



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

# PATIENT UPDATE 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/ACKNOWLEDGEMENT: (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 \$20 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 fee as follows: \$30 for adjustments, \$45 for half-hour massages, \$85 for 1-hour massages, and \$50 for new patient no-show appointments. 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**

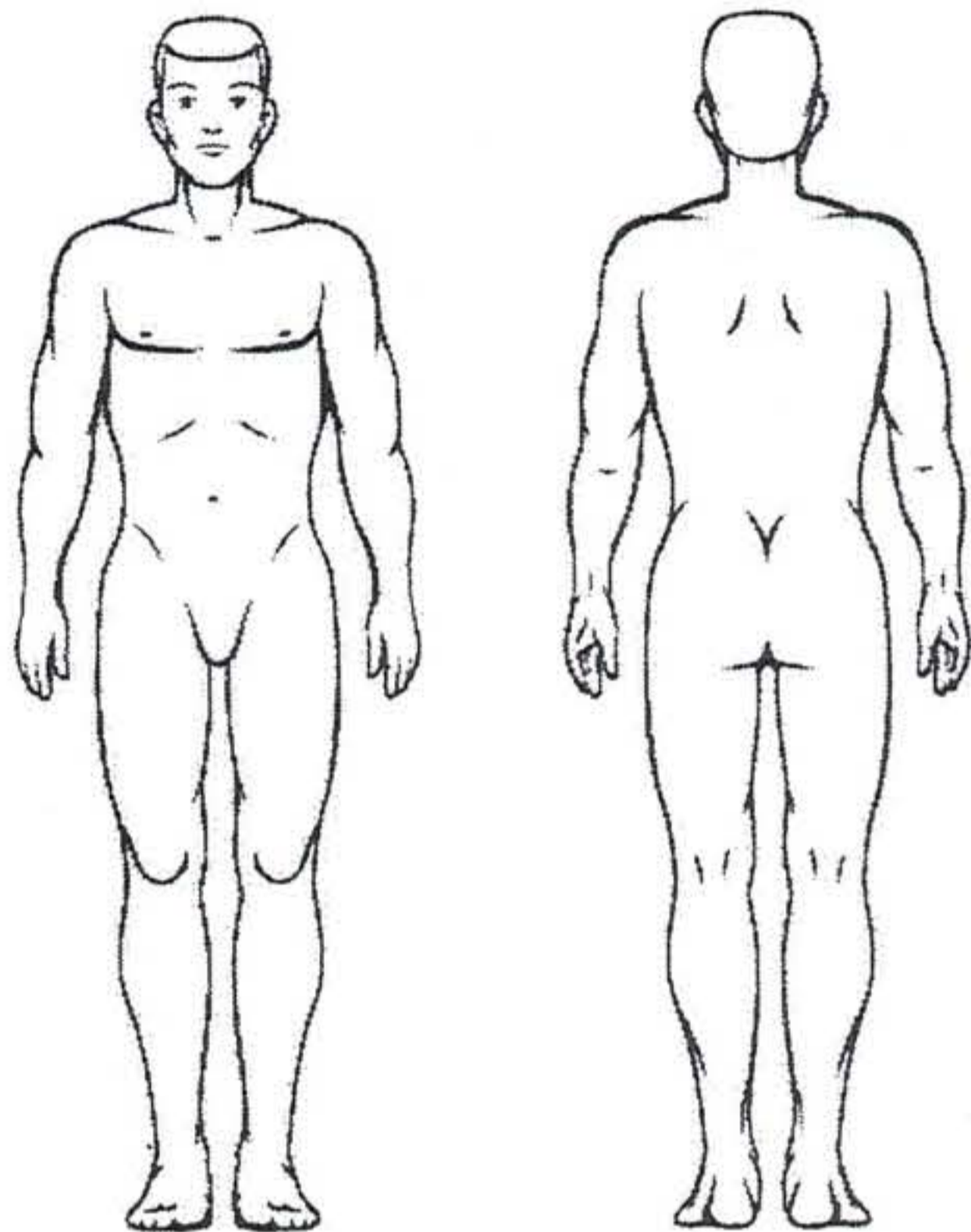
What is the reason for your visit today?  Headache  Neck Pain  Mid-Back Pain  Low Back Pain  Other\_\_\_\_\_

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

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**SURGERIES and/or HOSPITALIZATIONS (List and Date):**

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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.	5.	6.	7.
1.					
2.					
3.					

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? <input type="checkbox"/> Yes <input type="checkbox"/> No Times per week? Intensity? <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous Type?	
Do you currently smoke tobacco of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> Former smoker <input type="checkbox"/> Never been a smoker	
If "Yes", how often do you smoke: <input type="checkbox"/> Current every day smoker <input type="checkbox"/> Current sometimes smoker <u>Circle</u> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per week? For how many years?	
Do you drink caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No How many drinks per day? What type? <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soft Drinks <input type="checkbox"/> Energy Drinks	
Do you take pain killers? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely	
What type? <input type="checkbox"/> Aspirin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Tylenol <input type="checkbox"/> Other _____	
What do your work duties include? <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor <input type="checkbox"/> Other:	
Please describe your overall health right now? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
What is your current stress level? <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> High	
Have you seen a chiropractor in the past? <input type="checkbox"/> Yes <input type="checkbox"/> 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  | • Palpation                  | • Vital Signs      | • Range of Motion Testing |
| • Orthopedic Testing           | • Basic Neurological Testing | • Laser Treatment  | • Postural Analysis       |
| • EMS                          | • Ultrasound                 | • Hot/Cold Therapy | • 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 CHECK THE APPROPRIATE BOX AND SIGN BELOW:**

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: \_\_\_\_\_

## 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: \_\_\_\_\_

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:**

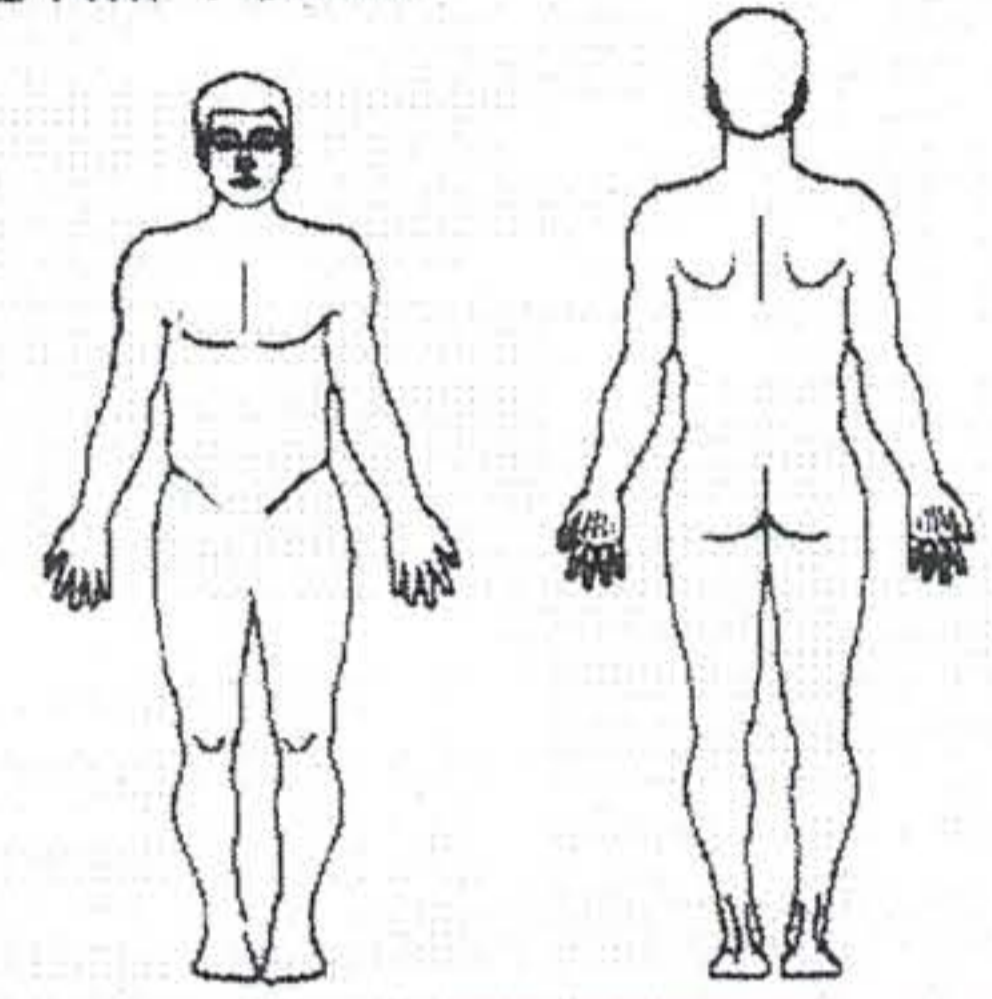
- Headache  Neck Pain  Mid-Back Pain  Low Back Pain  
 Other \_\_\_\_\_

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)?

\_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10  
 No interference 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:

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol/Drug Dependence                          | <input type="checkbox"/> Prostate Problems   |
| <input type="checkbox"/> Recent Fever                                     | <input type="checkbox"/> Menstrual Problems  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> High Blood Pressure                              | <input type="checkbox"/> Currently Pregnant, # Weeks _____   |
| <input type="checkbox"/> Stroke (Date) _____                              | <input type="checkbox"/> Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss |
| <input type="checkbox"/> Corticosteroid Use (Cortisone, Prednisone, etc.) | <input type="checkbox"/> Marked Morning Pain/Stiffness   |
| <input type="checkbox"/> Taking Birth Control Pills                       | <input type="checkbox"/> Pain Unrelieved by Position or Rest   |
| <input type="checkbox"/> Dizziness/Fainting                               | <input type="checkbox"/> Pain at Night   |
| <input type="checkbox"/> Numbness in Groin/Buttocks                       | <input type="checkbox"/> Visual Disturbances   |
| <input type="checkbox"/> Cancer/Tumor (Explain) _____                     | <input type="checkbox"/> Surgeries _____   |
| <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Tobacco Use - Type _____  |
| <input type="checkbox"/> Epilepsy/Seizures                                | Frequency _____/Day  |
| <input type="checkbox"/> Other Health Problems (Explain) _____            | <input type="checkbox"/> 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 \_\_\_\_\_

# 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, \_\_\_\_\_, a member being treated by Dr. Jennifer Wells, D.C. #/or Associate  
(Name of Patient/Member/Subscriber) (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 By Doctor / Therapist	\$ 20.00 / 45-85.00
_____	Maintenance / Supportive Care	\$ 65.00
_____	Ice Packs / Deluxe Pillow / Supports	\$ 10.00 - 60.00
_____	Laser Treatment (Class N laser)	\$ 30.00 per tx
_____	Treatment / Exams deemed not medically necessary	\$ 65.00 - 75.00

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**.

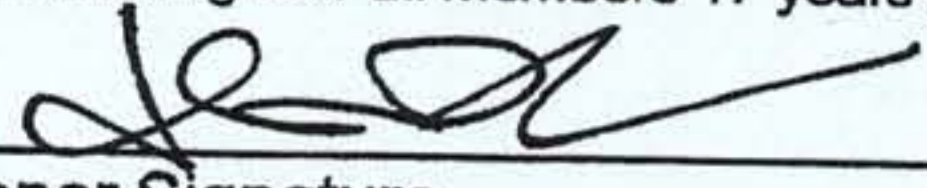
I acknowledge that I have received my Integrated Denial Notice explaining my denial rights, reviewed my coverage options, and have been told in advance of treatment what portion of my care I will have to pay for,

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

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

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

Member Health Plan ID# \_\_\_\_\_



Practitioner Signature  
MbrBillingAckMA070115.docx

Date \_\_\_\_\_