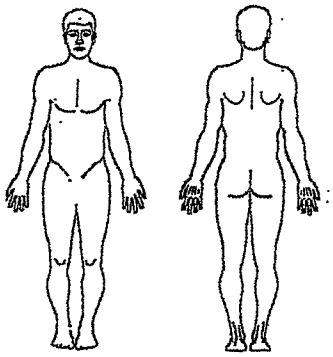
INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Sex: M / F
Address_____ City_____
State_____ Zip_____ Phone (____)_____ Patient Primary Language_____
Occupation_____ Employer_____ Work Phone_____
Address_____ City_____ State_____ Zip_____
Subscriber Name_____ Health Plan_____
Subscriber ID #_____ Group #_____ Spouse Name_____
Spouse Employer_____ City_____ State_____ Zip_____
Primary Care Physician Name_____ PCP Phone_____

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other_____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began_____
How Problem Began

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain)_____
☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Medications_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature_____ **Date**_____

FINANCIAL AGREEMENT

Richard Mordecai, D.C.

Christina Dumbadse, D.C.

Megan Mordecai D.C.

Chad Mordecai D.C.

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care possible for your current condition.
In order to familiarize you with the policy of this office, we would like to explain how your medical bills will be handled.

PPO and HMO Insurance policies: Most insurance companies cover chiropractic care, but this office makes no representation that your does. Insurance policies can differ greatly in terms of copayments, deductibles, and percentage of coverage for chiropractic care. It is our office policy to collect all copayments and deductible amounts at the time service is provided.

Cash and Time of service discounts: Some insurance policies without chiropractic benefits still offer a percentage off of our cash rates, this is known as a Time of Service Discount. It is our office policy to collect these types of payments at the time service is provided.

We will do our very best to verify your insurance coverage accurately, and will bill your insurance company (ies) in a timely manner. In return we ask that you maintain your insurance information with us on a current basis. If this arrangement becomes inconvenient for you, please see our office manager so that other arrangements can be made.

We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we welcome you to our office and we are excited to provide you with exceptional care.

I have read and agree to the above:

_____ _____

Patient Signature Date

Authorization to Realease protected Health Informaton:

Richard Mordecai D.C.

Christina Dumbadse D.C.

Megan Mordecai D.C.

Chad Mordecai D.C.

Patient's Full Name

Patient's Social Security Number/Medical Record Number

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   Mordecai Dumbadse Chiropractic

2. The following person (or class of persons) may receive disclosure of protected health information about me:
   - Any previous, current, or future health insurance company
   - Outside medical transcriptionist for reports (If Any)
   - Collection Agency (If required)

3. The specific information that should be disclosed is
   - Name, address, telephone number, DOB, Social Security Number (If required), Insurance identification number, group number, diagnosis and procedure information.
   - Billing information, procedure and diagnosis information, visit notes and details

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Mordecai Dumbadse Chiropractic in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. My purpose/use of the information is for

   _____.

7. This authorization expires on _____, 201___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:

   _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Individual*

Date of Individual's Signature

Witness Signature/ Office Staff

Date

Richard Mordecai D.C.
Christina Dumbadse D.C.
Megan Mordecai D.C.
Chad Mordecai D.C.

Mordecai Dumbadse Chiropractic
817 Second St. Santa Rosa, CA
95404

Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease		*X*		

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____/_____

Informed Consent for Chiropractic Treatment

Richard Mordecai D.C.

Christina Dumbadse D.C.

Megan Mordecai D.C.

Chad Mordecai D.C.

As with any health care procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1. **Some patients may experience some stiffness following the first few days of treatments.**
2. **Some types of manipulation have been associated with injures to the arteries or the neck leading or contributing to serious complications including stroke.**
3. **I will make every effort to screen any contraindication to care; however, if you have a condition that should otherwise not come to my attention it is your responsibility to inform me.**
4. **Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, constovertebral strains and separations and burns.**

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check during the history, examination and x-ray (when warranted)

I acknowledge I have had the opportunity to discuss the associated risk as well as the nature and purpose of treatment with my chiropractor.

I consent to the chiropractic treatment offered recommended to me by my chiropractor, including spinal manipulation. I intend this consent to apply to my present and future chiropractic care.

Patient Signature **Patient Printed Name**

Witness Signature **Date**

A. Notifier:

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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** new exam 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.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New Patient exam 99203	non-covered Benefit	140.00

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.**_____ 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.** new patient 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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Chiropractic maintenance care 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.** maintenance care below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
98940 Chiropractic manipulation, 1-2 areas 98941 Chiropractic manipulation, 3-4 areas 98942 Chiropractic manipulation, 5 areas	Medicare does not pay for chiropractic maintenance care	$77.00

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.** maintenance care 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.** maintenance care 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.** maintenance care 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.** maintenance care 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:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

R. Notificado:

B. Nombre del paciente: **C. Número de identificación:**

Aviso anticipado al beneficiario de no cobertura (ABN)

NOTA: Si Medicare no paga por D. quiropráctica cuidado de mantenimiento a continuación, es posible que tenga que pagar.

Medicare no paga todo, ni siquiera algunos cuidados que usted o su proveedor de atención médica tienen buenas razones para pensar que necesita. Es posible que Medicare no pague lo que se indica en D. quiropráctica cuidado a continuación.

D.	E. Razón por la que Medicare no puede pagar:	F. Costo estimado
98940 quiropráctica manipulación, 1-2 areas 98941 quiropráctica manipulación, 3-4 areas 98942 quiropráctica manipulación, 5 areas	Medicare no se paga quiropráctica cuidado de mantenimiento	$77.00

LO QUE NECESITA HACER AHORA:

- Lea este aviso para que pueda tomar una decisión informada sobre su cuidado.
- Háganos cualquier pregunta que pueda tener después de terminar de leer.
- Elija una opción a continuación sobre si desea recibir la **D.** quiropráctica cuidado mencionada anteriormente.

Nota: Si elige la opción 1 o 2, podemos ayudarle a utilizar cualquier otro seguro que tenga, pero Medicare no puede exigirnos que lo hagamos.

G. OPCIONES: Marque solo una casilla. No podemos elegir una casilla por usted.

☒ **OPCIÓN 1.** Deseo la **D.** quiropráctica cuidado mencionada anteriormente. Puede solicitar que se le pague ahora, pero también deseo que se le facture a Medicare por una decisión oficial sobre el pago, que se me envía en un Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable del pago, pero puedo apelar a Medicare siguiendo las instrucciones del MSN. Si Medicare paga, usted reembolsará cualquier pago que le haya hecho, menos copagos o deducibles.

☐ **OPCIÓN 2.** Deseo la **D.** quiropráctica cuidado mencionada anteriormente, pero no facture a Medicare. Puede solicitar que se le pague ahora ya que soy responsable del pago. No puedo apelar si no se factura a Medicare.

☐ **OPCIÓN 3.** No deseo la **D.** quiropráctica cuidado mencionada anteriormente. Entiendo que con esta elección no soy responsable del pago y no puedo apelar para ver si Medicare pagaría.

H. Información adicional:

Este aviso da nuestra opinión, no es una decisión oficial de Medicare. Si tiene otras preguntas sobre este aviso o la facturación de Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/ **TTY:** 1-877-486-2048).
Firmar a continuación significa que ha recibido y comprende este aviso. Puede solicitar recibir una copia.

I. Firma:	J. Fecha:

Tiene derecho a obtener información de Medicare en un formato accesible, como letra grande, braille o audio. También tiene derecho a presentar una queja si siente que ha sido discriminado. Visite Medicare.gov/about-us/accessibility-nondiscrimination-notice.