***(A)*Notifier(s):**
***(B)* Patient Name:** ***(C)* Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)*_____** 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)*_____** below.

Service(s): Check those that apply	***(E)* Reason Medicare May Not Pay:**	***(F)* Estimated Cost:**
Initial Evaluation Re Evaluation Massage Therapy Ancillary modalities Well visit, non-acute NSSD - Spinal decompression Electrodes	Item Not Covered Under Medicare	$100.00 TOS $75.00 TOS $10 per visit $15/visit TOS (Per MC rate) TOS $50.00 TOS$8/pads

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)*_____** 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)*_____** 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)*_____** 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)*_____** 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:**

Health First Rehab, INC
dba Lewis Bay Chiropractic

NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

Your Medicare coverage of chiropractic care is limited. It does not pay for all services. It will only pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules.

PLEASE READ CAREFULLY! **Be advised that you are responsible for payment any/all services rendered that are not covered by your Medicare Policy. Additionally, Medicare has a deductible of $240.00 and a 20% co-insurance for 2024. You are ultimately responsible for any/all deductible and co-insurances that are not covered by any secondary insurance policy. We highly encourage you to contact your secondary insurance company (if applicable) in advance to determine whether they cover the deductible and co-insurances assessed by Medicare.**

There are three categories of Medicare services: 1) non-covered 2) always-covered, and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON-COVERED. Hopefully, the U.S. Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then, here is a summary:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits - to evaluate and manage, re-evaluate, advise, or give counsel regarding your health.
- Physiotherapy - such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or Treatments:

- Non-spinal manipulation to the shoulder, arm, leg, etc.
- Maintenance Care - you are stable and not making any more improvement.
- Wellness Care - to promote better health.

ALWAYS-COVERED SERVICES

A Medicare COVERED service is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are improving. This phase of care is call "active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example, "98940-AT."

PERHAPS-COVERED SERVICES

Your Chiropractic Adjustment must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustment is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for continued care.

MAINTENANCE CARE SERVICES

Maintenance Care such as "once every month" treatment is not a covered benefit under Medicare Policy.
Patient is responsible any/all charges related to maintenance Care.

I understand and will comply with medicare benefit policies as it relates to my chiropractic care.

Patient Signature : _____ Date: _____/_____/_____

HEALTH FIRST REHAB, INC
dba Lewis Bay Chiropractic

Patient Name:
Patient D.O.B.:

Chiropractic Physician
☐ Robert Harmon, DC
☐ Joshua Lindauer, DC
☐ Mark Walcutt, DC
☐ Roberta Walcutt, DC

Informed Consent for Chiropractic Services

I have been <u>informed</u> of the following:

1. By signing below, I consent to the services being rendered during this visit by the above-named chiropractic physician (s) or any other chiropractic physician who now or in the future treat me while employed by, working or associated with or covering for the above-named chiropractic physician.
2. I have been informed that the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (ribs, legs, arms etc.), often, but not necessarily resulting, in an audible pop or clicking sound;
3. I have been informed that in addition to the Chiropractic Adjustment, one or more "Supportive Therapies" may be applied by the chiropractor or by staff under their direction and supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, heat, cold, and/or nutritional/lifestyle recommendations;
4. I have been informed that coinciding with the process of a Chiropractic Adjustment and/or Supportive Therapies there may be, at times, some temporary soreness and/or stiffness; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely tissue bruising and/or swelling, more rare joint/bone separation/fracture; and extremely rare, disc, nerve or vascular injury;
5. I have been informed that at times treatment techniques may include skin to skin contact, tissue mobilization and/or stretching of involved or related areas and digital pressure/light touch/brushing over regions both on and/or away from your primary complaint location;
6. I have been informed that certain techniques may require close proximity between clinician and patient;
7. I have been informed of my condition, possible benefits, risks of treatment if any, options, and financial obligations;
8. I have been informed that it is my responsibility to inform the chiropractor of any condition(s) that would otherwise not come to their attention;
9. I have been informed that the chiropractor has made no guarantee of a positive outcome from treatment; and
10. I have been afforded ample opportunity for questions and answers.

<u>Therefore, by signing below:</u>

I <u>consent</u> to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I <u>consent</u> to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Guardian Name (if applicable):_____

Guardian Signature (if applicable):_____Date:_____

Witness Signature:_____Date:_____

Office Policies - Health First Rehab, Inc.

dba. Lewis Bay Chiropractic

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Privacy Notice Acknowledgement

In accordance with the ***Health Insurance Portability and Accountability Act of 1996 (HIPAA)***, by signing below, I acknowledge that a copy of the Notice of Privacy Practices for Protected Health Information for this office has been made available to me. I am advised to read this document carefully, for it outlines the use and limitations of the disclosure of my health information and my rights as a patient. I have been given the opportunity to ask any questions that I may have regarding these policies.

Authorization to Release Medical Information

I authorize my healthcare provider(s) to furnish information from my medical records to any company that may be responsible for payment of all or part of my visit and provider charges, including my insurance companies and their representatives, and my information to this provider for continuing care.

Massage Therapy Non-Covered Service Waiver

Massage therapy services performed by a licensed massage therapist in this office are not a covered benefit under your current health plan, as these procedures are not performed directly by a participating physician/provider.

There is a fee of ***$10.00*** per visit for this service. _____**Initial**

Authorization for Direct Payment of Insurance Benefits

I, or my representative, authorize direct payment to the provider(s) and/or clinic rendering any services during this visit of any insurance benefits otherwise payable to me.

Health Insurance/Patient Payment Policy

We will file your insurance claims for you. However, we cannot guarantee or take responsibility for what your health insurance will or will not cover. Ultimately, all services rendered to you are charged directly to you and you are personally responsible for payment. Payment for all services, including copays, coinsurance and deductibles, are expected at the time of service unless prior arrangement are made with us. **If you have a cash balance with our office greater than *45 days*, there will be a finance charge of *5% per month applied to your account***.

Treatment Compliance. Appointment Cancellation Policy

We require 24 hour notice for patient cancellations. Health First Rehab, INC reserves the right to charge *$60* for missed appointments if this policy is abused. This amount is not covered by any insurance plan and will be the patient's responsibility. Further, **greater than 2 missed appointments will be considered non-compliance and subject to discharge from care**.

_____**Initial**

I have read the Health First Rehab, Inc. office policies and will honor them:

_____	_____	_____
Print Name	**Patient Signature**	**Date**

Patient Information

Date:_____

Name: DOB:

Address:

Town: State: Zip:

Home Phone: Cell #:

E-mail address:

Social Security # - -

Marital Status:

Emergency Contact:

Relation: Phone:

Occupation:

Primary Care MD:

Permission to send treatment notes: Yes NO

PATIENT PAIN FORM

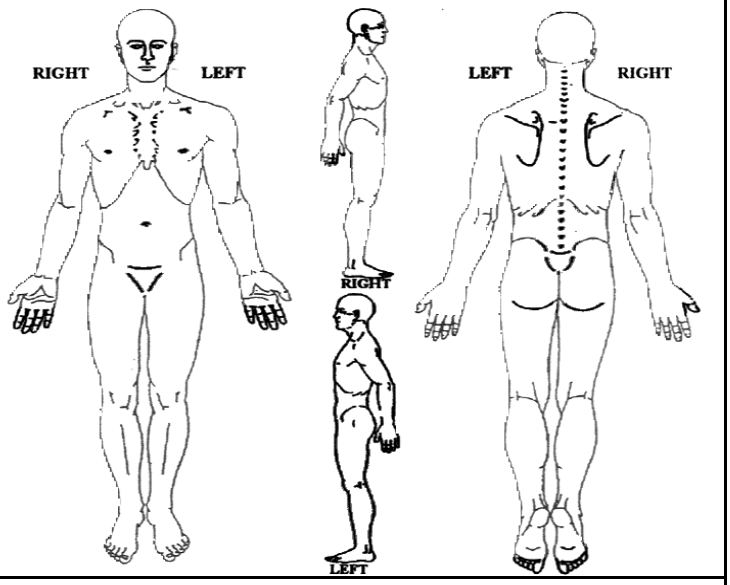
Health First Rehab, INC
dba Lewis Bay Chiropractic

Patient: _____ **Date of Birth:**_____ **Today's Date:** _____

☐ **MVC** ☐ **WC Date of Injury (if applicable):** _____

SHOW US YOUR PAIN
USE THE LETTERS BELOW TO INDICATE THE TYPE
AND LOCATION OF YOUR SYMPTOMS TODAY

KEY: **A** = ACHE **B** = BURNING **N** = NUMBNESS **P** = PINS & NEEDLES
S = STABBING **X** = STIFFNESS **T** = THROBBING **O** = OTHER



0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Pain)

1. When did your symptoms first begin?

2. What caused your recent symptoms?

3. Is this an exacerbation of a chronic condition?

☐ **Yes** ☐ **No**

4. Have you had these symptoms in the past?

☐ **Yes** ☐ **No**

Please sign Here:

I experience the above symptoms: ☐ Constantly ☐ Very Often ☐ Occasionally ☐ Infrequently

I feel that my symptoms are: ☐ Getting Better ☐ Getting Worse ☐ Staying About the Same

My symptoms are: ☐ Dull, Achy ☐ Stiffness ☐ Sharp/stabbing ☐ Burning ☐ Throbbing ☐ Numbness ☐ Tingling/Pins and needles

Symptoms radiate/refer to my: ☐ Head ☐ Shoulders (B R L) ☐ Both arms ☐ Right arm ☐ Left Arm ☐ Flank/ribs ☐ Hips (B R L) ☐ Buttocks (B R L) ☐ Both Legs ☐ Left leg ☐ Right Leg

Symptoms are worse with: ☐ Standing ☐ Sitting ☐ Driving ☐ Bending ☐ Lifting ☐ Work Activity

Other, please explain:

Symptoms are relieved with: ☐ Rest/Lying down ☐ Ice ☐ Heat ☐ Stretching ☐ Movement ☐ Massage ☐ Other, please explain:

I am unable to perform the following activities due to pain:

List current medications/Supplements: ☐ See current medication list provided

1. 2. 3. 4. 5.

I am experiencing the following symptoms (please check all that apply) :

☐ Shortness of breath
☐ Difficulty breathing
☐ Pain with coughing
☐ Bowel/bladder changes
☐ Urinary incontinence
☐ Blood in stool
☐ Other symptoms:

☐ Nausea /Vomiting
☐ Fevers / Chills
☐ Light-headed, dizziness
☐ Visual changes
☐ Hearing changes
☐ "Foggy/Hazy" feeling

☐ Difficulty sleeping
☐ Difficulty concentrating
☐ Memory problems
☐ Mood swings, irritability
☐ Loss of appetite/Weight loss
☐ Fatigue

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Personal Care

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.
- ☐ I cannot lift or carry anything at all.

Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all because of neck pain.

Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight neck pain.
- ☐ I can drive my car as long as I want with moderate neck pain.
- ☐ I cannot drive my car as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty concentrating when I want.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

Recreation

- ☐ I am able to engage in all my recreation activities without neck pain.
- ☐ I am able to engage in all my usual recreation activities with some neck pain.
- ☐ I am able to engage in most but not all my usual recreation activities because of neck pain.
- ☐ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ☐ I can hardly do any recreation activities because of neck pain.
- ☐ I cannot do any recreation activities at all.

Work

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work but no more.
- ☐ I can only do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Calculate Score

Score Neck

Back Index

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is very severe.
- ☐ The pain is very severe and does not vary much.

Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal sleep is reduced by less than 25%.
- ☐ Because of pain my normal sleep is reduced by less than 50%.
- ☐ Because of pain my normal sleep is reduced by less than 75%.
- ☐ Pain prevents me from sleeping at all.

Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than 1/2 hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases pain immediately.

Walking

- ☐ I have no pain while walking.
- ☐ I have some pain while walking but it doesn't increase with distance.
- ☐ I cannot walk more than 1 mile without increasing pain.
- ☐ I cannot walk more than 1/2 mile without increasing pain.
- ☐ I cannot walk more than 1/4 mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

Personal Care

- ☐ I do not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights.

Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ☐ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel except that done while lying down.
- ☐ Pain restricts all forms of travel.

Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

Changing degree of pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better or worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Calculate Score

Index Back Score