

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Bay State Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Bay State Chiropractic and my insurance company. I request that Bay State Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Bay State Chiropractic that fees will be due and payable immediately.

Patient's signature (or guardian if patient is a minor) Date

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name: _____

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a \$_____ deductible, \$_____ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.
2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a \$_____ deductible, \$_____ of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving \$_____ co-pay of each visit due by you.

Bay State Chiropractic Center **FINANCIAL POLICY**

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Health Insurance

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

“ON THE JOB” INJURY (Worker’s Compensation)

If you are injured on the job, your care should be paid for under your employer’s Worker’s Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor’s Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to **(six)** months after your care is completed.

Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is **ONLY** manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are **NON-COVERED**. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

We are preferred providers for the following companies (List Name of any HMO’s or PPO’s).

- You are required to pay a \$ _____ co-pay at the time of service.
- A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

- Benefits are available for up to _____ visits per year. A \$ _____ co-pay is due at the time of service.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a ‘flex plan’. We will be happy to provide you with a statement of your charges for reimbursement.

**Bay State Chiropractic Center
405 Frederick Road
Suite 15
Catonsville, Maryland 21228
410-744-8800 (phone) 410-744-8856 (fax)
www.baystatechiro.com**

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or canceled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Please be advised that there will be a \$50.00 fee assessed for broken and/or canceled appointments that do not fall within these guidelines.

Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Signature

Date

Bay State Chiropractic Center
405 Frederick Road, Suite 15, Catonsville, MD 21228
410-744-8800 (O)/ 410-744-8856 (FAX)

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

Patient

Signature

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) _____

Staff signature

Date

Bay State Chiropractic Center
405 Frederick Road Suite 15 Catonsville, MD 21228
(410) 744-8800 FAX (410) 744-8856
www.baystatechiro.com

Financial Policy Summary

Notice:

In an effort to maintain compliance with various State and Federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided.

You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan.
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of a DMPO we may join (ie. Chirohealth USA) Patients who are uninsured, or under-insured (limited benefits for chiropractic care), will be entitled to network discounts similar to our insured patients. Membership is \$49.00 a year and covers you and your dependents. Ask our team for more information.
- If you are eligible and choose an auto-debit plan or a “prompt payment” option.
- Patients who meet State and or Federal poverty guidelines or other special circumstances outlined in our “Hardship Policy” may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of September 1, 2016, our office will be unable to extend any type of discounts other than those offered above.

Acknowledged By: _____ **Date:** _____

Bay State Chiropractic Center Child History Form

Date: _____

Child's Name: _____ Home Phone: _____

Address: _____

Pediatrician's Name: _____ Phone Number: _____

Name of Previous Chiropractor: _____ Date of Last Visit: _____

Child's Height: _____ Child's Weight: _____ Date of Birth: _____

Parent(s) or Guardian(s): _____

I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent or Guardian Signature: _____

What are your chief concerns, if any, with your child's health?

What is your main reason for seeing us?

List any other care your child has undergone with regards to this complaint (including medication).

Date of Onset: _____

Pattern of Problem: (Circle One)
Constant Intermittent Occasional Cyclical

Duration of Problem/Episode: (Circle One)
Minutes Hours Days Months Years

Onset: (Circle One)
Sudden Gradual Associated w/ Event

Initiating Factors: _____

Aggravating Factors: _____

Relieving Factors: _____

How does this problem affect your child's body function and daily activities?

Prior occurrences or episodes: _____

Bay State Chiropractic Center Child History Form

History of Birth:

Hospital / Birthing Center: Home Medical Midwife
Was the Birth Assisted? Yes [Forceps Vacuum Extraction C-Section Induced Labor] No
Were medications given to the mother at birth? Yes (explain: _____) No
APGAR at Birth: _____ APGAR after 5 Minutes: _____ Birth Weight: _____ Birth Length: _____

Growth and Development:

Was the infant alert & responsive within 12 hours after delivery? Yes No (Explain: _____)
At What age did the child: Respond to sound? _____ Follow an Object? _____ Hold up Head? _____
Vocalize? _____ Sit Alone? _____ Teethe? _____ Crawl? _____ Walk? _____
Do their sleeping patterns seem normal? Yes No
Describe any health problems on the maternal side: (e.g. Cancer, Diabetes, etc.) _____

Paternal side:

Do the child's siblings have any health problems? Yes (Describe: _____) No

The following information is very important because many of the problems that chiropractors work with are caused by stressors.

Chemical Stressors:

During the pregnancy, did the mother do any of the following:

- 1) Smoke Yes No
- 2) Drink alcohol? Yes No
- 3) Take supplements/vitamins Yes No
- 4) Take Drugs? Yes (explain: _____) No
- 5) Become ill? Yes (explain: _____) No
- 6) Receive Ultrasounds? Yes (How many? _____) No
- 7) Receive any invasive procedures (e.g. amniocentesis, CVS, etc). Yes (explain: _____) No
- H. Was your child breastfed? Yes [For how long? _____ Weeks Months Years] No

At what age was were the following introduced?

- 1) Formula: _____ (what brand: _____) 2) Cow's Milk: _____ 3) Solid Foods: _____
- Was your child vaccinated? Yes (Which vaccines? _____) No Any Reactions? Yes No
Has your child had antibiotics Yes No If yes, how many courses and why: _____
Any pets at home? Yes (what kind: _____) No Any smokers at home? Yes (how many? _____) No

Bay State Chiropractic Center Child History Form

Psychological Stressors

Any difficulties with lactation? Yes No

Any problems bonding? Yes No

Does your child seem normal to you? Yes No

Does your child have any behavioral problems? Yes No; If yes, please explain: _____

Does your child have difficulty sleeping (e.g. night terrors, sleep walking, etc)? Yes (specify: _____) No

Does your child go to daycare? Yes (from what age: _____) No

Average no. of hours of TV/Computer use per week? _____ hrs

Traumatic Stressors

Any evidence of trauma during birth?

Bruises Oddly shaped head Stuck in birth canal Fast or excessively long birth

Respiratory Depression Cord wrapped around neck Other _____

Any falls or accidents during pregnancy? Yes No

Has the child had any major falls since birth? Yes No

If so did the fall result in a fracture or stitches? Yes (Please describe: _____) No

Any Hospitalizations? Yes (Please explain: _____) No

Does your child play sports? Yes No

Number of hours per week? _____

Age Child began: _____ yrs

Weight of school backpack? _____ lbs

Approximate no. hours spent at play per week? _____ hrs.