3350 NW Boca Raton Blvd.
Suite A24
Boca Raton Fl 33431

DR. ERNEST S. CARUSO
Chiropractic Physicians

Patient ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____ Date: ____/____/____

Birth Date: _____ Age: _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient's E-mail address _____ Do you accept E-mails? ☐ yes ☐ no

Type of Referral: ☐ Insurance ☐ Internet ☐ Friend ☐ 800 # ☐ Other _____

No of Children _____ Ages of children: _____

Home Address _____ (Street) (City) Home Phone: _____

_____ (State) (Zip) Social Security No. _____

Patient employed by _____ (Name of Company) Occupation: _____

Business address _____ (Street) (City) (State) (Zip) Business Phone: _____

Name of spouse _____ (Last) (First) (Middle) (Maiden)

Spouse's Birth Date: _____

Spouse employed by _____ Occupation: _____

Nearest relative not living with you _____ (Full Name) (Address) (Phone)

Name of person legally responsible
(if patient is a minor, name of parent, guardian, etc.) _____

List All Members of Immediate Family _____

Have you had chiropractic care before? _____ When? _____

INSURANCE:
Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of services rendered. We do accept certain insurance assignments but all insurance arrangements must be approved in advance.

Do you have Medicare? ☐ Yes ☐ No _____

OTHER INSURANCE:

1st Insurance company _____ Have you met your deductible this year? ☐ Yes ☐ No

2nd Insurance company _____ Are you the insured? ☐ Yes ☐ No

Group Policy No. _____ Or dependent? ☐ Yes ☐ No

Have You Ever Suffered From:

☐ Dizziness ☐ Anemia ☐ Digestive Disorders ☐ Asthma ☐ Sinus Trouble
☐ Diabetes ☐ Backaches ☐ Rheumatic Fever ☐ Orthopedic Problems
☐ Arthritis ☐ Tuberculosis ☐ Heart Trouble Describe _____
☐ Neuritis ☐ Headaches ☐ Hypertension *(Blood Pressure)* If so are you on medication? _____

Purpose of
This Appointment _____

Other Doctors seen for this Condition _____

Date of accident/illness _____ Hour _____ AM _____ PM Location: _____

How did accident occur? ☐ Auto Collision ☐ On-the-Job (Worker's Compensation) ☐ Other _____

Please describe the circumstances _____

Have you lost time from work? ☐ Yes ☐ No

Have you been treated for any health condition by a physician in the last year? ☐ Yes ☐ No

Describe. _____

Remarks and any additional information _____

HEALTH QUESTIONNAIRE:

Please indicate for each of the questions below your present or previous symptoms which led to your condition.

Musculo-Skeletal System Code

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Painful joints
___ Stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Ruptures
___ Broken bones

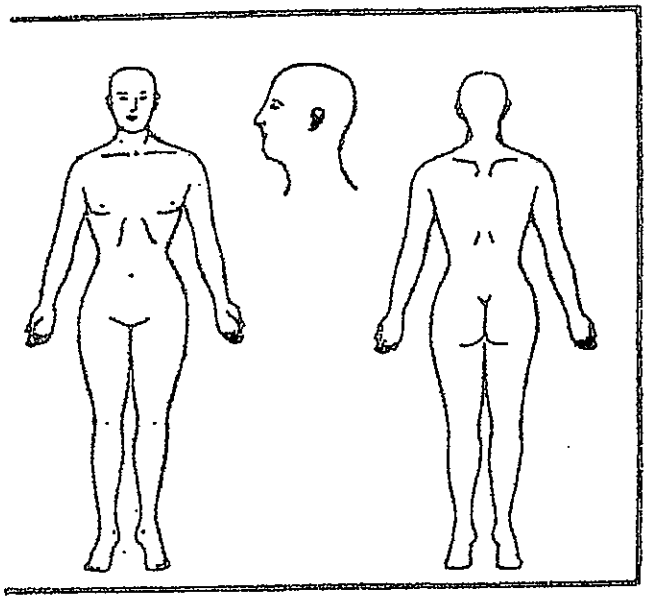
Genito-Urinary System Code

___ Bladder trouble
___ Excessive urine
___ Scanty urination
___ Painful urination
___ Discolored urine

Female Code

___ Vaginal discharge
___ Vaginal bleeding
___ Vaginal pain
___ Breast pain
___ Lumps on breast

Please mark your areas of pain on the figures shown below.....



Gastro-Intestinal System Code

___ Poor appetite
___ Excessive hunger
___ Difficult chewing
___ Difficult swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Black stool
___ Bloody stool
___ Hemorrhoids
___ Liver trouble
___ Gall bladder problems
___ Weight trouble

Nervous System Code

___ Numbness
___ Loss of feeling
___ Paralysis
___ Dizziness
___ Fainting
___ Headaches
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Confusion
___ Depression

Cardio-Vascular-Resp. Code

___ Chest pain
___ Pain over heart
___ Difficult breathing
___ Persistent cough
___ Coughing phlegm
___ Coughing blood
___ Rapid heartbeat
___ Blood pressure problems
___ Heart problems
___ Lung problems
___ Varicose veins

Eye, Ear, Nose & Throat Code

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain
___ Ear noises
___ Hearing loss
___ Ear discharge
___ Nose pain
___ Nose bleeding
___ Nose discharge
___ Difficult breathing thru nose
___ Sore gums
___ Dental problems
___ Sore Mouth
___ Sore Throat
___ Hoarseness
___ Difficult speech

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic 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 this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to 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 and treatment, any fees for professional services rendered to me will be immediately due and payable.

*Signature*_____

(If Patient Is A Minor, Name of Parent, Guardian, Etc.)

DO NOT WRITE BELOW THIS LINE

SURGERY _____

MEDICATIONS _____

ACCIDENTS _____

FAMILY _____

GENERAL EXAMINATION

Time: IN _____ OUT _____

Height Ft Inches | Weight Lbs | Blood Pressure / | Temp. | Pulse | Vascular Tests VBI [+] [-] / Peripheral: _____

Body Type: [ ] Ectomorph [ ] Mesomorph [ ] Endomorph [ ] Obese

Systems Review: WNL / Checked Significant Findings:
- EENT [ ]
- CV System [ ]
- Resp System [ ]
- GI/Abdominal [ ]
- GU [ ]

Observations

AP Curve	WNL	Decreased	Increased
Cervical			
Thoracic			
Lumbar			

Scoliosis

	Convex R / L	Apex	Mild	Moderate	Marked
Cervical					
Thoracic					
Lumbar					
Other:					

Postural Symmetry

	Left	Right	Absent
Head Tilt			
High Shoulder			
Rib Hump			
High Iliac Crest			

Antalgic Lean: Left / Right / Anterior / Lumbar / Cervical

Subluxation: _____

Spinal Palpation (Tenderness) 1-4

Level	L	M	R

Level	L	M	R

Soft Tissue Evaluation

List Region/Muscle

	L R	Hypertonicity 0 1 2 3 4 5	Atrophy 1 2 3 4	Tender	Trig Pts. A L	Strength 0 1 2 3 4 5 R

Additional Info: _____

CERVICAL ROM [ ] WNL

	Active°	Passive°	A	D	S	L	M	R	Limit/Pain
Flexion (50°)									
Extension (70°)									
LL Lat Flex (45°)									
RL Lat Flex (45°)									
LL Rotation (85°)									
RL Rotation (85°)									

THORACIC [ ] WNL

	Active°	A	D	S	L	M	R	Limit/Pain
Flex/Ext (90°)								
LL Trunk Rot. (45°)								
RL Trunk Rot. (45°)								

A = Absent D = Dull S = Sharp

L = Left M = Midline R = Right

LUMBOPELVIC [ ] WNL

	Active°	A	D	S	L	M	R	Limit/Pain
Flexion (90°)								
Extension (30°)								
LL Lat Flex (35°)								
RL Lat Flex (35°)								
LL Rotation (30°)								
RL Rotation (30°)								

ORTHOPEDIC/NEUROLOGICAL

CERVICAL

Stretch Tests	+	-	Dull	Sharp	Left	Midline	Right	Cervical	Shoulder	Arm/Hand	Thoracic
LL Shoulder Depression											
Rt. Shoulder Depression											
Solo Hall Test											

Compression Tests	+	-	D	S	L	M	R
LL Cervical Comp.							
RL Cervical Comp.							

LL Roos	+	-	RL Roos	+	-

Distraction Tests							
Cervical	+	-	LL Bakody's	+	-	RL Bakody's	+ -

Reflexes (0-5)

	L	R
Biceps		
Brachio		
Triceps		
Patellar		
Achilles		

LOW BACK

Stretch Tests	Degrees	+	-	Dull	Sharp	Left	Midline	Right	Lumbar	Gluteal	Along Knee	Below Knee
LL SLR												
RL SLR												
LL Braggard's												
Rt. Braggard's												
LL Bechterew's Test												
Rt. Bechterew's Test												

Compression Tests	+	-	D	S	L	M	R
LL Kemp's							
Rt. Kemp's							
Milgram's							
Valsalva Test							

Mechanical Tests	+	-		+	-		+	-
LL Gaenslen			LL Fabere			LL Yeoman		
RL Gaenslen			Rt. Fabere			Rt Yeoman		

Sensory

	WNL	Left	Right	Description

Neurological Eval/Other Tests: _____

RADIOGRAPHIC EVALUATION

VIEWS TAKEN _____ DATE _____ WHERE IF NOT THIS CLINIC _____ ADDITIONAL VIEWS REQUESTED

Subluxation (level)

Scoliosis Location/ Apex | L | R | Cobbs | # Levels

	L	T	R
AP Cervical Curve			
Thoracic			
AP Lumbar Curve			

Sacral Base Angle _____

LL Short Leg (mm) _____

Rt. Short Leg (mm) _____

DDD	DJD	Level	Loss	Narrowing	Foramen
Osteoporosis:					

Other Findings/Recommendations: _____

Comment/Additional clinical information: _____

All the information provided above is a true, accurate and complete representation of _____ PATIENTS NAME

_____ D.C. SIGNATURE _____ DATE

SOAP NOTE

NAME: _____ DATE: _____

ADDRESS: _____ PHONE: ( ) _____

SUBJECTIVE COMPLAINTS

PRIMARY COMPLAINT: _____ INTENSITY: BETTER <1 2 3 4 5 6 7 8 9 10> WORSE

DESCRIPTION: _____ FREQUENCY: _____

ONSET: _____ CAUSE: _____

PATIENT/GUARDIAN SIGNATURE: _____

I HAVE RECEIVED ALL TREATMENTS OR SUPPORTS LISTED BELOW. I ALSO, REPRESENT THE SUBJECTIVE COMPLAINTS THAT I HAVE ARE EXISTENT AND TRUE ACCORDING TO THE LEVELS INDICATED, AND UNDERSTAND THE LIABILITY OF PERJURY.

ADDITIONAL DOCTOR'S NOTE: PLEASE NOTE THAT SORENESS FOR SEVERAL DAYS AFTER AN ADJUSTMENT IS TO BE CONSIDERED NORMAL DUE TO THE NATURE OF THE TREATMENT.

OBJECTIVE FINDINGS:

⇧⇩ _____ RANGE OF MOTION

TENDERNESS NOTED AT _____

MUSCLE SPASM AT _____

JOINT FIXATIONS AT _____

TRIGGER POINTS AT _____

SHORT LEG: RIGHT / LEFT

SENSATION: ⇧ ⇩ _____

ANTALGIC LEAN TO THE: RT / LT

VERTEBRAL SUBLUXATION COMPLEX:

OCCIPUT,C1,C2,C3,C4,C5,C6,C7,T1,T2,T3,T4, T5,T6,T7,T8,T9,T10,T11,T12,L1,L2,L3,L4,L5, SACRUM

ABNORMAL POSTURE EVALUATION

___LORDOSIS ___KYPHOSIS ___SCOLIOSIS

ASYMMETRICAL MUSCLE CONTRACTION

R/L CERVICAL R/L THORACIC R/L LUMBAR

POSITIVE TEST:

___ORTHOPEDIC ___NEUROLOGICAL

_____

_____

_____

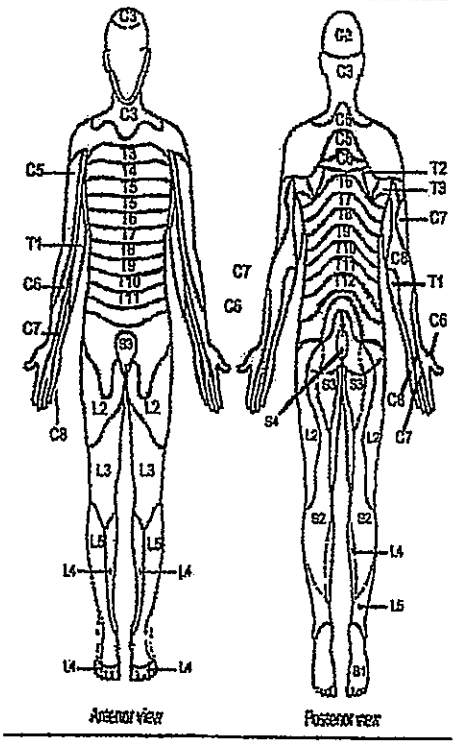
__CHANGE IN MEDS __NO CHANGE IN MEDS

_____

_____

SUBJECTIVE AREAS OF PAIN:

_____



OBJECTIVE SCALE OF FINDINGS:

(DETERMINED BY X-RAYS)

_____1. EXCELLENT-LITTLE CHANCE OF SURGERY. 50/50 CHANCE OF LONG TERM.

_____2. GOOD-SLIGHT CHANCE OF SURGERY. 50/70 CHANCE OF LONG TERM.

_____3. POOR-MODERATE CHANCE OF SURGERY. 80% CHANCE OF LONG TERM.

_____4. GUARDER-MARKED CHANCE OF SURGERY. 90% CHANCE OF LONG TERM.

_____5. CLINICALLY UNSTABLE-PROBABILITY OF SURGERY. SURGERY CONSULT INDICATED.

CARE PLAN:

_____3X FOR 3 WEEKS THEN RE-EVALUATE

_____2X FOR 3 WEEKS THEN RE-EVALUATE

_____1X FOR 3 WEEKS THEN RE-EVALUATE

_____OTHER _____

GOALS:

⇩PAIN ⇩TENDERNESS ⇩SWELLING

⇩FIXATIONS ⇩SPASMS

⇧ROM ⇧STRENGTH ⇧STABILITY

⇧COORDINATION ⇧POSTURE

_____

ASSESSMENT:

_____Heat/Ice: 97010__; EMS: G0283__

_____Ult-sound: 97035__; Atd EMS: 97032__

_____Massage: 97124

_____NMR: 97112__; Man Thera__97140-59

_____Mechanical Traction: 97012

_____Ther Activ: 97530__; ADL: 97535__

_____Sp D, (C/L): S9090; _____SW 0101T

_____Therapeutic Isotonic Rehab: 97110

_____Spinal Manip: 98940__; or 98941__

_____Extremity Adjustment: 98943-AT-59

Occiput C1 C2 C3 C4 C5 C6 C7
T1 T2 T3 T4 T5 T6 T7 T8 T9 T10 T11 T12
L1 L2 L3 L4 L5 S1 Illium

ACTIVITIES OF DAILY LIVING:

(SUBJECTIVELY)

THINGS THAT MAKE YOU WORSE: _____

_____

_____

_____

_____

THINGS THAT MAKE YOU BETTER: _____

_____

_____

_____

_____

BODY ANALYSIS:

AGE: _____ FAT: _____

HT: _____ MUSC: _____

WT: _____ KCAL: _____

BMI: _____ VISC FAT: _____

DIAGNOSIS:

_____

_____

_____

_____

_____NEW CONDITION _____DOI

_____RE-EXACERBATION _____DOI

_____MAINTENANCE CARE _____DOS

TIME IN: _____ OUT: _____

BOCA HEALTH & WELLNESS CENTER
3350 NW BOCA RATON BLVD. SUITE A24
BOCA RATON, FL 33431
OFFICE: (561) 447-2228/FAX (561) 447-2230

Ernest S Caruso D.C.P.A.

ERNEST S CARUSO D.C,P.A.

Dr. Ernest S. Caruso
CHIROPRACTIC PHYSICIAN

OFFICE CONFIDENTIALITY

I. STATEMENT OF PURPOSE

a. To protect the patient from invasion of privacy by preventing indiscriminate and unauthorized access to confidential health information.

b. To promote appropriate usage and maintenance of confidentiality when health information is requested.

II. STATEMENT OF POLICY

a. The medical record is the property of and shall be maintained to serve the patient, the health care providers and this facility in accordance with legal, accrediting, and regulatory agency requirements.

b. The information contained in the medical record belongs to the patient and the patient is entitled to have that information protected.

c. All patient information shall be regarded as confidential, whether written, verbal or observed and available only to authorized users.

III. PROCEDURE

Access to patient records is limited to practitioners, and other health care professionals and insurers and their representatives with legitimate resons for accessing the chart.

a. Release of information
Confidential information regarding the patient's admission, condition, and case management denils (including all records, tests and reports within the medical record) will be discussed only with the patient or his/her designee.

1. Information submitted, collected and prepared for the purpose of evaluating and improving patient care, determining the health care services professionally indicated or performed in compliance with applicable standards shall be deemed confidential.

b. Fax Transmission
Prior to fax transmission of any data that contains patient/medical record information, it must be confirmed that the requesting party has the consent of the patient (Independent Health may obtain their members' records, as all members sign such an agreement upon joining the HMO).

2. Confirm the fax number before transmitting to avoid non-transmissioins and errors. The fax cover sheet is labeled "Confidential Material." Verification that the data was received by the proper party should be done.

Any proven breach of confidentiality represents a failure to meet professional and ethical standards. Appropriate action will be taken to address the confidentiality breach.

I have read, fully understand and agree to comply with the confidentiality policy as stated above.

Name: _____ Date: _____

PLUMTREE CENTRE
3350 NW BOCA RATON BLVD., SUITE A24, BOCA RATON, FL 33431
OFFICE: (561) 447-2228 FAX: (561) 447-2230

Boca Health and Wellness Center
3350 NW Boca Raton Blvd. Suite A24
Boca Raton, Fl 33431

NOTICE OF PRIVACY PRICTACES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

Effective April 14. 2003

The privacy of your medical information is important to us. You may be aware that the U.S. government regulators established privacy rule "HIPAA" governing protected health information (PHI). This notice tells you about how it may be used and about certain rights that you have.

Use and Disclosure of Protected Information.

Federal law provides that we may use medical information (protected health information – PHI) for treatment of you, without further specific notice to you or written authorization by you. For example, if we refer you to a specialist, we may provide laboratory or test data to that specialist (subject to more stringent Florida State laws, such as restriction on disclosure of information concerning HIV/AIDS).

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you or written authorization by you. For example, under your health plan, we are required to provide them with a diagnosis code for your visit and a description of the services rendered.

Federal law provides that we may use your medical information for health care operations without further specific notice to you or written authorization by you. For example, our accountants may see your name, dates of treatment and procedure codes during audits of our books or we may use your information for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you or specific authorization by you, where:

1. required by law ;
2. required for public health purposes;
3. required by law to report child abuse;
4. where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. required by law in Judicial or administrative proceedings;
6. required for law enforcement purposes by a law enforcement official;
7. required by a coroner or a medical examiner;
8. permitted by law to a funeral director;
9. permitted by law for organ donation purposes;
10. permitted by law to avert a serious threat to health or safety;
11. permitted by law and required by military authorities if you are a member of the U.S. armed forces

Florida State law provides additional protection for information regarding HIV/AIDS. We will continue to follow Florida State Law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering devise or with any person who answers the phone at your residence.

We may release PHI to a friend or a family member involved in your care or who assists in caring for you. For example, if a family member or a babysitter brings a child to the office for treatment, we may discuss the child's treatment and they may have access to protected information.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manor.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights That You Have

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated bellow, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you whether we agree and disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

You have the right to obtain a paper copy of this notice from this office.

Obligations That We Have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is in effect.

We reserve the right to revise this notice and to make a notice effective for all protected health information we maintain. Any revised notice will be posted in our office and copies will be available there.

If you feel your privacy rights have been violated, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us.

If you would like further information about our privacy policies or have any questions or concerns, please contact our privacy officer bellow:

Dr. Ernest S Caruso – Business Owner
Plumtree Centre
3350 NW Boca Raton Blvd. Suite A 24
Boca Raton, FL 33431
(561) 447-2228

No retaliatory action will be taken against you for any complaint that you make.

Dr. Ernest S. Caruso
CHIROPRACTIC PHYSICIAN

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable. Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. In pertaining to strokes, the reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit. I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

PLUMTREE CENTRE
3350 NW BOCA RATON BLVD., SUITE A24, BOCA RATON, FL 33431
OFFICE: (561) 447-2228 FAX: (561) 447-2230

ERNEST S. CARUSO D.C. P.A.
3350 NW 2nd Avenue, Suite A24
Boca Raton, FL 33431

Code	Description	Regular Price/per unit
72040	CERVICAL SPINE X-RAY, 2-3 VIEWS	$125
72070	THORACICSPINE X-RAY, 2 VIEWS	$150
72100	LUMBAR SPINE X-RAY, 2-3 VIEWS	$150
73100	X-RAY WRIST, 2 VIEWS	$125
73560	X-RAY – KNEE 1-2 VIEWS	$125
97010	HOT/COLD PACK	$40
97012	TRACTION	$70
97014/G0283	ELECT MUSCLE STIMULATION	$40
97035	ULTRASOUND 15 MIN	$40
97110	THERAPEUTIC EXERCISE 15 MIN	$75
97112	NEUROMUSCULAR RE-ED 15 MIN	$75
97124	MASSAGE THERAPY 15 MIN	$50
97140	MANUAL THERAPY 15 MIN	$75
97530	THERAPEUTIC ACTIVITIES	$75
98940	SPINE MANIPULATION 1-2 REGIONS	$75
98941	SPINE MANIPULATION 3-4 REGIONS	$85
98943	EXTRA SPINAL ADJ 1 REGION	$70
99070	SUPPLIES (LUMBAR CUSHION, ETC)	$60
99202	OFFICE VISIT NEW PATIENT	$200
99203	OFFICE VISIT NEW PATIENT (CAN ONLY)	$250
99204	INTIAL VISIT (PIP ONLY)	$360
99211	OFFICE VISIT BRIEF (RE-EVAL)	$150
99213	OFFICE VISIT NEW PATIENT – FINAL EXAM	$300
99214	OFFICE VISIT – ESTABLISHED PT	$50
S9090	SPINAL DECOMPRESSION	$150

Cash Courtesy Adjusted Amount: _____

Total Paid Today: _____

Due to financial hardship and/or not having health insurance, I am requesting a cash pay discount.

Patient Signature: _____

NOTICE TO ALL PATIENTS:

THERAPY IS PART OF THE HEALING PROCESS AND THE DOCTOR CREATES A TREATMENT PLAN FOR EACH PATIENT AFTER THEIR INITIAL EXAM.

DUE TO GUIDELINE CHANGES IN MANY HEALTH INSURANCE PLANS, IT HAS COME TO OUR ATTENTION THAT THE THERAPIES/SERVICES (EMS/ULTRASOUND, etc.) ARE NO LONGER INCLUDED AS PART OF COVERAGE AND/OR THE INSURANCE COMPANY WILL ONLY PAY FOR ONE OF THEM.

BY SIGNING THIS NOTICE YOU UNDERSTAND THAT IT CAN BE NECESSARY, AS PART OF YOUR TREATMENT, TO RECEIVE SOME OF THESE THERAPIES/SERVICES WHICH ARE NOT INCLUDED IN YOUR COPAY. IF THIS IS THE CASE, AN ADDITIONAL CHARGE WILL BE NECESSARY FOR THESE THERAPIES AT THE TIME THEY ARE GIVEN. PLEASE NOTE THE THERAPY AND ITS CHARGE BELOW:

Electric Stim (EMS) and Moist Heat or Ice - This type of chiropractic therapy is beneficial for reducing pain by raising endorphin levels and increasing blood flow into the injured area which will promote the healing process.**($10.00)**

Ultra Sound - As the ultrasound waves pass from the treatment head into the skin they cause the vibration of the surrounding tissues, particularly those that contain collagen. This increased vibration leads to the production of heat within the tissue. In most cases this cannot be felt by the patient themselves. This increase in temperature may cause an increase in the extensibility of structures such as ligaments, tendons, scar tissue and fibrous joint capsules. In addition ultrasound may also help to reduce pain and inflammation as well as reducing muscle spasms to promote the healing process.**($10.00)**

X-ray - An X-ray is a necessary part of the chiropratic treatment because it is a useful tool in detecting abnormalities within the body. They help to diagnose problems such as broken bones, tumors, infection, disease and bone loss. Also, X-rays are used to determine how to adjust the chiropractic patient due to the subluxation (positioning of bones) theory. **($70.00)**

SERVICES AND/OR THERAPIES NOT PAID FOR:

_____ **X-RAYS ($70.00 PER XRAY), EXERCISE ROOM ($10.00)**

_____ **EMS (ELECTRIC STIMULATION) with HEAT/COLD PAKS ($10.00)**

_____ **ULTRASOUND ($10.00) , FLEXION/DISTRACTION TABLE ($10.00)**

YOUR INSURANCE COMPANY, _____WILL ONLY PAY FOR _____VISITS.

ANY VISITS AFTER THE ALLOTTED NUMBER ARE THE RESPONSIBILITY OF YOU THE PATIENT TO PAY FOR.

_____

Signature of Patient

MEMBER BILLING ACKNOWLEDGMENT

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

Chiropractic

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your medical insurance benefits. ASH recommends that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, _____ (Name of Patient/Member/Subscriber), a member being treated by Dr. _____ (Chiropractor Name),

do hereby acknowledge that a certain portion of my care will not be covered by my HMO, insurance company, or health plan under the terms of my Benefit Plan with _____ (Name of Health Plan).

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
		$
		$
		$
		$
		$
		$

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Chiropractor may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Chiropractor may not bill the member for the difference between what the ASH Contracted Chiropractor bills and what the ASH Contracted Chiropractor agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Chiropractor agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the Member. This agreement may only be used to allow the member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have reviewed my coverage options and that I have been told in advance of treatment what portion of my care I will have to pay for, including non-covered services as described above, and agree to make financial arrangements with my chiropractor,

Dr. _____ (Chiropractor Name), to pay for these services myself.

Dated at _____ (city), _____ (state) this _____ (date) day of _____ (month), 20_____ (year).

Member Signature
(Guardian must sign for all members 17 years or younger)

Member Health Plan ID#

Practitioner Signature

Date