you are responsible for verifying your own coverage and for payment of your bill.**

If, for any reason, you thought you had coverage and, after billing, your claim is rejected, you are fully responsible for paying your outstanding balance in this office. Balances due beyond 30 days will result in a 1.5% finance charge, compounded monthly to 18% per year, plus a \$5.00 billing fee per month. Any legal fees incurred to collect on this account become your financial responsibility.

In addition, you are responsible for notifying us immediately of any change in your coverage  
Initial: \_\_\_\_\_ Date: \_\_\_\_\_

**Co-payments are expected at the time of service.**

## Self Pay Patients:

**Payment is expected at the time of services.**

Billing for any outstanding balance will result in a \$5.00 charge per bill per month, to cover our time and expenses.

Balances due beyond 30 days will result in a 1.5% finance charge, compounded monthly to 18% per year, unless prior payment plans were agreed to and signed. Any legal fees incurred to collect on this account become your financial responsibility.

Payment will be made on each office visit by: \_\_\_ cash \_\_\_ check and/or \_\_\_ VISA

### **TO ALL PATIENTS**

We realize that your time is important and we do everything we can to see you on time and treat you in a timely manner. Our time is also important.

**Cancellation of appointments requires 24 hours notice...**

(with few exceptions: extreme weather and emergencies/illness).

Otherwise, missed appointments are the full financial responsibility of the patient (even those patients with insurance coverage) and will be charged to the patient at **\$40.00 per missed appointment in addition to a \$5.00 billing fee.**

I, \_\_\_\_\_, have read, understood and agree to the above financial policies.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

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## MEDICARE PAYMENT POLICY

The purpose of this form is to help you make an informed choice about whether or not you want to receive, and be financially responsible for, services and/or items not covered by your Medicare insurance.

**Medicare covers 80% of the cost of 12 chiropractic manipulations/year only.** That leaves you a co-pay of 20% for that service. In addition, you may have a deductible of \$ 100.00/year before any coverage begins and you are 100% responsible beyond the 12 manipulations/year.

**Medicare does not cover any other services performed or items purchased in this office.** You, and/or your co-insurance, if you so choose, bear the full financial responsibility for any service/item not covered by your Medicare insurance.

Items/services not covered by Medicare:

1. Initial Examination:
2. Use of physical therapy modalities: including, but not limited to:
  - interferential therapy
  - hot or cold packs
  - EMS (various forms of electric muscle stim)
  - ultra-sound
  - trigger point therapy
3. Instructional time: including, but not limited to:
  - x-ray interpretation and/or review
  - home-based exercises
  - home instructions
  - nutritional advice
4. Items: including, but not limited to:
  - low back supports
  - hot or cold packs
  - other braces, supports, orthotics
  - nutritional supplements

**The cost of the initial examination, and subsequent exams at one year intervals, is \$80.00 if you pay at the time of service; \$90.00 if we have to bill you.**

As a courtesy to our senior patients we will discount all physical therapy modalities and instructional time 57% and charge for only one additional service performed per visit; for a cost to you of \$ 20.00/ov in addition to your co-pay.

Any item, orthotic, nutritional supplement, etc. will be charged at the per item cost, plus sales tax.

**OPTION 1:**  **YES:** I want to receive the services and/or items deemed necessary for my health care treatment in this office. I understand Medicare will cover 80% of the 12 manipulations/year only, after a deductible, leaving me financially responsible to Dr. Peter May, DC, for my 20% co-pay and any other services performed and/or items purchased above and beyond the 12 manipulations/year . \_\_\_\_\_ Date: \_\_\_\_\_

**OPTION 2:**  **NO:** I have decided NOT to receive any service or item not covered by Medicare. I understand Dr. May will not accept me as a patient without first performing an examination. \_\_\_\_\_ Date: \_\_\_\_\_

## Informed Consent to Chiropractic Treatment

All medical doctors, physical therapists and chiropractors are required by law to obtain your informed consent before starting treatment.

I, \_\_\_\_\_, of \_\_\_\_\_ do hereby give my consent to the performance of conservative, non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Supportive physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

**Soreness:** I am aware that like exercises it is common to experience muscle soreness in the in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur, but are relatively rare.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal single dose of aspirin or Tylenol causing death.

**Physical Therapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be temporary increase of pain and possible blistering. This should be reported to Dr. May.

Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

### Treatment Results

I also understand there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

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I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by Dr. May and such other persons of the doctor's choosing.

#### Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including: rest, home applications of therapy, prescription or over the counter medications, exercises and treatment with my medical physician, including the possibility of surgery.

**Medications:** Medications can be used to reduce pain or inflammation. I am aware that long term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapies. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve or joint tissues.

**Surgery:** Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read (or have had read to me) the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO my signing this consent form. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Print name: \_\_\_\_\_ Witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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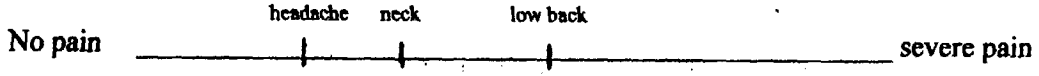
Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Pain Questionnaire / Assessment

**Purpose:** to help us (and insurance companies) understand how pain has affected your everyday life and as a measure of progress.

**Instructions:** put a vertical mark on the line that best rates your pain. If you have more than one area of pain, put another mark and label each area as in the following example.



1. What is your pain RIGHT NOW?

No pain \_\_\_\_\_ severe pain

2. What is your TYPICAL or AVERAGE DAILY pain?

No pain \_\_\_\_\_ severe pain

3. What is your pain AT ITS BEST / LOWEST?

No pain \_\_\_\_\_ severe pain

4. What is your pain AT ITS WORST / HIGHEST?

No pain \_\_\_\_\_ severe pain