Dr. Jennifer M. Wells, D.C.
and Associates

NEW PATIENT INTAKE FORM

PERSONAL INFORMATION

First Name:_____ **MI:**____ **Last Name:**_____ **Preferred Name:**_____

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

Birthdate:____/____/____ **Age:**_____ **Gender:** ☐ Male ☐ Female ☐ Unspecified **SSN:**_____-_____-_____

Primary Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Email:_____

By providing my email address, I authorize my doctor to contact me via the email address provided.

Preferred Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Occupation:_____ **Employer:**_____

Status: (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated **Children?:** ☐ Yes ☐ No How Many:_____

Spouse's Name: (if applicable)_____

Emergency Contact: (Name, Relationship, Phone #)_____

How were you referred to Back Country Chiropractic?:_____

INSURANCE OR PRIVATE PAY INFORMATION

Type of Insurance: ☐ Private Insurance ☐ Medicare ☐ Auto Insurance ☐ Worker's Comp ☐ Other_____

Primary Insurance Carrier:_____ **Phone:**_____

Policy #:_____ **Group #:**_____ **Claim #:**_____

Name of Policy Holder:_____ **Relationship to Patient:**_____

Policy Holder's Birthdate:____/____/____ **Policy Holder's SSN:**_____-_____-_____ **Employer:**_____

Is patient covered by another insurance? ☐ Yes ☐ No

Secondary Insurance Carrier:_____ **Phone:**_____

Policy #:_____ **Group #:**_____ **Claim #:**_____

Name of Policy Holder:_____ **Relationship to Patient:**_____

Policy Holder's Birthdate:____/____/____ **Policy Holder's SSN:**_____-_____-_____ **Employer:**_____

ASSIGNMENT/AUTHORIZATION/RELEASE/ACKNOWLEGEMENT: (check all applicable boxes and initial)

☐ I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Back Country Chiropractic all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. **Initial:**_____

☐ Some Insurance plans are not allowing any treatment other than a basic adjustment or manipulation 98940 paid code that is medically necessary only. Therefore, any "extraspinal" adjustments or treatments by the doctor, to include massage by the doctor 97124, flexion-distraction 97012, or electrical stimulation 97014 *MAY* be an additional $10 to $25 fee on top of your regular co-pay or insurance. Also, any care deemed not medically necessary by your insurance will be reduced to our out-of-pocket daily fee schedule. **Initial:**_____

☐ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Person responsible for this account:_____ **Initial:**_____

☐ **Cancellation or No-Show Fees:** Cancellations for adjustments or massages without a 24-hour notice may be subject to a $25 fee for adjustments, $30 for 1-hour massages, and $15 for half-hour massages. **Initial:**_____

☐ **A Credit Card on File Requirement:** By checking this box, I authorize my credit card on file to be charged if not paid for at the time of service for the following: deductibles, co-insurance, non-covered therapies as stated above, cancellations without a 24-hour notice, and no-show fees or any care deemed not medically necessary by my insurance company. **Initial:**_____

CC #:_____ _____ _____ _____ **Exp. Date:**____/____ **CVV:**_____ **Signature:**_____

Signature of Patient, Parent, or Legal Guardian: X_____ **Date:**_____

REASON FOR VISIT

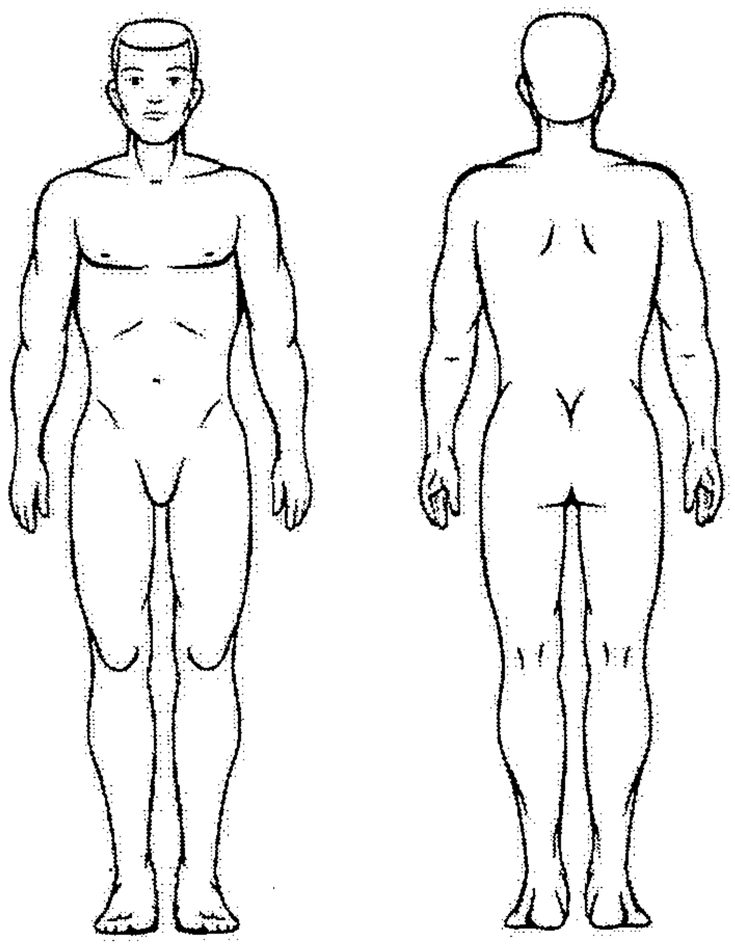
What is the reason for your visit today? ☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain ☐ Other_____

What caused this complaint(s)?_____

When did this complaint begin?____/____/____ **Is it getting worse?** ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Have you had this or similar complaint in the past? ☐ Yes ☐ No If "Yes", when?_____

What does your complaint(s) feel like? Circle all that apply: *Sharp / Dull / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Numbness / Other:*_____



← Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.

Area for doctor's notes:

On the scale below, please circle the severity of your main complaint right now:

No Pain				*Moderate Pain*					*Worst Possible Pain*
1	2	3	4	5	6	7	8	9	10

What area(s) does the pain radiate, shoot, or travel to? (if applicable)_____

What aggravates this complaint(s)? Circle all that apply: *Sitting / Standing / Walking / Getting Up From Seat / Walking Stairs / Inactivity / Sleeping / Physical Activity / Exercise / Movement / Bending Forward / Bending Backward / Twisting / Reaching / Lifting / Desk Work / Coughing / Everything / Unknown / Other:*_____

What relieves this complaint(s)? Circle all that apply: *Sitting / Standing / Walking / Resting / Exercise / Movement / Stretching / Massage / Chiropractic / Heat / Ice / Lying Down / Medication / Acupuncture / Nothing / Other:*_____

Are you interested in learning more about acupuncture: ☐ Yes ☐ No

How often do you experience your symptoms? ☐ 25% of the day ☐ 50% of the day ☐ 75% of the day ☐ 100% of the day

Time of complaint: Check appropriate box: ☐ Morning ☐ As day progresses ☐ Afternoon ☐ Evening ☐ While sleeping

☐ During activities ☐ After activities ☐ Symptoms are constant and do not change ☐ Other:_____

With time, are your symptoms: ☐ Improving ☐ Worsening ☐ Not changing

Have you seen other doctors for this complaint? ☐ Yes ☐ No If "Yes", please provide the following information:

Doctor's Name:_____ Date Consulted:____/____/____ Diagnosis:_____

Is this condition interfering with your: Circle all that apply: *Sleep / Getting in or out of bed or chair / Personal care / Travel / Work / Recreation / Lifting / Walking / Standing / Daily routine / Social activities / Exercise / Other:*_____

Is your complaint interfering with your daily activities? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

NAME:_____ **DATE:**_____

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.				**Family History** Mark **ALL** conditions that run in your family	Relationship: (Father, Mother, Sister, Brother)
☐	Osteoarthritis/Degenerative Joint Disease	☐	Whiplash Injury *Date of injury:*	☐ Cancer *Type:*	
☐	Asthma	☐	Headaches	☐ Anemia	
☐	Diabetes ☐ Type I ☐ Type II Was your blood/lab work test for hemoglobin A1c > 9.0%? ☐ Yes ☐ No ☐ Not Sure	☐	Joint Pain (circle location of pain): Shoulder, Elbow, Hip, Knee, Ankle Other:_____	☐ Diabetes (check one) ☐Type I ☐ Type II	
☐	Anemia	☐	Migraines	☐ Heart Problems / Stroke	
☐	Cancer/Tumor	☐	Osteoporosis /Osteopenia	☐ High Blood Pressure	
☐	Rheumatoid Arthritis	☐	Epilepsy / Seizures	☐ Genetic Disorders	
☐	Depression/ Anxiety	☐	Fibromyalgia / Chronic Fatigue	☐ Rheumatoid Arthritis	
☐	Disc Herniation	☐	Genetic Disorders	☐ Other (List):	
☐	High Blood Pressure /Hypertension	☐	Please list any other medical conditions:		
☐	Heart Disease / Stroke				

WOMEN ONLY: **Currently Pregnant?** ☐ Yes ☐ No **Painful /Abnormal Menstrual Cycle?** ☐ Yes ☐ No **Menopause?** ☐ Yes ☐ No
Miscarriage? ☐ Yes ☐ No **Do you have children?** ☐ Yes ☐ No **If "Yes"**, type of birth? **Circle** Vaginal or C-Section

FRACTURES (Broken Bones, Sprains, Strains, Major Trauma/Injury (List and Date:)

_____

_____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ☐ Yes ☐ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** ☐

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any known allergies you have had to prescription medications. If NO medication allergies are known, check here ☐

1._____ 2._____

SOCIAL HISTORY

Do you exercise? ☐ Yes ☐ No **Times per week?** **Intensity?** ☐ Light ☐ Moderate ☐ Strenuous **Type?**

Do you currently smoke tobacco of any kind? ☐ Yes ☐ Former smoker ☐ Never been a smoker

If "Yes", how often do you smoke: ☐ Current every day smoker ☐ Current sometimes smoker **Circle level below ↓:**

If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

Do you drink alcohol? ☐ Yes ☐ No **How many drinks per week?** **For how many years?**

Do you drink caffeine? ☐ Yes ☐ No **How many drinks per day?** **What type?** ☐ Coffee ☐ Tea ☐ Soft Drinks ☐ Energy Drinks

Do you take pain killers? ☐ Yes ☐ No **How often?** ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely
What type? ☐ Aspirin ☐ Ibuprofen ☐ Tylenol ☐ Other_____

What do your work duties include? ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor ☐ Other:

Please describe your overall health right now? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What is your current stress level? ☐ Mild ☐ Moderate ☐ High

Have you seen a chiropractor in the past? ☐ Yes ☐ No **If so, when was your last treatment?**

What are your hobbies?

NAME:_____ **DATE:**_____

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment:

The primary treatment I use, as a Doctor of Chiropractic, is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- Spinal Manipulative Therapy
- Orthopedic Testing
- EMS
- Palpatation
- Basic Neurological Testing
- Ultrasound
- Vital Signs
- Laser Treatment
- Hot/Cold Therapy
- Range of Motion Testing
- Postural Analysis
- Radiographic Studies
- Other (please explain)_____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatments. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

1. Self-administered, over-the-counter analgesics and rest
2. Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
3. Hospitalization
4. Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE <u>CHECK THE APPROPRIATE BOX AND SIGN BELOW</u>:

☐ **I have read** or ☐ **have had read to me** the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor of Chiropractic at Back Country Chiropractic and have had my questions answered to my satisfaction. I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any staff member at Back Country Chiropractic responsible for any errors or omissions that I may have made in the completion of this form. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name:_____ **Signature: X**_____ **Date:**_____

Physician's Name:_____ **Signature: X**_____ **Date:**_____

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present, or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as to back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgement for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here **X**_____. Effective as of the date of first professional services.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Name:_____ **Signature: X**_____ **Date:**_____

Parent or Guardian:_____ **Signature: X**_____ **Date:**_____

Witness Name:_____ **Signature: X**_____ **Date:**_____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

May we phone, email or send you a text to confirm appointments? ☐ Yes ☐ No

May we leave a message on phone numbers or with any family members? ☐ Yes ☐ No

May we discuss medical condition with any member of your family? ☐ Yes ☐ No

If so, list name(s) of member(s) allowed?_____

_____

Patient Name (print):_____

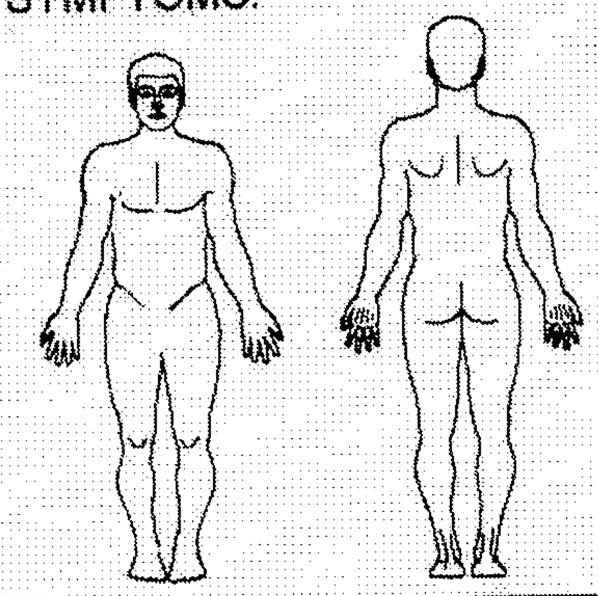
Signature of Patient, Parent, or Legal Guardian: X_____ **Date:**_____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
California Only Fax: 877.427.4777 All Other States Fax: 877.304.2746

INITIAL HEALTH STATUS
Chiropractic

Patient Name_____ Birthdate_____ Gender: 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? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

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**_____

American Specialty Health (ASH)
P.O. Box 509001, San Diego, CA 92150-9001
Fax: 877.248.2746

MEMBER BILLING ACKNOWLEDGMENT
For Medicare Advantage Member

For questions, please call ASH at 800.972.4226

IMPORTANT NOTICE: You may have additional coverage options for these services through your Medicare Advantage plan. If you have not received an Integrated Denial Notice from ASH or your Medicare Advantage plan, we recommend that you contact your health plan to inquire regarding coverage for these services prior to signing this form.

I, _____ (Name of Patient/Member/Subscriber), a member being treated by Jennifer M. Wells, D.C. (Practitioner Name)

do hereby acknowledge that a certain portion of my care will not be covered by my Medicare Advantage plan with _____ (Name of Health Plan).

I understand and agree to be responsible to self-pay for the following services:

LIST OF SERVICES TO BE PAID FOR BY MEMBER:

Date	Procedure	Charge
	Massage (1-unit by Doctor) $/or +traction	$ 10.00
	Massage by staff or therapist	$ 10.00 → 75.00+
	Supportive or Maintenance Care	$ 50.00+
	Deluxe Cervical Pillow/Ice Pack/supports/supplements/vitamins	$ 10.00 → 80.00+
	Laser Therapy	$ up to 30.00 ea.+x

Separately list each date of service on which non-covered services will be rendered and have the member initial the charge. Please attach additional Member Billing Acknowledgment for Medicare Advantage Member form(s) for additional services.

This form is only to be used if an ASH member desires to self-pay for non-covered services. Non-covered services include services such as supplements that are not covered by the member's health plan. Non-covered services may also include services determined by ASH to be maintenance-type services.

The ASH Contracted Practitioner may not bill the member during the course of an ASH approved treatment program unless there is a copayment, deductible, coinsurance, or the member is receiving non-covered services.

The ASH Contracted Practitioner may not bill the member for the difference between what the ASH Contracted Practitioner bills and what the ASH Contracted Practitioner agreed contractually to accept as payment for services. This difference represents an amount the ASH Contracted Practitioner agreed contractually to waive.

This agreement may not be used as a "blanket" or "retroactive" agreement to bill members for any services not reimbursed by ASH. Such use will render this agreement "void" and non-binding on the member. This agreement may only be used to allow the member to agree to "self pay" for specific services **in advance**.

I acknowledge that I have received my Integrated Denial Notice explaining my denial rights, reviewed my coverage options, and have been told in advance of treatment what portion of my care I will have to pay for,

and agree to make financial arrangements with my practitioner, Jennifer M. Wells, D.C. (Practitioner Name), to pay for these services myself.

Dated at _____ (city), _____ (state) this _____ (date) day of _____ (month), 20_____ (year).

_____ Member Signature
(Guardian must sign for all members 17 years or younger)

_____ Member Health Plan ID#

_____ Practitioner Signature

_____ Date