Welcome to New England Spine Institute, PC.

In order to best meet your chiropractic needs, please complete the attached forms.

Medicare: The following information is necessary to initiate your claim.

We will require a copy of your Medicare card. If you have supplement health insurance, we will require a copy of your card.

We ask that you sign the attached Medicare Advance Beneficiary Notice (ABN) because Medicare pays for only a portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services and goods that may be necessary during care.

Medicare will deny payment for your initial examination and consultation. If you are an established patient presenting with a new problem or you have not been seen in the last six months, Medicare will deny payment for a reexamination.

Please fill out the Release of Records with the name and address of any specific physician or other person you would like to receive a copy of your evaluation.

We thank you for your cooperation and if you have any questions, please do not hesitate to ask.

Sincerely,

New England Spine Institute, PC
www.nespineinstitute.com

REGISTRATION FORM

(Please Print Clearly)

Today's Date _____/_____/_____ For office use only - Chart No. _____________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs. ❑Miss ❑ Ms. ❑ Dr.	Marital Status (select one) ❑ Single / ❑Mar / ❑ Div ❑ Sep / ❑ Wid

Social Security No.	Home Phone No. ( )	Cell Phone No. ( )	Birth Date / /	Age	Gender ☐M ☐F

Street Address	City	State	ZIP Code	Email Address

Occupation	Employer	Employer Phone No. ( ) Ext _____

Employer Address	City	State	ZIP Code

Who may we thank for referring you? ❑ Patient _________________ ❑ Dr. ____________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________________

Primary Care Physician (PCP)	PCP Street Address	PCP Phone No. ( )

WORK OR AUTO ACCIDENT INFORMATION (PLEASE FILL OUT ALL INFORMATION REQUESTED IF APPLICABLE)

Is Injury Work or Auto related? ❑ Yes ❑ No	Date of Injury / /	Name/Address of Insurance Carrier (For Claims)	Adjusters Name and Phone No.
Claim No.	Injury reported? ❑ Yes ❑ No		( )

Attorney Name	Attorney Address	Attorney Phone No. ( )

COMMERCIAL INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)

Is patient covered by insurance? ❑ Yes ❑ No Primary Insurance Type ❑ HMO ❑ PPO ❑ Indemnity ❑ Other __________

Please indicate primary insurance ❑ MEDICARE ❑ MASSHEALTH ❑ BCBS ❑ TUFTS ❑ HARVARD

❑ CIGNA ❑ UNITED HEALTHCARE ❑ GIC ❑ HCVM ❑ Other ____________________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I assign directly to **New England Spine Institute, PC** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Name:____ Date:__________________ File:____________

Pain Diagram

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.

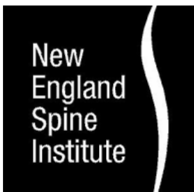
Numbness - - - -   Pins & Needles oooo   Burning xxxx   Aching ****   Stabbing ////

L   R

R   L   L   R

Please circle the number that best indicates the severity of your complaint right now.

Neck Pain	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worse Pain Imaginable
Low Back Pain	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worse Pain Imaginable
Other_________	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worse Pain Imaginable



225 South Franklin Street
Holbrook, MA 02343
Phone: (781) 767-5555
Fax: (781) 767-9751

Southeast Medical Center
One Compass Way
East Bridgewater, MA

Date: _____/_____/_____ File #: ________________

HEALTH HISTORY

Name: *(Last, First, M.I.)*	☐ M ☐ F	DOB _____/_____/_________

What is the reason for your visit?

What do you think caused this problem?

PERSONAL HEALTH HISTORY

Please list any current medical conditions or symptoms you are currently experiencing, or have experienced during the past year:

Please tell us about any hospitalizations, serious illnesses or surgeries:

Year	Reason	Hospital	Outcome

List your prescribed medications, over-the-counter medications, herbs, vitamins and inhalers:

Name	Dosage	Frequency Used

Please provide details of any known allergies. (e.g., latex, medications, foods)

Allergen	Reaction

HEALTH HABITS	
Exercise:	☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous Exercise (i.e., work or recreation, less than 4x/week for 30 min.) ☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
Diet:	Are you dieting? .... ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet? .... ☐ Yes ☐ No # of meals you eat in an average day?______________ Please rate the quality of your diet: *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible*
Caffeine:	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day? ______
Alcohol:	How many alcohol containing beverages do you consume: daily _____ weekly_____
Tobacco:	Do you use tobacco? .... ☐ Yes ☐ No ☐ Cigarettes - # Pks/day_____ # of Years _____ ☐ Year Quit _____
Sleep:	Does your complaint disrupt your sleep? ☐ Yes ☐ No How do you rate the quality of your sleep? *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible* Do you use a special neck pillow? ☐ Yes ☐ No
Stress:	Please rate your stress management strategies: *Perfect* 0 1 2 3 4 5 6 7 8 9 10 *Terrible* Please rate your daily stress level: None 0 1 2 3 4 5 6 7 8 9 10 *Terrible*
Pregnancy / Children:	# pregnancies _______ # Birth children _____ # Cesarean sections_____

FAMILY HEALTH HISTORY

Please help us to identify your potential health risks by placing a check in any column that applies to you or your blood relatives.

Condition / Body System	Self	Grandparent	Parent	Sibling	Child
Aids / HIV					
Arthritis					
Bleeding disorders					
Cancer					
Endocrine / glandular (diabetes, thyroid)					
Hepatitis					
Immune					
Stroke / TIA					
Circulatory Problems (blood vessels, heart)					
Ear, Nose, Throat					
Heart Problems					
High blood pressure					
Neurological (brain, nerves)					
Gastrointestinal (stomach, intestines)					
Muscle / Joint / Bone					
Genitourinary (urinary, kidney, prostate)					
Psychological					
Respiratory (lung, breathing)					
Skin					

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

______________________________ ______________________________

Patient Signature **Date**

Patient's Guide to Insurance Verification

We encourage you to verify your insurance benefits and have developed the following guide to assist with the process. Please record all relevant information to cross-check with our verification process.

You will find a customer service number on your insurance card. Please contact a service representative and ask the following questions about each recommended service.

It is always recommended that you record the name of the person with whom you discussed your coverage.

Name: Date: ____________________

Treatments that we commonly provide include the following:

Procedure	Procedure Code	
Examination	99211-99215	[ ] Yes [ ] No
Spinal manipulation	98940	[ ] Yes [ ] No
Ultrasound	97035	[ ] Yes [ ] No
Electrical muscle stimulation	97014	[ ] Yes [ ] No
Exercises and stretches	97110	[ ] Yes [ ] No
Massage	97140	[ ] Yes [ ] No

Please ask the following questions.

Is my provider covered / part of your network? [ ] Yes [ ] No If no, ask next question

Is there an out of network benefit? [ ] Yes [ ] No Details: ________________________________

Do I need a primary care physician referral? [ ] Yes [ ] No

Is there a deductible? [ ] Yes [ ] No Amount: ____

Has it been met this year? ____Yes______ No

How many treatments may I receive?____

Is there a maximum allowable payment for each service? ____________ Amount: _________________

Can you send me confirmation of this conversation? [ ] Yes [ ] No Confirmation #: ____________________

As you complete this process, please feel free to call our Patient Services Manager, Nancy Morgan at 781-767-5555. If you would like to cross check the information that you obtain, please fax this form to 781-767-9751. As always, we request your feedback on how we might improve this form.

Credit / Financial Policy

Restoring your health is our foremost objective. Our treatment will always be rendered solely on the base of need. Please advise us if you are unable to fulfill this policy so that we may discuss and consider alternative payment options. We require payment at the time of service unless special arrangements have been previously made. Our fees comply with the "usual and customary" rates for this region. We accept cash, checks and some credit cards. For patients who are unable to pay at the time of service, special arrangements are available upon request.

REGARDING ALL INSURANCE We cannot promise that an insurance company will pay for your care, even when it is preauthorized. We will submit bills to your insurance carrier, but will not become involved in disputes between the insured and the insurance company. This courtesy will commence as soon as we are able to confirm coverage for chiropractic services and have the proper, signed insurance forms. Payment of non-covered and services balances, co-payments and deductibles is expected at the time of services. We strongly urge you to contact the insurance company to verify your benefits; sometimes incorrect information is provided to us.

If an insurance company fails to pay for services within ninety days, the undersigned is responsible for payment. Ultimately, you are responsible for all outstanding balances. If the insurance company erroneously pays directly to the insured, the amount shall be forwarded to this office within three days.

MEDICARE: Medicare pays for only a portion of chiropractic services and limits the number of reimbursable treatments. Reimbursable care is limited to spinal manipulation and does not include other therapies, services and goods that may be necessary during care. Please be advised of the following Medicare restrictions and regulations.

- Medicare will pay for a maximum number of treatments per calendar year, based on your diagnosis. When the maximum number of treatments has been rendered, payment is expected at the time of service.
- Medicare will not pay for an initial examination. This fee is the patient's responsibility and will not apply to the patient's deductible.

PERSONAL INJURY, WORKER'S COMPENSATION AND/OR LITIGATION: If your complaint is the result of an occupational or automobile accident, or if litigation is pending, please notify us. If an attorney is involved, patients are required to sign a Physician's Lien that will be forwarded to the attorney for signature. If we do not receive the signed lien from the attorney within fourteen days, all services must be paid for by the patient at the time rendered. It is our policy to bill the insurance company directly and will provide the attorney with a monthly statement.

Instances will arise when we exhaust all reasonable efforts to secure payment from your insurance company, but the insurance company refuses payment. We will do our best to assist you in securing payment, but all balances are ultimately your responsibility.

MISSED APPOINTMENTS: There is a $30.00 charge for missed appointments without a 24 hour notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointments. We may request a deposit for future appointments. If more than three appointments are missed without notification, we will recommend that you seek treatment at another facility, or schedule care when you are able to commit to the recommended treatment program.

In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

I have read this policy and understand that I am financially responsible for all unpaid balances for my care.

Patient Signature:____ Date:_________________

Reviewed by:____ Date:_________________

I have been offered / received a copy of the New England Spine Institute, PC Notice of Privacy Practices.

____

RELEASE OF RECORDS

Date: ______________________

Patient Name: ____ Date of Birth:_______________

I request and authorize New England Spine Institute, PC to release my chiropractic records to the organization, agency, or individuals named below.

I certify that this request has been made voluntary and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Re-disclosure of my medical records by those receiving the above-authorized information may not be accomplished without further written consent. Without my expressed revocation, this consent will automatically expire upon satisfaction of the need for disclosure, or, not later than _____________.

Please release my records to:

☐ Primary Care Physician:

____

____

☐ Other Physicians:

____

____

____

☐ Attorney:

____

____

☐ Myself / Other:

____

____

(Signature of patient or person authorized to sign for patient)

____

(Relationship to patient of person authorized to consent)

☐ I decline your offer to send records to any of the above and will advise you in writing if I wish you to do so in the future. ____

(Signature of patient or person authorized to sign for patient)

HOLBROOK
225 South Franklin Street
Holbrook, MA 02343
Phone: (781) 767-5555
Fax: (781) 767-9751

SOUTHEAST MEDICAL CENTER
One Compass Way
East Bridgewater, MA
(508) 350-2920
Fax: (508) 250-2317

SOUTHEAST MEDICAL CENTER
At Stonewood Health and Fitness
160 Main Street
Carver, MA 02330
508-866-7555