THE RUSSELL CENTER FOR CHIROPRACTIC & SPORTS MEDICINE
319 ELLIOTT STREET, BEVERLY MA 01915 | PHONE 978-927-2607 | FAX 978-927-2463

# NOTICE OF POLICIES

## Welcome to our office! PLEASE READ

**CONFIDENTIALITY** Our office complies with HIPAA standards to protect the privacy of your personal health information. We do not release your PHI without your written consent unless required or permitted by law. We may contact you for reminders and announcements, as well as offers and health news.

If, in any way, you believe we have violated your privacy, please bring it to our attention.

**APPOINTMENTS POLICY** Thank you for understanding and respecting our valuable time.

CHANGES: We will do our best to accommodate time changes up to date of service.

SAME DAY APPOINTMENTS: Subject to availability. We welcome you to call if you are experiencing discomfort and usually can fit you into our busy schedule.

CANCELLATIONS: 48 hours in advance. SAME DAY cancellations are subject to $25 charge.

NO SHOWS: First time - $25.00
Second time - $25.00 minimum charge.
Third time - $50.00 minimum charge.
Fourth time - We may be unable to schedule you in advance.

**FINANCIAL AGREEMENTS: Copays and current charges are required at time of service.**

We accept most insurance plans. You are expected to know the general details of your coverage. Although we can estimate possible contracted charges, each policy, individual circumstances and contributing factors are unique.

Some insurance charges may be delayed as long as several months while we wait for your insurer to process claims. You are responsible for all charges not paid by insurance within 90 days of service including (but not limited to) New Patient Evaluation, Examination, Established Patient Re-evaluation, additional modalities such as E-stim, Laser, Heat Therapy, K-taping, Manual Therapy, Treatment of Extremities or General Consultation.

**Past Due Invoices:** Payments are due upon receipt of invoice. Accounts PAST DUE over 90 days will be subject to monthly finance charges. In no case will those charges be less than $15 and will be assessed monthly. Please call to resolve and settle any invoices. We can often help with discounts or terms.

**UNINSURED TREATMENT:** Our cash prices are affordable and competitive. If you are unable to afford recommended treatment, ask our Practice Manager about an extended payment plan that fits your budget.

**X** _____ _____ _____

Patient Signature (print name) Date

*We take care of the most important piece of equipment you own… YOU!*

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NAME: _____

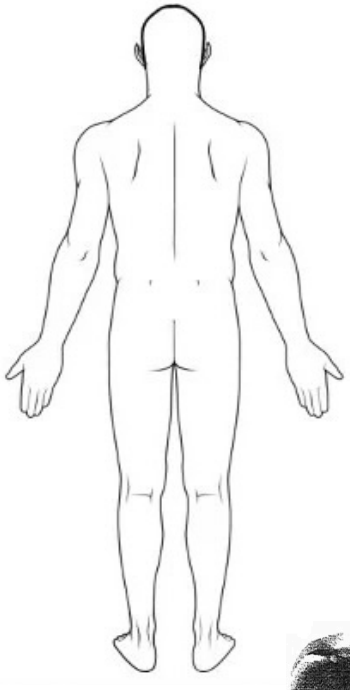
D.O.B. _____ Today's Date: _____

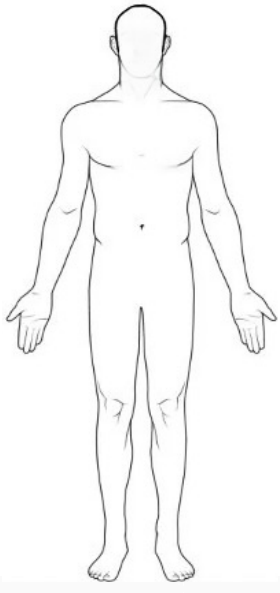
Have you ever been diagnosed with any of the following conditions? (Check if yes)

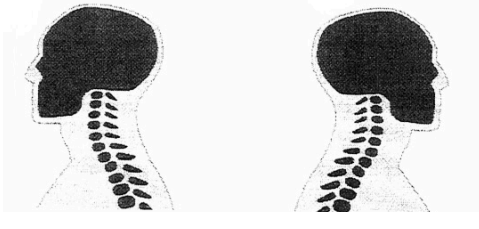
__ Alcoholism
__ Allergies
__ Anemia
__ Arteriosclerosis
__ Arthritis (type: _____)
__ Asthma
__ Back Pain
__ Breast Lump(s)
__ Bronchitis
__ Bruise Easily
__ Cancer (type: _____)
__ Chest Pains/Conditions
__ Constipation
__ Cramps
__ Depression
__ Diabetes (type: _____)
__ Digestion Problems
__ Dizziness
__ Ears Ringing (Tinnitus)
__ Excessive Menstruation
__ Eye Pain or Difficulties
__ Fatigue
__ Frequent Urination
__ Headache
__ Hemorrhoids
__ High Blood Pressure
__ Hot Flashes
__ Irregular Heart Beat
__ Irregular Cycle
__ Kidney Infection
__ Kidney Stones
__ Loss of Balance
__ Loss of Memory
__ Loss of Smell
__ Loss of Taste
__ Neck Pain or Stiffness
__ Nervousness
__ Nosebleeds
__ Pacemaker
__ Polio
__ Poor Posture
__ Prostate Trouble
__ Sciatica
__ Shortness of Breath
__ Sinus Infections
__ Sleep Problems or Insomnia
__ Spinal Curvatures
__ Stroke
__ Swelling of Ankles
__ Swollen Joints
__ Thyroid Condition
__ Tuberculosis
__ Ulcers
__ Varicose Veins
__ Venereal Disease
__ Other: _____

Please use the following letters to indicate the TYPE and LOCATION of the symptoms you are currently experiencing:

A = Ache  O = Other  B = Burning
P = Pins & Needles  N = Numbness  S = Stabbing







Are you seeking treatment following an Automobile or Workplace accident?

__ AUTO
__ WORK

*Have you filed a claim? Y / N*

CARRIER _____

CLAIM # _____

*We take care of the most important piece of equipment you own… YOU!*

**A. Notifier:** THE RUSSELL CENTER 319 ELLIOTT ST BEVERLY MA 01915

**B. Patient Name:** **C. Identification Number:** YEARS 2023-2025

# (ABN) Advance Beneficiary Notice of Non-coverage

NOTE: If your insurance doesn't pay for **D**. (see below), you may be required to pay. Insurance or 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, MassHealth and some commercial insurance policies may not pay for **D**. (see below)

| D. Treatment | E. Reason May Not Pay: | F. Estimated Cost |
|---|---|---|
| EXTRA-SPINAL TREATMENT | NON-COVERED SERVICE | $40.00 |
| THERAPEUTIC MODALITY | NON-COVERED SERVICE | $25.00 |
| NEW PATIENT EVALUATION | NON-COVERED SERVICE | $150.00 |
| RE-EVALUATION | NON-COVERED SERVICE | $100.00 |

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**.

Note: If you choose Option 1 or 2, we may help you to use any other insurance you have, but Medicare or your insurer 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**. _____ listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I may be able to appeal to my insurer according to their terms. I understand that if my insurer doesn't pay, I am responsible for payment. If my insurer does pay, you will credit any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2**. I want the **D**. _____ listed above, but do not bill Medicare or my insurer. You may ask to be paid now as I am responsible for payment. I cannot appeal if insurer is not billed.

☐ **OPTION 3**. I don't want the **D**. _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to my insurer.

**H. Additional information:**

This notice gives our opinion, not an official decision. if you have other questions on this notice or billing, call **1-800-MEDICARE** (1-800-633-4227 / TTY: 1-877-486-2048), or the phone number provided on your commercial insurance card.

Signing below means that you have received and understand this notice. You may request a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

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Name: _____ D.O.B. _____ Today's Date: _____

Have you been treated for any conditions in the last year? __ No / __ Yes
If Yes, please describe: _____
Date of last physical exam: _____ Is there a chance you are pregnant? __ No / __ Yes
Have you had X-rays taken? __ No / __ Yes If yes, where? _____
What medications are you taking and for what conditions? (Please list dosage and frequency)

_____

_____

What vitamins, minerals and herbal supplements are you taking and for what conditions? (Please list dosage and frequency)

_____

_____

Please tell us about the following: (if yes, please explain)

| | | |
|---|---|---|
| Broken Bone(s) | __ No / __ Yes | _____ |
| Hospitalization(s) | __ No / __ Yes | _____ |
| Auto Accident(s) | __ No / __ Yes | _____ |
| Sprain(s) / strain(s) | __ No / __ Yes | _____ |
| Struck Unconscious | __ No / __ Yes | _____ |
| Surgery | __ No / __ Yes | _____ |

Family Members - Present and past health conditions (ie: heart disease, cancer, diabetes, arthritis, etc.)

_____

_____

Do you experience pain every day? __ No / __ Yes
Do your symptoms interfere with daily life? __ No / __ Yes
Does pain wake you up at night? __ No / __ Yes
Are your symptoms worse at certain times of day? __ No / __ Yes
Do changes in weather affect your symptoms? __ No / __ Yes
Do you wear orthotics? __ No / __ Yes
What activities aggravate your symptoms? _____

| | | | | |
|---|---|---|---|---|
| Alcohol | __ None | __ Light | __ Moderate | __ Heavy |
| Coffee / Caffeine | __ None | __ Light | __ Moderate | __ Heavy |
| Tobacco | __ None | __ Light | __ Moderate | __ Heavy |
| Drugs | __ None | __ Light | __ Moderate | __ Heavy |
| Exercise | __ None | __ Light | __ Moderate | __ Heavy |
| Sleep | __ None | __ Light | __ Moderate | __ Heavy |
| Appetite | __ None | __ Light | __ Moderate | __ Heavy |
| Soft Drinks | __ None | __ Light | __ Moderate | __ Heavy |
| Water | __ None | __ Light | __ Moderate | __ Heavy |
| Salty Foods | __ None | __ Light | __ Moderate | __ Heavy |
| Sugary Foods | __ None | __ Light | __ Moderate | __ Heavy |
| Artificial Sweeteners | __ None | __ Light | __ Moderate | __ Heavy |

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