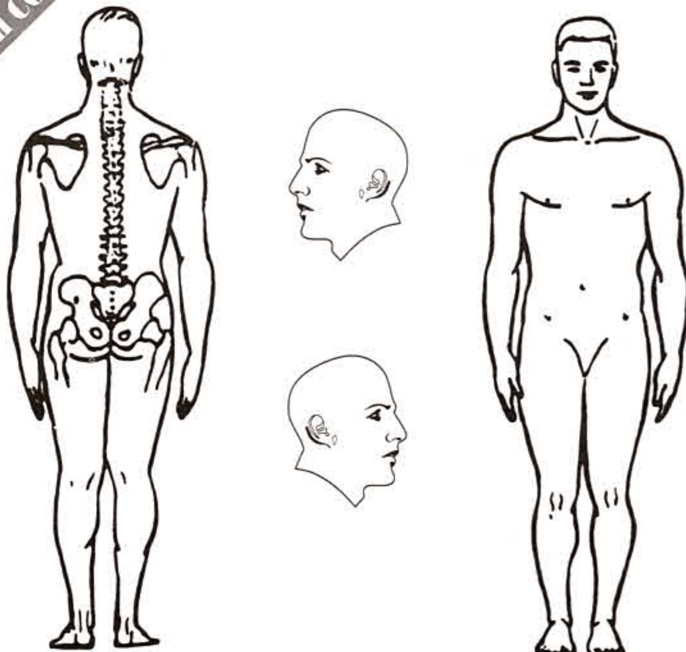
APPLICATION FOR TREATMENT

PERSONAL INFORMATION

Name: ______________________ Today's Date: ___/___/___
Address: ______________________ City/State/Zip: ______________________
E-mail Address: ______________________
Birth Date: ___/___/___ Age: ________ Are you Pregnant: ❒ Yes ❒ No
Employer's Name & Address: ______________________
Occupation: ______________ Work Phone No.: ______________ Home Phone No.: ______________
Who referred you to our office: ______________________
What type of care do you desire: ❒ Temporary Relief ❒ Lasting Correction ❒ Best Care Possible

CURRENT HEALTH CONDITION

Please circle the exact location of any pain you are experiencing. Then describe the type of pain, i.e. dull, sharp, constant, on & off, etc.



In order of importance, list the health problems you are most interested in getting corrected:
1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

In order of severity, list those body functions that you are unable to perform, or that produce pain upon performance, i.e. walking, sitting, bending, etc.
1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

When was the first time you noticed this problem:
____
____

Describe any accidents, falls, injuries, sudden movements, etc. that may have caused your problem: ______________________
____

Have you had any similar health problems or injuries before? ❒ Yes ❒ No If yes, please explain: ______________________
____

Names of all other doctors you have seen for this problem: ______________________
____

Diagnosis and type of treatment you received (please include where and when you received treatment, and the results):
____
____

Has your health problem been: ❒ Improving ❒ Worsening ❒ Staying the Same
Please describe anything you do that improves your condition, or worsens it: ______________________
____

Please check off and describe how this problem interferes with your work and/or personal life:
❒ Home Activities Effected: ______________________
❒ Work Activities Effected: ______________________
Have you missed any work days? ❒ Yes ❒ No If yes, dates missed: ______________________
❒ Recreational Activities Effected: ______________________
❒ Rest or Sleep Effected: ______________________

(Please complete reverse side.)

PREVIOUS HEALTH HISTORY

During the last year, has a doctor treated you for any health problem? ❐ Yes ❐ No
If yes, please explain: ____

____

____

Have you ever received Chiropractic care? ❐ Yes ❐ No If yes, please list the doctor's name, location of office and for what problems: ____

____

____

Please check off the drugs you are now taking: ❐ Pain Killers ❐ Muscle Relaxers ❐ Anti-inflammatory
❐ Blood Pressure Medication ❐ Insulin ❐ Birth Control Pills ❐ Tranquilizers ❐ Diet Pills
❐ Nerve Medication ❐ Sleeping Pills ❐ Anti-depressants ❐ Other (please list): ______________

____

List the approximate dates of any accidents, operations or serious injuries (including broken bones) you have had: _____

____

____

If you have been in an automobile accident, when? ❐ This Year ❐ Last Year ❐ Past 5 Years ❐ Over 5 Years

Please check off the following that apply to you within the past 2 years: ❐ Went to a Health Spa
❐ Purchased Vitamins ❐ Purchased Health Foods ❐ Received a Massage
Please explain why you choose to do any of the above: ______________________________

____

FAMILY HEALTH HISTORY

Marital Status: ❐ Married ❐ Single ❐ Widowed ❐ Divorced ❐ Separated

Names & Ages of Children: ____

Name of wife or husband: ____

Spouse's Employer: ______________________ Business Phone: ______________________

FINANCIAL RESPONSIBILITY

Who is responsible for your bill? ❐ I am ❐ Spouse (Spouse's Birthdate: _____/_____/_____)
❐ My Employer ❐ Insurance ❐ Other: ______________________
Type of Insurance: ❐ Worker's Comp. ❐ Health ❐ Automobile
Insurance Company's Name & Address: ____

____

If you are responsible for your health care fees, payment will be made by: ❐ Cash ❐ Check ❐ Credit Card

Your fees are due and payable at the time examinations, X-rays, and treatments are received, unless other arrangements have been made in advance. X-rays remain property of this clinic.

I, the undersigned, hereby give permission for treatment.

Patient's Signature ______________________ Social Security No: ______________________ Date: ___/___/___

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Patient Name:_________________________________ Number________ HWBP______ Chiropad______

Activities of Daily Living

Please circle all of the activities below that are affected by your condition. (Those activities that you cannot do or avoid performing, that cause you pain or aggravate your condition when performed.)

General:

- Bending
- Chewing
- Climbing stairs
- Exercising
- Getting in/out of auto
- Getting out of a chair
- Kneeling
- Lifting
- Lifting children
- Lying in bed
- Playing piano
- Reaching behind
- Reaching overhead
- Reading
- Running
- Sexual intercourse
- Sitting
- Sitting in recliner
- Sleeping
- Standing
- Swimming
- Using telephone
- Using typewriter/computer
- Walking

Exercise:

- Baseball
- Basketball
- Cycling
- Golf
- Hockey
- Lifting weights
- Running
- Soccer
- Tennis
- Working out in Gym

Housework:

- Caring for pets
- Carrying groceries
- Cooking
- Doing Laundry
- Dusting
- Ironing
- Making beds
- Vacuuming
- Washing dishes

Personal Grooming:

- Brushing teeth
- Combing hair
- In/out bathtub
- Putting on bra
- Putting on socks
- Shaving

Travel:

- Driving
- Flying
- Riding (passenger)

Yard work:

- Gardening
- Hammering
- Mowing lawn
- Painting
- Raking leaves
- Sawing

Patient's signature: ____Date:_________________

For Office Use Only

Smoker _____ Non Smoker _____ Former Smoker_____ H _______ W _______ BP _______ P _______

Health _________

ADL's ________

Prescriptions

Medication

- Active NKM _____
- Allergies NKDA _____

Nutrition

- Active NKNS _____
- Allergies NKNA _____

FAMILY HEALTH HISTORY

To help the doctor determine if your health problem is hereditary: 1) please check off (✓) the health problems of your family members; 2) leave blank those health problems they don't have; 3) circle those relatives who live within 30 miles of you, as some hereditary conditions are affected by a similar climate.

Patient Name: ______________________ **Date:** ____________

HEALTH PROBLEM	MOTHER Age ( )	FATHER Age ( )	BROTHER(S) Age ( )	BROTHER(S) Age ( )	SISTER(S) Age ( )	SISTER(S) Age ( )	SPOUSE Age ( )	CHILDREN Age ( )	CHILDREN Age ( )	CHILDREN Age ( )
Allergies										
Arm Pain – Numbness/Tingling										
Arthritis										
Asthma										
Back Pain										
Bursitis, Tendinitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Emphysema										
Epilepsy										
Hand Pain – Numbness/Tingling										
Hay Fever										
Headaches										
Heart Trouble										
High Blood Pressure										
Insomnia										
Kidney Trouble										
Leg Pain – Numbness/Tingling										
Liver Trouble										
Low Blood Pressure										
Migraine										
Neck Pain										
Nervousness										
Neuritis										
Neuralgia										
Pinched Nerves										
Scoliosis										
Shoulder Pain										
Sinus Trouble										
Stomach Trouble										
Whiplash										

If any of your immediate family members (Mother, Father, brother, sister, or children) are deceased, please list their age at death and cause: ______________________

____

____

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Dr. Gerald A.Nadeau - Dr. Robert G. Nadeau
336 Center St., Auburn, ME 04210 ~ T: (207) 777-1104 F: (207) 777-7354 ~ drgnadeau@gmail.com

HIPPA NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:___________________________ Date of Birth:____________________________

Address:____

Home Phone:_________________ Cell Phone:______________ Work Phone:______________

Email Address:____

I,____ authorize Nadeau Chiropractic Associates to discuss Information pertaining to my appointments, treatments, financial matters and In case of an Emergency to:

Name: ____

Phone Number: ____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Nadeau Chiropractic Associates. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow up among the healthcare providers who may be directly and indirectly involved in providing my treatment. Obtain payment from third party payers.Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that the notice describes the uses and disclosures of my protected health information by Nadeau Chiropractic Associates and informs me of my rights with respect to my protected health information.

____ ___________________________
Patient's Signature or legal Representative Today's Date

____ ___________________________
Print Name of Patients Representative *Legal Representative Relationship*

FOR OFFICE USE

We have made every effort to obtain written acknowledgement of receipt of out Notice of Privacy from this patient but it could not be obtained because:
___ The patient refused to sign ___ Due to emergency situation it was not possible to obtain an acknowledgement ___Communication barriers prohibited obtaining the acknowledgement

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Notice of Receipt of Privacy Notice of Nadeau Chiropractic Associates

By signing below, I acknowledge that I have received and reviewed the Privacy Notice of Nadeau Chiropractic Associates, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

______________________________	______________________________
Name of Individual (printed)	Signature of Individual
______________________________	______________________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):	Relationship
Date Signed ____/____/____	Witness:________________________

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Irrevocable
Assignment, Lien and Authorization
Insurance Benefits and Attorney

To Whom it May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly **Nadeau Chiropractic Associates** such sums may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reasons of any other bills that are due this Office, and to withhold such a sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, Worker's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on behalf as may be necessary to adequately protect said Office. I hereby further give lien to said Office against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the Office's services provided.

In the event that my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payment, upon demand by me of this Office, I hear by assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve such claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the Office for their services. I further understand and agree that this Assignment, Lien, and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collecting collections under the Assignment, Lien and Authorization. I agree that the above mentioned Office be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse the Office for all costs of such collection efforts, including but not limited to all court costs and attorney fees.

Signed____Date:_______________________________

Witness:____Date:______________________________

VERIFICATION OF INSURANCE COVERAGE

Nadeau Chiropractic Associates ________________________ Date/Time _______________________

PATIENT INFORMATION

Name: ______________________________ DOB: _________________ Patient # ___________

Relationship to Insured: Self ___ Spouse ___ Child ___

INSURED INFORMATION (POLICY HOLDER)

Name: ______________________________ TID# ______________________________

DOB: _________________________ Group # _________________________________

INSURANCE PAYER INFORMATION

Carrier Name: ____

Name of Insurance Representative: ____

Phone: _________________________ Electronic Claims to ___________________________

Mail Claims to: ____

COVERAGE DETAILS

Effective Date: ____________________
Referral Needed: __ Yes __ No
Deductible: __Yes __ No Amount: $_______
Met? __ Yes __ No Next Due _______
Copay: $% _______
X-Rays Covered: __ Yes __ No
Out of Pocket Amount: $_________________
Visit Limit: ____________________________

CPT CODE COVERAGE

97140 Manual Therapy __ Yes __ No
98943 M8 __ Yes __ No
29200 – 29500 __ Yes __ No
99201 – 99204 __ Yes __ No
Taping Codes __ Yes __ No

BENEFITS SUMMARY

Pre-Existing Conditions: __ Yes __ No
Carryover Clause for Deductible: __ Yes __ No

REPORTING REQUIREMENTS

Special Reports Needed: __ Yes __ No If yes, when _______________________

The Doctor's treatment plan will be based upon what he determines is in the best interest for your health and benefit. Please note: We have no influence over your insurance company's reimbursement policies or rationales for denials. We will report clinical information to your Primary Care Physician and insurance company to ensure maximum benefit reimbursement. However, please be aware that you will be responsible for the cost if your insurance company limits the number of adjustments, exams or services, (ie: modalities, exercises, etc.).

We recommend that you verify your chiropractic insurance coverage as well.

Patient Signature: ____ Date: _____________________

Witness: ____ Date: _____________________

A. Notifier: Nadeau Chiropractic Associates, 336 Center St, Auburn Me. 04210 207-777-1104

B. Patient Name:________________________ **C. Identification Number:________________**

Advance Beneficiary Notice of Noncoverage (ABN)

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

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.___service(s)_** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated
Exam	Medicare/Medicare Replacements and Mainecare do not cover these services in a Chiropractors office. For the year of January 2023 to December 2023.	$80.00 to $ 70.00
X-rays		$60.00 to $220.00
Therapies		$10.00 to $ 19.00
Extra Spinal Adjustments		$ 35.00
Supplements		$ 10.00-$300.00

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 **D.___service(s)_** 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.

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

☐ **OPTION 1.** I want the **D.__service(s)__** 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 **D.__service(s)__** 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 **D.__service(s)__** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. 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.

I. Signature:	J. Date:

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