reviewed for completeness

<<staff initials

Welcome

North Shore Spine & Rehab
dba Woburn Family Chiropractic
20 Cummings Park
Woburn, MA 01801
ph# 781-938-9400 fax# 781-938-9323

Tell us about You

★ *this section-mandatory*
if there is anything you are not comfortable completing, please leave it blank & discuss with the staff

Today's Date

Patient Name
last first mi what should we call you?

Birthdate Age gender ☐ male ☐ female

Social Security#

Guardian Name if Minor

relationship

Mailing Address

City state zip

Home Ph#

Cell Ph#

Work Ph# ext#

Other Ph#

E-Mail Address

IT HELPS TO GET TO KNOW WHAT YOU DO & IF IT IMPACTS THE REASONS YOU ARE HERE TODAY...

Employer

what do you do?

how long ?

ARE YOU >> ☐ minor ☐ single ☐ married ☐ divorced ☐ widowed

Spouse's Name

Do you have kids? ☐ no ☐ yes If yes, how many?

☐ I DO NOT HAVE HEALTH INSURANCE ☐ I HAVE HEALTH INSURANCE

Insurance Info

★ circle ANY/ALL Insurance Coverage that applies to you

>>>continue if you have health insurance>>>

BCBS UNITED AETNA HPHC TUFTS CIGNA other

MEDICARE MEDEX AARP other SR plan(s)

MASS HEALTH NETWORK HEALTH other state plan(s)

Are you the Policy Holder ? YES NO

if you're NOT policy holder, please complete this section

★ Policy Holder Name

★ Relation ★ their DOB / /

★ different address?

Is Visit related to *(circle if appl)* **Car Accident** **Work Injury**

If so, please be sure to present any insurance or attorney info you may have upon your first visit... thanks

Please be sure to present any ins cards you hold at your visit-copy required for file

Reason for Visit

Please fill out everything that applies
if the questions below do not apply, you are not sure of the answers or you are uncomfortable answering any of them, please leave it blank & discuss with the staff

The reason for this visit is a result of (please circle) work sports auto trauma chronic other

Explain what happened

since onset, have you experienced any of the following: check all that apply...

☐ loss of range of motion if checked, what body part?

☐ visual disturbance If checked, please explain

☐ dizziness if checked, how often?

☐ anxiety If checked, how often?

☐ depression If checked, how often?

☐ difficulty sleeping If checked, how often?

If auto – did you go to ER? If YES, on your own or by ambulance?

When did condition begin? / /

Is this condition getting worse? ☐ yes ☐ no ☐ constant ☐ comes & goes

Is this condition interfering with your (please circle) work sleep daily routine

If so, please explain

Have you had this or similar conditions in the past? ☐ yes ☐ no

If so, please explain

Have you been treated for this condition? ☐ yes ☐ no

If so, where? how long?

I have participated in the following treatments/therapies(circle all that apply)

chiropractic accupuncture physical therapy pain clinic orthopedic surgery massage therapy

I would be interested in the following treatments/therapies in this facility (circle any that apply)

chiropractic accupuncture physical therapy massage therapy spinal decompression Nu

INITIAL HERE when completed:

ALL PATIENTS MUST COMPLETE A MEDICAL HISTORY

ALL MASSAGE PATIENTS MUST COMPLETE A MEDICAL HISTORY

PERSONAL MEDICAL HISTORY

please check all that apply (up to and including today)

- Alcohol/Drug Abuse
- Allergies
- Anemia
- Arthritis
- Artificial Bones/Joints
- Artificial Valves
- Asthma
- Blood Pressure-high/low
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- COPD
- Diabetes
- Difficulty Breathing
- Digestive Issues
- Earaches
- Emphysema
- Epilliepsy/Seizures
- Fainting/Dizziness
- **Headaches**
  - **migraine**
  - **tension**
  - **other**
- Heart Attack/Stroke
- Heart Murmur
- Heart Surgery
- Hepatitis
- HIV / AIDS
- Kidney Issues
- Mitral Valve Prolapse
- Pacemaker
- **Pain- Arms/Hands**
- **Pain- Back**
- **Pain - Legs/Feet**
- **Pain- Neck**
- **Pain- Other**
- **Pain- Other**
- **Pain- Other**
- Psychiatric Condition(s)
- **Rheumatic Fever**
- Shingles
- Sinus Problems
- Skin Condition(s)
- Tuberculosis
- Ulcers
- Venereal Diseases
- other
- other

MEDICATIONS that I am taking...

☐ muscle relaxers	☐ blood pressure meds
☐ stimulants	☐ insulin / diabetes meds
☐ tranquillizers	☐ inhalers / oxygen
☐ psychiatric meds	☐ vitamins
☐ seizure medication	☐ herbal / natural supplements
☐ other	☐ other
☐ other	☐ other
☐ other	☐ other

do you exercise?	☐ yes	☐ no
do you smoke?	☐ yes	☐ no
do you wear contacts?	☐ yes	☐ no
do you have dentures?	☐ yes	☐ no
do you use hearing aids?	☐ yes	☐ no
do you use cane / other?	☐ yes	☐ no
do you use heel/arch supports?	☐ yes	☐ no

how old is your mattress?

Primary Care Physician or Group

Address

Phone#

Fax#

if applicable, explain any allergies noted in column to left...

Have you had any surgeries?if yes, give approx dates & outcome

Have you had any serious accidents in the past? (when?)

WOMEN ONLY

are you/could you be pregnant?	☐ yes	☐ no	any concerns you'd like to address?
have you recently given birth?	☐ yes	☐ no	
if yes, are you nursing?	☐ yes	☐ no	
are you menopausal?	☐ yes	☐ no	
are you on hormones or meds?	☐ yes	☐ no	
menopausal alternatives? ie;herbs, etc	☐ yes	☐ no	

FAMILY MEDICAL HISTORY please tell us about any illnesses in your family

condition_____ relative_____ year_____

condition_____ relative_____ year_____

condition_____ relative_____ year_____

condition_____ relative_____ year_____

BACK PAIN

circle/mark where you have pain or discomfort

- tingling?
- numbness?
- tightness?
- stiffness?
- other?

if you've answered yes to anything above, or checked 'OTHER' please feel free to provide more detail in this section...

I have completed my health information and history to the best of my knowledge/ability.
Should I experience any changes in my health, medications or conditions, I realize that it is my responsibility to inform my health care provider(s)

PRINT patient NAME & DOB

SIGN patient name

date

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/ rep print

parent/guardian / rep sign

★If patient is a minor, signature must be of the parent/guardian. Printed name should be both

Emergency Contact (mandatory for minor)

Who should we contact?

Relationship(parent, guardian, etc)

Home Ph# Work Ph#

PCP Name / Ph#

Account Info

Person ultimately responsible for account- In the event you terminate ins or you opt for non-covered services you acknowledge the cost of services

Please Print Name Relationship(ie; self, spouse, child)

Address

phone# work or other ph

by signing this page below, I authorize assignment of my insurance benefits to this provider. If I have no coverage of hese services through my health insurance or have no health insurance at all, I acknowledge that I am responsible for the cost of services provided to me. I agree to compensate this facility for care and will make payments per visit or arrangements with the administrative staff for payment options and plans.

Consent to Contact

Please let us know the best way to contact you if we need to reach you regarding your schedule, care or file, etc.

I prefer that you use the following number(s)....

s there a bad time of day to call you?

☐ home phone ☐ cell phone ☐ work phone

please do not call me... use the following..

☐ e-mail ☐ mail ☐ other

by signing this page, I acknowledge& allow contact

Massage Patients, please complete

take a minute and fill this out in the event you decide you'd like to schedule a massage

Have you ever had a massage before? ☐ yes ☐ no If yes, how often?

Difficulty with position? (ie, back, side, fron:)

During your daily ativities(work, home, etc) do you do repetetive movements?

do you experience any of the following? ☐ family stress ☐ work stress ☐ anxiety ☐ muscle tension ☐ pain ☐ migraines/headaches

☐ insomnia ☐ irritability ☐ stiffness ☐ other

I understand and acknowledge that this service is provided for the purpose of relaxation and relief of muscular tension. If I experience any discomfort, I will inform the provider of this in order to make adjustments for my level of comfort. I acknowledge that massage shouldn't be construed as a substitute for care of a condition for which I should be consulting a chiropractor,physician or qualified specialist in regard to. This provider will not perform adjustment, diagnoses, prescribe any physical/mental illness. I understand that full health disclosure is mandatory to initiate proper care. It is my responsibility to update this facility as to changes in my health and this provider is not held liable due to any failure to disclose on my part.

Consent to Share Information with Facility Staff/Providers

According to HIPAA privacy act, you're entitled to restrict communication and use of your information within this facility if you so choose. Should you decide to initiate any of the other services available(such as mallsage, decompression or acupuncturist) in this facility and you would like your files shared among the providers, herein, please authorize these actions by signing this section. This will include our associates of massage and acupuncture.

by signing below, I understand and agree to the content of this page.

PRINT patient NAME & DOB	SIGN patient name	date

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name parent/guardian rep sign name

North Shore Spine & Rehab dba Woburn Family Chiropractic
20 Cummings Park / Woburn, MA 01801 781-938-9400
AOB - ASSIGNMENT OF BENEFITS BY A PATIENT TO A PHYSICIAN
Complete only one of the top 2 boxes
BCBS patients & patients involved in an accident - complete box 3 as well

If minor child or unable to complete paperwork a Parent, Guardian or Representative's Signature is required
In accordance with Chapter 272 of the Acts of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, Health Ins, etc.) available to you before we can process your claim for personal injury benefits (P.I.P.) Any medical expenses in excess of $2,000.00 will not be paid under P.I.P. If those expenses will be compensated, paid or indemnified by an outside carrier (HMO, Medicare, Health Ins, etc.). Bills submitted for Payment over the $2,000.00 limit must be accompanied by a statement from your health carrier as to their reason for non-payment.

I DID NOT HAVE AN ACCIDENT

Only check one below

☐I have Health Ins. **Chiropractic Care is a covered benefit.** A copy of my ins card(s) will be taken for my file. I hereby assign to my physician in this facility, all benefits for such services, which I may be entitled to under any insurance policy. I request all benefits be paid directly to my physician in this facility upon submission of an appropriately completed claim form.

☐I have Health Ins. My benefits **do not include** chiropractic care. **I am responsible** for cost of services.

☐**I do not have any health ins. I am responsible** for cost of services.

print patient name & dob _____ sign patient name _____ Date_____

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

I HAD AN ACCIDENT on: Mo _____day_____ Year_____

I will be treating in this facility for injuries sustained in the accident. A copy of any ins cards I hold will be taken for my file. I hereby assign to my physician in this facility, all benefits for such services, which I may be entitled to under any insurance policy. I request all benefits be paid directly to my physician in this facility upon submission of an appropriately completed claim form.

Only check one below

☐I have health ins. **Chiropractic Care is a covered benefit.** A copy of my card was taken for my file

☐My health ins **does not include** chiropractic care. A copy of my card will be taken for my file.

☐**I do NOT have any health ins**

PI WAIVER / Medical Practitioner's Lien - NOTICE OF MEDICAL LIEN – MASS GENERAL LAW – Chapter 111 – Section 70B-70D
On Behalf of North Shore Spine (Dr. Michael Pendolino) – 20 Cummings Park – Woburn, MA 01801

I acknowledge that I have read, understand, attest and agree to the contents of this section and this page... I am aware that if/when the P.I.P. benefits are exhausted, my care/treatment will be billed through any other health insurance that I may carry, which is usual. In the event that my insurance falls to cover costs of services/care rendered and billed, I understand that I will be held responsible for the expenses of my care in this facility and that any/all unpaid charges will be my responsibility. As well, I understand that if I have an open/pending or settled/unsettled case (related to my injuries) that a medical provider's lien is appropriate and that this document shall serve as such. Pursuant to the forgoing statute, notice is herby given that the provider of medical services, North Shore Spine & Rehab (Dr. Michael Pendolino) has a lien for services furnished to the injured person, whose name, address and date of injury are set forth herein, signed and agreed with pertinent information including injured person/patient, other responsible persons (alleged-liable persons), insurance companies, entities, legal representatives, etc(when available/applicable).

PRINT patient name / dob / address _____

Ins Co / Claim # / Date of Injury_____

Attorney Name / Address / Ph# (if applicable) _____

Complete remainder info hereafter, if available...
Name / Address of alleged liable person(s) _____

Ins Co / Claim# of alleged liable person(s) _____

signature of injured person/patient _____ Date_____

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

I had an Accident and/or I have BCBS

WAIVER OF NON-COVERED SERVICES OF MY HEALTH INSURANCE

If you have been in an accident OR you are a BCBS MEMBER (some plans are limited .. we will check for you)... please read this section...
It has been brought to my attention that my health insurance may not cover all chiropractic services that will be performed and billed by North Shore Spine & Rehab. I have been informed that any/all non-covered services will be my responsibility and may be billed back to my PIP carrier for re-imbursement or may be subject to a doctor's lien.

In regards to **Blue Cross Blue Shield (typically policies beginning with the prefix MTN or MTP**, but not limited to) it is required to obtain authorization for treatment beyond 12 visits. I am aware that Healthways Whole Health Network may not authorize further treatment and I have been notified prior to the service being rendered that I am responsible for payment of said services and if my injury/condition is the result of an accident, that these services may be billed back to my PIP carrier for re-imbursement as well.

print patient name & dob _____ sign patient name _____ Date_____

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

parent/guardian/rep print name _____ parent/guardian/rep sign name _____ Date _____

NORTH SHORE SPINE & REHAB dba. Woburn Family Chiropractic
20 Cummings Park - Woburn, MA 01801 - Phone 781-938-9400 - Fax 781-938-9323

RECORD OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

All persons listed below are privileged to receive and/or provide (as specified) information regarding this patient, their records, reports, notes, films and any other information requested. By adding names and facilities below, you are allowing them and us to view and share that information regarding your care as specified.

(1) Check box one if you are authorizing this person / facility/ provider to receive/provide/share information for this patient
(2) Type of Information Requested: "T" / treatment records "P" / payment records "O" / healthcare operations Insert detail when necessary
(3) Enter method preferred or used for the disclosure requested, received or sent (ie; fax / mail / e-mail / any/all acceptable, etc)

Date	Disclosure to/from Include ph#'s (when available)	Desc/Purpose of Disclosure	By Whom Disclosed	(1)	(2)	(3)
	Name Location Ph#					
Info requested/provided & date:			Info requested/received & date:			
	Name Location Ph#					
Info requested/provided & date:			Info requested/received & date:			
	Name Location Ph#					
Info requested/provided & date:			Info requested/received & date:			
	Name Location Ph#					
Info requested/provided & date:			Info requested/received & date:			

THIS SECTION FOR INDIVIDUALS (ie; DR, family member, etc)that you want/allow to see your file or receive/give information from/to.

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by an individual. Healthcare entities must keep records of PHI disclosure. Information provided, if completed properly, will constitute and adequate record. ***NOTE: Uses/-Disclosures of TPO may be used without prior permission in event of Emergency***

patient name & dob / print patient name / sign

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS & DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED/DISCLOSED & HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION-REVIEW CAREFULLY – Full text version of these regulations is available/posted in the waiting area. As a rule, North Shore Spine & Rehab dba Woburn Family Chiropractic (heretofore represented as NSSR) will not disclose your information obtained from your contacts, your file/records here, or the fact that you are my patient except with your written consent. However, there are some important exceptions to this rule of confidentiality - some exceptions created voluntarily by policies in this office, and some required by law. Only in cases of dire emergency when your medical information may be critical to your care elsewhere (ie; E.R.) and you are unable to communicate any information, only then will your medical information be released in order to benefit your care elsewhere in an emergency or critical care situation. If you wish to receive services in this facility, under Federal HIPAA regulations, you must sign this form indicating that you understand and accept NSSR policies about confidentiality and its limits. NSSR will discuss these issues with you now. As well, you may reopen the conversation at any time during treatment. In general, no persons are privileged to review your medical information without written permission.

By signing below, I acknowledge that I give permission to those listed above to receive/provide information regarding my care. I also acknowledge that I understand my HIPAA rights as described above and posted in the waiting area of this facility.

Print patient name & DOB patient name / signature

phone # today's date

COMPLETE SHADED AREA IF PATIENT IS A MINOR or PATIENT IS UNABLE TO COMPLETE ON THEIR OWN

print name parent/guardian/rep sign name parent/guardian/rep

. . . ONLY if you are a MEDICARE PATIENT, please complete this form . . .

(A)Notifier(s): North Shore Spine & Rehab–20 Cummings Park–Woburn, MA 01801–781-938-9400

(B) Patient Name & DOB: **(C) Identification Number:**

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for ***(D)services*** 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:
The following treatments are listed under non-covered services, however, the list is not limited to these therapies. There could be others based on your plan and/or supplement (if available): * *Spinal Decompression* * *Modalities: incl moist heat, cryotherapy, e-stim, muscular work, therapeutic massage, trigger point, ultrasound, etc.* * *Massage Therapy as a separate treatment*	*The afore-mentioned are non-covered services and do not fall under coverage for your medical insurance policy*	*Various between $17.00 -- $155.00*

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)services*** 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)services* 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)services* 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)services* 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: NONE**

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:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.