Patient Information

Date:_____

Last Name: _____

First Name:_____Prefer:_____

Middle Initial:_____

Address:_____

City:_____ State:_____ Zip:_____

Birth Date:_____SSN:_____

☐Married ☐Widowed ☐Single ☐Divorced

Home Phone:(_____)_____

Cell Phone: (_____)_____

Occupation:_____

Employer:_____

Employer Phone:(_____)_____

Spouse's Name:_____ Birthdate:_____

Children's Names/Ages:_____

_____

How did you hear about us?_____

Who can we thank for referring you?_____

Primary Care Physician:_____

PCP Phone Number: (_____) _____

Financial Agreement

Who is responsible for this account?_____

Relationship to Patient:_____

Insurance Company:_____

Group#:_____

ID#:_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscribers Name:_____

Relationship to Patient:_____

Insurance Company:_____

Group#:_____

ID#:_____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above Insurance Company(ies) and assign directly to *Dr. Maillette* all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named Doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Sign:_____

Print:_____

Date:_____

Contact Information

Cell Carrier (Ex: Sprint/Verizon):_____

Email:_____

Which do you prefer: ☐Text ☐Email

Accept Text messages? ☐Yes ☐No

Would you like electronic appointment reminders? ☐Yes ☐No

IN CASE OF EMERGENCY CONTACT:

Name:_____

Relationship;_____

PhoneNumber:(_____)_____

Current Condition Information

Current symptoms?_____

When did this condition begin?_____

Is the condition due to an accident? ☐Yes ☐No

Date:_____

Type of accident: ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Worker Comp

☐ Other:_____

Attorney Name (If applicable):_____

MAILLETTE
FAMILY CHIROPRACTIC

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TERMS OF ACCEPTANCE

When a patient seeks Chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to obtain it. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment of these findings, we will recommend that you seek the services of a health care provider that specializes in that area.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specifically adjusting to correct vertebral subluxations.

I _____ have read and fully understand the above statements.

Print Name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____

Signature **Date**

PRIVACY NOTICE

I have either read, or been offered a copy of Maillette Family Chiropractic Privacy Notice.

_____ _____

Signature **Date**

GOOD WILL ESTIMATE

The good faith estimate is **NOT** a contract and does not require the uninsured individual to obtain the items or services from any of the providers or facilities identified in the good faith estimate. I have received, read, and understand this disclosure.

_____ _____

Signature **Date**

Name:_____

AUTHORIZATION OF SERVICES/ RELEASE OF INFORMATION

I understand that my imaging studies are being sent to Professional Imaging Consultants, Inc (PIC) for interpretation and a written report by a board certified chiropractic radiologist. I understand that PIC will bill my insurance carrier and/or attorney for this service and that I am responsible for any unpaid balance (depending on insurance coverage). I authorize the release of my medical records to the insurance carrier and/or attorney. I also authorize that any payments from the insurance carrier and/or attorney be made directly to PIC. **I also understand that if I am covered by Medicare, MEDICARE DOES NOT PAY for these services.** A photocopy of this assignment will be considered as valid and effective as the original.

Patient Signature:_____**Date:**_____

NAME:_____ DATE:_____

HEALTH HISTORY - Fill out carefully as these answers can affect your overall course of care.

Are you wearing any foot supports? ☐Yes ☐No

Are you currently pregnant? ☐Yes ☐No

Previous Care for this Condition:

Have you seen other doctors for THIS CONDITION? ☐Yes ☐No

Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? ☐Yes ☐No

Explain: _____

Current Medications/ Supplements: List any you are CURRENTLY taking.

☐Attached is a list of my current medications/ supplements

Any injuries/surgeries: (Injuries such as falls, head injuries, broken bones, dislocations.)

Date	Description

Please List any allergies.

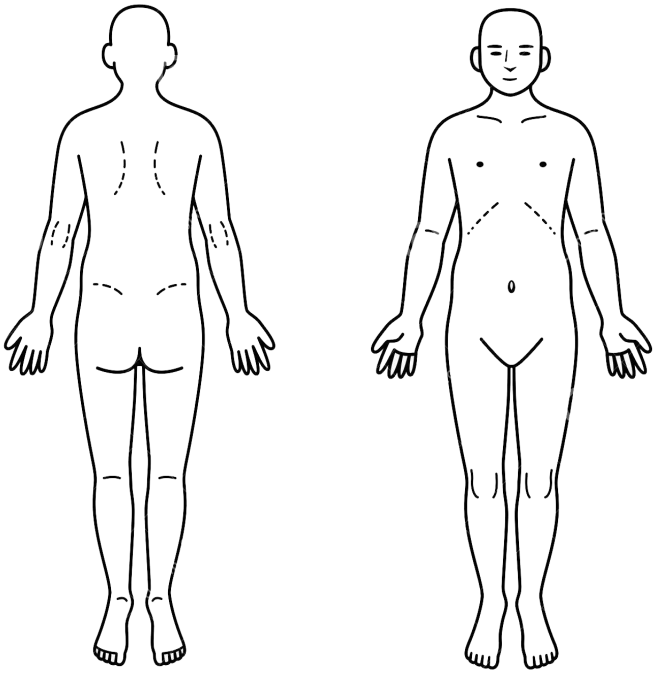
Exercise		Work Activity		Habits			
	None		Sitting		Smoking	Packs/Day	
	Moderate		Standing		Alcohol	Drinks/Day	
	Daily		Light Labor		Coffee/Caffeine Drinks	Cups/Day	
	Heavy		Heavy Labor		High Stress Level	Reason	

Family History: Write any/all that apply. List any specific conditions past or present.

Relationship	History	Deceased	Cause of Death

NAME:_____ DATE:_____

PLEASE CIRCLE ON THE DIAGRAM THE AREA OF DISCOMFORT



Rate your discomfort level 0-10 where 0= no discomfort and 10= severe discomfort.

0 1 2 3 4 5 6 7 8 9 10

What are your goals for care in our office?_____

_____

Does the above condition hinder you from any activities you enjoy? ⬜ Yes ⬜ No

If yes, explain:_____

_____

Is there anything else the doctor should know?_____

_____

Doctors Use Only

B/P	HR	O2

_____

_____

Good Faith Estimate & Disclosure Form

Patient Name:	Date of Birth:

If you do not have health insurance or choose not to bill your health insurance; or, your health benefit plan may or may not provide coverage for all the health care services you are scheduled to receive; or, our practice does not participate with your insurance:

Your health benefit plan may or may not reimburse a provider for all services provided if the provider is not in your health benefit plan network. You may be responsible for the costs of the services that are not covered by your health benefit plan.

A nonparticipating provider must provide good faith estimates of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You also may contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services that you need.

Estimated Services and Items | **Date of Appointment**

Description (in clear, understandable language)	Diagnosis Code (ICD-10 Code)	Service Code (CPT, HCPCS, DRG)	Quantity	Expected Cost
New Patient Exam		99202	1	$80-$125
Cervical X-Ray (2)		72040	1	$58.00
Thoracic X-Ray (2)		72070	1	$58.00
Lumbar X-Ray (2)		72100	1	$59.00
Spinal Manipulation		98940 /98941	R	$45.00
Traction		97012	R	$15.00
Therapeutic Massage		97124	R	$60.00
Extremity Adjustment		98943	R	$10.00
R - Recurring Services or item (valid for up to 12 months from date on this form) Highlighted Services are NOT a contract benefit		**Total Expected Charges $**		
		Date of Good Faith Estimate:		

Disclaimers:

There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. Actual items, services, or charges may differ from the good faith estimate. Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is $400 or more than your Good Faith Estimate, federal law allows you to dispute the bill.

If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.

You can contact us, let us know the billed charges are higher than the Good Faith Estimate, and ask us to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (approximately four months) of the date on the original bill.

If you dispute your bill, we cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, we are required to cease collection efforts. We must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. We also cannot take or threaten to take any retributive action against you for disputing your bill.

There is a $25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the $25 fee. If the SDR entity disagrees with you and agrees with us, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises/consumers or call 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

The initiation of the dispute resolution process will not adversely affect the quality of health care services furnished to you by our practice.