Please check which one applies to you

Typically, no insurance coverage is 100%, but if you have any benefits for chiropractic coverage for our office, we certainly will do everything we can to help your out of pocket expenses be as low as possible.

O **No Insurance:** Easy! Our care plans and simple payment plans have helped over thousands of people and will work great for you too!

O **Health Insurance / HSA:** Many insurances today pay very little or limited amounts for natural drugless care to get you healthy. We make it easy! We verify any benefits you have and file these claims directly to your insurance company. You are responsible for any deductibles, co-pays, co-insurance, and unpaid visits. For your convenience, all payment arrangements are made in advance.

O **Auto Injury:** Auto accidents are typically covered at 100%, even if you were at fault, not at fault, or were a passenger. You can get the care you need and it costs nothing. Great for you! All we need is a claim #, insurance information, and / or your attorney's information.

O **Work Injury:** Work injuries are covered 100% for between 12-24 visits. All we need is your claim # and worker's comp information.

O **Medicare:** Regardless of your condition, Medicare pays for a maximum of 12 weeks of care. They have strict rules and limitations and do NOT cover all office services. When benefits are exhausted, you are eligible for a significant discount.

O **VA (Veteran's Administration)**: We love helping our veterans. You will need a direct referral and authorization. Typically, 12 total visits are allowed per year. Certainly, this helps cover the cost of some of your initial care! VA does not cover all of our servives.

Initial ___

Patient History: Dr. Sheppard, D.C.

Name: _____ Who can we thank for referring you? _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail (please **print** clearly): _____

Birthdate: _____ Sex: _____ Age: _____ Marital Status: _____ Number of Children: _____

Occupation: _____ Employer: _____

Emergency contact name and phone number: _____ Relationship: _____

Social Security Number: _____ Medical doctor name: _____

REMEMBER: ALL INFORMATION YOU GIVE IS CONFIDENTIAL

Major Complaints #1: _____

Major Complaints #2: _____

Major Complaints #3: _____

Other symptoms / health issues: _____

How long have you had your condition(s)? _____

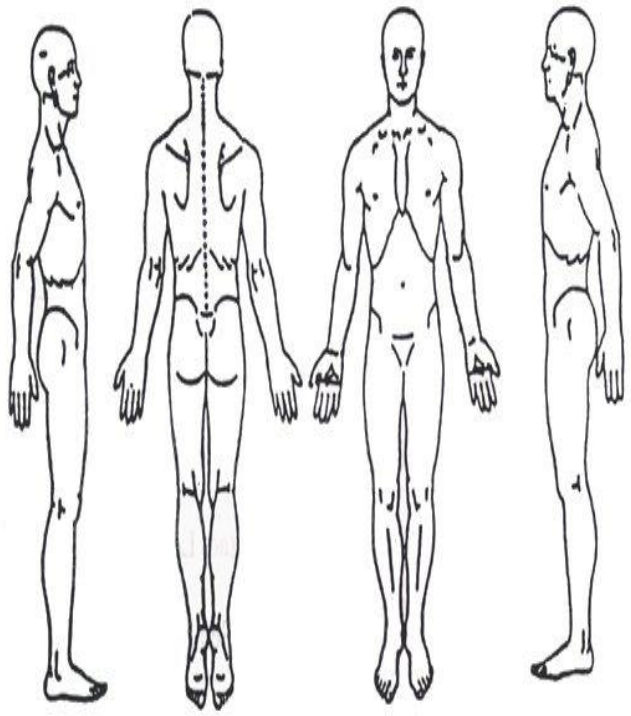
Have you missed any work due to this? Yes / No If so, how much? _____

Have you had this similar condition before? Yes / No When? _____

Have you ever been to a chiropractor? Yes / No

PLEASE CHECK THE BOXES AND MARK THE PAINFUL AREAS

Past	Present	Condition
O	O	Headaches
O	O	Migraines
O	O	Arthritis
O	O	Allergies / Asthma
O	O	Anemia
O	O	Joint pain
O	O	Depression
O	O	Irritability
O	O	Sinus problems
O	O	Bruise easily
O	O	Frequent colds
O	O	Fatigue / low energy
O	O	Trouble sleeping
O	O	Shortness of breath
O	O	Chest pain / tightness
O	O	Anxiety
O	O	Dizziness
O	O	Heart problems
O	O	Vision trouble
O	O	Vertigo
O	O	Stroke
O	O	Infectious diseases
O	O	Prostate problems
O	O	Uterus problems
O	O	Tobacco use
O	O	Pacemaker
O	O	Pregnancy



How would you like to have your problem handled? (check which one)

O Temporary Relief: Help the symptom, but do not fix the underlying cause of the problem.

O Maximum Allowable Correction: Correct the underlying cause while optimizing my future health.

Why did you choose this office and what are "your" expectations? _____
_____
_____

On a scale from 1-10: (10 being the most and 1 being the least)
How committed are you from the following?
_____ Being at your maximum health potential.
_____ Your family to be at their maximum health potential.
_____ Preventing spinal arthritis.
_____ Preventing degenerative disc disease.
_____ What is your pain level today?

Check if you have had the following surgeries: (what kind and when?)
O Spine _____
O Hip _____
O Knee _____
O Foot / Ankle _____

List medications you currently take (prescription and over the counter): _____
_____
_____

Who else have you seen for this condition?

O Family doctor / PA
O Orthopedic / Neurologist
O Physical therapist
O Chiropractor
O Massage therapist
O Other _____

AUTHORIZATIONS: (I agree)

Dr. Sheppard (Wellness One of Hickory, Inc.) can release or request records as needed for my care.
Authorize assignment of any insurance benefits (if applicable) paid directly to the provider.
Authorize the staff and doctor to render care as deemed appropriate for me, my child, or my children.
After any initial promotional offers, fees are rendered at usual and customary.
I am responsible for all bills incurred at this office.
I authorize this office to send my x-rays to any board-certified radiologist if deemed necessary for a review.

Please feel free to discuss all of our fees with us as it relates to your care. Fees are payable when services are rendered unless other arrangements are made in advance. Auto accidents, work injuries, and VA (Veteran's Administration) typically are not the patient's per visit responsibility.

Signature: _____ Date: _____

A. Notifier:

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.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
• X-ray • Examination • Therapy • Decompression	**Medicare is responsible for treatment of subluxation documented by X-ray or exam. If the condition does not improve, the condition is considered chronic care and is a non-covered service.**	

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:

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