MEDICARE

Patient Information

PATIENT NAME: _____

Street Address: _____

City, State, Zip Code: _____

Phone #: (_____)_____ Date of Birth:_____ Age: _____

Social Security #:_____ Sex: _____ Marital Status: ___S___M___D___W

Out of State Address:_____

Next of Kin:_____ Relationship:_____

Address:_____

Phone #: (_____)_____

PT Diagnosis:_____

Onset Date: _____ Prescription Date:_____ Eval Date: _____

Primary Insurance:_____ Policy #: _____

Policyholders Names:_____

Secondary Insurance:_____ Policy #: _____

Policyholders Names:_____

Name of Referring Doctor: _____

Address: _____

Phone #: (_____)_____ UPIN or NPI#: _____

Jupiter West Medical Center
2632 West Indiantown Road
Jupiter, FL 33458
Phone: 561-744-7373 Fax: 561-743-1192

ASSIGNMENT OF BENEFITS

I, the undersigned patient, hereby assign my Personal Injury Protection insurance benefits under my policy of automobile insurance or all other applicable Private policies benefits under my medical insurance, for all causes of actions to **MICHAEL PAPA, D.C.** its subsidiaries and its agents, including but not limited to **MICHAEL PAPA, D.C.** for services rendered to the undersigned patient in accordance with Florida Statue 627.736(5), that would otherwise be payable to me for services rendered.

I fully understand that by the execution of this assignment of benefits, that I also grant **MICHAEL PAPA, D.C.,** its subsidiaries and its agents including but not limited to **MICHAEL PAPA, D.C.** full power of attorney and authority to act in or on my behalf insofar as the endorsing and cashing of checks as well as the execution of any other documents that may be related to this matter or claim. I agree to be fully responsible for the services provided regardless of settlement, judgment or verdict. I further direct my Private insurance carrier to provide any medical provider with an updated copy of the PIP Payment Log. A photocopy of this document shall be as binding as the original signature page.

PATIENTS/INSURED SIGNATURE_____

INSURANCE COMPANY_____

DATE_____

DATE OF ACCIDENT_____
(If applicable)

FINANCIAL POLICY AGREEMENT

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless our staff has approved payment arrangements in advance. We accept CASH, CHECK, MASTER, DISCOVER, AMERICAN EXPRESS, or VISA CARDS. We will be happy to help you process your insurance claim-form for your reimbursement.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of **1.5 %** per month. We will gladly discuss your proposed treatment ans answer any questions relating to your insurance.

You must realize, however that:

1- You insurance is a contract between you, your employer and the insurance company. We are not a party to contract.

2- Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (50% or 80%) of "U.C.R."
"U.C.R." is defined as usual, customary and reasonable. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical providers, our relationship is with you and not with your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage PLEASE do not hesitate to ask us. We are here to help you.

PATIENTS/INSURED SIGNATURE_____

INSURANCE COMPANY_____

DATE_____

DATE OF ACCIDENT_____
(If applicable)

PATIENT CONSENT FORM

I hereby indicate my wish to be a participant in the rehabilitation program offered by:

_____

I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during my treatment.

I have been informed of the procedures and methods of treatment that will be administered to my _____, and I fully understand what is required for me as a patient.

I verify that my participation is fully voluntary, no coercion of any sort has been used to obtain my participation, and I may withdraw from treatment at any time.

I understand that the facility administrator maintains an open door policy and encourages patients to participate or any reason.

SIGANTURE: _____

PRINT NAME: _____

DATE: _____

A Medicare Approved
Comprehensive Outpatient Rehabilitation Facility

INSURANCE ASSIGNMENT FORM

Patients Name: _____ Patients Insurance ID #: _____

Instructions: Please read this form carefully, check the applied spaces, and sign at bottom.

Insurance authorization-Patient release and authorization

_____ I hereby authorize payment directly to _____ for the benefits due to me in my pending claim and/or Major Medical Benefits otherwise payable to me, but not to exceed the physicians and/or the Corporation's regular charges for therapy for this treatment period.

_____ I further authorize the release of any medical information required by the insurance carrier(s).

_____ I understand that I am financially responsible for charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

Medicare Authorization –Patient Release and Authorization

_____ I verify that the information given by me in applying for payment under title XVIII of the Social Security Act is covered.

_____ I authorize any holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carries any information to be used in place of the original and releases payment of medical insurance benefits either to myself or the party who excepts assignment.

Notice: Anyone who misrepresents or falsifies confidential information reported by this form may upon conviction be subject to fine and imprisonment under federal law.

Medicare Acknowledgment- Rehabilitation Services billing and Reimbursement

_____ I am aware that Medicare and/or insurance will not reimburse some costs of my rehabilitation.

_____ I am aware that Medicare Law requires_____ to make me aware that I will be billed for these non-reimbursement services.

_____ I am aware that these procedures are integral to my rehabilitation and cannot be ___ therefore, I may expect to be billed for any difference between the final bill and allowable charges. Please contact this office to make financial arrangements.

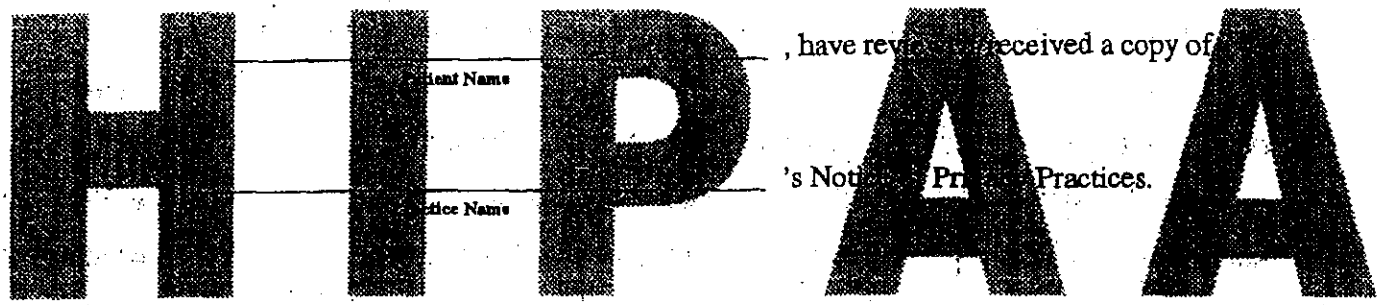
_____ I have read the above and understand that I am financially responsible for paying any and all charges incurred in the rehabilitation program not reimbursed.

Date: _____ Patient: _____

Witness: _____ For Patient: _____

PRACTICE NAME

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM



_____ , have reviewed / received a copy of _____'s Notice of Privacy Practices.

Signature of Patient / Guardian

Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

MICHAEL PAPA, D.C.
2632 W. INDIANTOWN DRIVE
JUPITER, FL 33458
PHONE: 561-744-7373

Patient Name: _____ **Identification Number:** _____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box 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 items listed or checked in the box below.

Listed or Checked Items Only:	**Exams, Therapies, X-rays, Tests, Supplies**		
Reason Medicare May Not Pay:	Medicare has limited coverage for services provided by Chiropractic Physicians to manual adjustment of the spine. 98940,98941 & 98942 are the only covered Chiropractic services allowed by the law to be reimbursed by Medicare		
Estimated Cost:			

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 checked items listed in the first box 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.

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

- ❑ **OPTION 1.** I want the _____ 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 _____ 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 _____ listed above. I understand with this choice I am **not responsible for payment,** and I cannot appeal to see if Medicare would pay.

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.

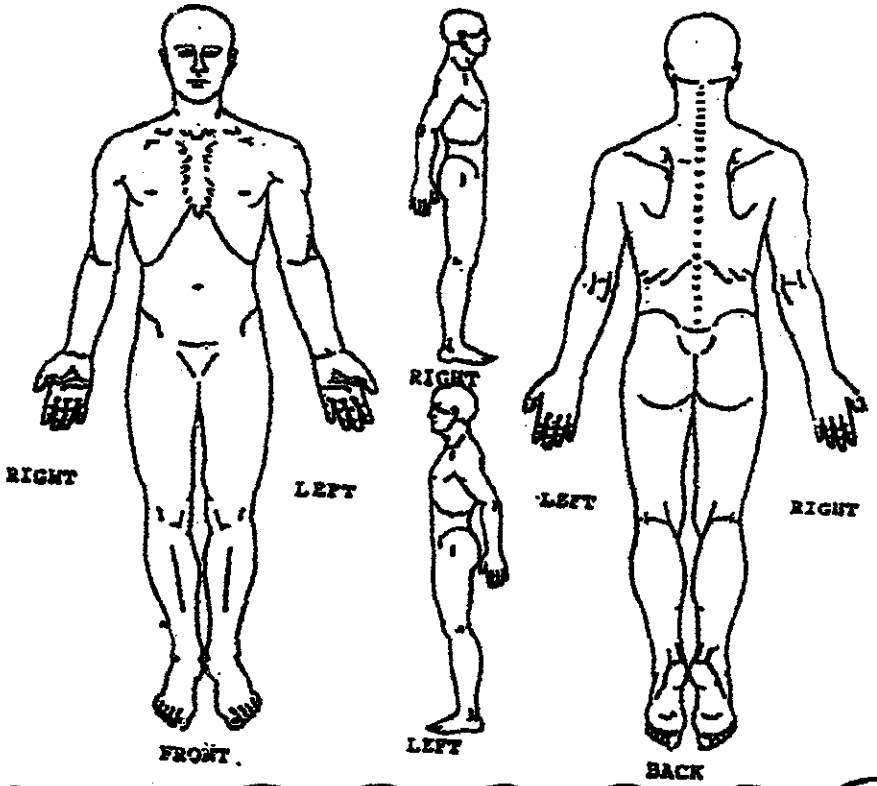
Signature:	**Date:**

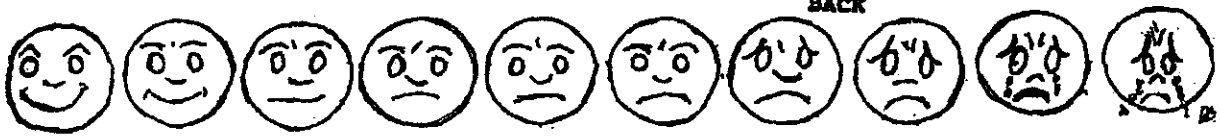
PAIN CHART

NAME_____ **DATE**_____

Please indicate the type and area of your pain on the drawings below, by using the abbreviations provided:

D= Dull Pain	**T=Tingling**
B= Burning	**N= Numbness**
P= Sharp Pain	**S= Stiffness**





Please Give A Numeric Value To Your Pain On The Pain Scale Below

1 2 3 4 5 6 7 8 9 10

NO PAIN **VERY BAD PAIN**

MEDICARE

Patient Questionnaire

PATIENT NAME: _____ DATE: _____

Date of Last Physical: _____

PLEASE LIST ANY SURGERIES/ HOSPITALIZATIONS: _____

_____

HAS A DOCTOR EVER TOLD YOU THAT YOU SUFFER FROM ANY OF THE FOLLOWING PROBLEMS?
(Please mark with X)

DIZZINESS		SHORTNESS OF BREATH		DIGESTIVE DISORDER	
BALANCE DYSFUNCTION		TUBERCULOSIS		NUMBNESS	
BACKACHES		HEADACHES		ASTHMA	
NERVOUSNESS		MIGRANES		DIABETES	
RHEUMATIC FEVER		SINUS PROBLEMS		FAINTING	
ARTHRITIS		CANCER		STROKE	
DEPRESSION		HEART PROBLEMS		ANEMIA	
FATIGUE		ANGINA PECCTORIS			

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:
(Please Indicate YEAR)

_____HYPERTENSION _____METAL IMPLANTS _____PACE MAKER

_____SEIZURE _____THR/ TKR

ANY OTHER SYMPTOM/ ILLNESS/ PAIN? : _____

OTHER PHYSICIANS SEEN FOR THESE PROBLEMS? _____

ARE YOU PREGNANT? **Yes** **No** DO YOU SUSPECT TO BE PREGNANT? **Yes** **No**

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PLEASE LIST ANY RECENT TESTS YOU HAVE TAKEN: _____

PLEASE LIST ANY ALLERGIESYOU MAY HAVE: _____

PLEASE LIST ANY OTHER IMPORTANT INFORMATION YOU FEEL MAY HELP US WITH YOUR TREATMENT: _____

I hereby authorize JUPITER WEST MEDICAL CENTER to release any of my medical information to my insurance for assistance in claim filing.

PATIENT/ GAURDIAN SIGNATURE: _____DATE: _____