***Our** Team of Providers*

Dr. Gary K Adams, MD FACP *Medical Doctor*
Suzanne Hornsby, FNP-C *Nurse Practitioner*
Dr. Corey Idrogo, DC *Chiropractic Physician*
Dr. John Fee DC *Chiropractic Physician*

Patient Check-In Form

Today's Date ___________

Name: ____ Birthdate: ______________ Age: ______ Gender (circle): M F

Marital Status (circle): Single Married Widowed Divorced Engaged Separated Minor

If a minor, Legal Guardian Name: ______________________________ Relationship: ___________Birthdate: _____________

Address: ______________________________________ City: _____________________ State: ____ Zip: ___________

Home Phone: _________________ Cell Phone: _________________ Email: ___________________________________

Check box for consent for office to leave detailed voicemail messages: ☐ Yes ☐ No

Occupation: _______________________________ Employer: _________________________

Emergency Contact Name: _______________________ Relationship: _________________ Phone: __________________

How did you hear about Centered Spine & Joint? ____

What is the main reason for your visit? ____

____

____

____

****Women Only****

Are you pregnant? (circle one) Yes No Number of pregnancies? ________ Miscarriages __________

What was the first day of your last menstrual cycle? ___________ If menopausal, last menstrual period (estimate year) ___________

Check if the following apply to you:

Preventative Medical Care:

- ☐ Medical/Gynecological exam in the last year
- ☐ Bone density in the last 12 months
- ☐ Mammogram in the last 12 months
- ☐ Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Hysterectomy with ovary removal
- ☐ Hysterectomy only
- ☐ Oophorectomy

Birth Control Methods

- ☐ Pills
- ☐ IUD
- ☐ Tubal ligation
- ☐ Hysterectomy

I, (signature) ______________________ am not pregnant, if I am pregnant I understand that it is required I report my pregnancy to the physician and staff immediately.

****

Pain Questionnaire

What is your primary pain complaint? ____

How long have you been experiencing your primary pain? ____

Have you seen any other doctors/specialists for this condition? ____

Have you had any imaging for this condition? Yes No Where/When? _____________________________________

When do you notice the pain most? (circle one) AM PM How long does the pain last? ______________________

Have you experienced this pain before? Yes No Have you been out of work due to pain? Yes No

On the scale below, please circle the percentage of time you experience your primary pain:

Occasional				Intermittent			Frequent		Constant	
0%	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**

On the scale below, please circle the severity of your primary pain complaint:

None			Slight		Mild	Moderate		Severe	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What makes the pain feel worse? ____

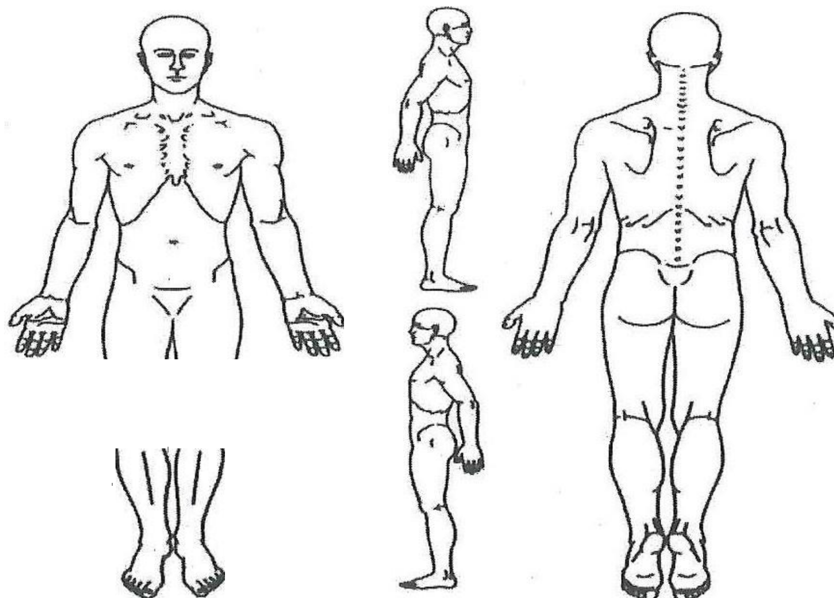
What makes the pain feel better? (check all boxes that apply):
☐ ice ☐ heat ☐stretching ☐ therapy ☐chiropractic care
☐ massage ☐ medication ☐ other: _____________

What has this prevented you from doing normally, either partially or totally? ___________________________________

____

Have you had any of the following diagnoses?
☐ sciatica ☐ bulging disc ☐ TMJ dysfunction ☐ lumbar degenerative disc
☐ spondylolisthesis ☐ spinal stenosis ☐ lumbar radiculitis ☐ herniated disc
☐ lumbar spondylosis ☐ myalgia

On the diagram(s) below, please circle the region where you are experiencing the most pain of your present complaints using the following letters:
A: ache
B: burning
C: cramping
D: dull pain
N: numbness
R: throbbing pain
S: sharp pain
T: tingling



Review of Systems

Check all the boxes that apply:

General
- ☐ difficulty with sleep
- ☐ fatigue
- ☐ mental fog

Skin
- ☐ rashes
- ☐ itching
- ☐ change in hair or nails

Head
- ☐ headaches
- ☐ head injury

Eyes
- ☐ glasses/contacts
- ☐ changes in vision
- ☐ eye pain
- ☐ double vision
- ☐ flashing lights
- ☐ glaucoma/cataracts
- ☐ last eye exam: __________

Ears
- ☐ change in hearing
- ☐ ear pain
- ☐ ear discharge
- ☐ ringing
- ☐ dizziness

Nose/Sinuses
- ☐ nose bleeds
- ☐ stuffiness
- ☐ frequent colds

Allergies
- ☐ hives
- ☐ swelling of lips/tongue
- ☐ hay fever
- ☐ asthma
- ☐ eczema/sensitive skin
- ☐ sensitivities to substances

Mouth/Throat
- ☐ bleeding gums
- ☐ sore tongue
- ☐ sore throat
- ☐ hoarseness

Neck
- ☐ lumps
- ☐ swollen glands
- ☐ goiter
- ☐ stiffness

Breast
- ☐ lumps
- ☐ pain
- ☐ nipple discharge

Respiratory/Cardiac
- ☐ shortness of breath
- ☐ cough
- ☐ production of phlem
- ☐ wheezing
- ☐ coughing up blood
- ☐ chest pain
- ☐ fever
- ☐ night sweats
- ☐ swelling in hands/feet
- ☐ blue fingers/toes
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ skipping heart beats
- ☐ heart murmur
- ☐ history of heart medication
- ☐ bronchitis/emphysema
- ☐ rheumatic heart disease

Urinary
- ☐ difficulty urinating
- ☐ pain or burning with urination
- ☐ frequent urination at night
- ☐ urgent need to urinate
- ☐ urinary incontinence
- ☐ dribbling
- ☐ decreased urine stream
- ☐ blood in urine
- ☐ UTI/stones/prostate infection

Gastrointestinal
- ☐ change in appetite or weight
- ☐ problems swallowing
- ☐ nausea
- ☐ vomiting
- ☐ vomiting blood
- ☐ constipation
- ☐ diarrhea
- ☐ change in bowel habits
- ☐ abdominal pain
- ☐ excessive belching
- ☐ excessive flatus
- ☐ yellowing color of skin
- ☐ food intolerance
- ☐ rectal bleeding/hemorrhoids
- ☐ acid reflux/heartburn

Peripheral Vascular
- ☐ leg cramps
- ☐ varicose veins
- ☐ clots in veins

Psychiatric
- ☐ anxiety
- ☐ depression
- ☐ memory problems
- ☐ difficulty concentrating
- ☐ change in mood

Musculoskeletal
- ☐ broken bone
- ☐ serious sprains
- ☐ arthritis
- ☐ gout
- ☐ pain
- ☐ swelling
- ☐ stiffness
- ☐ decreased joint motion

Neurological
- ☐ seizures
- ☐ loss of consciousness
- ☐ paralysis
- ☐ weakness
- ☐ loss of muscle size
- ☐ muscle spasm
- ☐ tremor
- ☐ involuntary movement
- ☐ incoordination
- ☐ numbness
- ☐ feelings of pins and needles

Hematologic
- ☐ anemia
- ☐ easy bruising/bleeding
- ☐ past transfusions

Endocrine
- ☐ abnormal growth
- ☐ increased thirst
- ☐ increased urine production
- ☐ thyroid trouble
- ☐ heat/cold intolerance
- ☐ excessive sweating
- ☐ diabetes

Past Medical History

Surgical History:

List any/all surgeries you have had and the corresponding dates: ____
____
____
____

Have you had any issues with anesthesia? (circle one) Yes No

Food, Drug, or Other Allergies: ____
____

Please List all medications, vitamins, and nutritional supplements that you are currently taking:

Medication/Supplement	Dosage	Reason for Taking

Family History:
Check any of the following diseases that run in your family (mother/father/siblings)

☐ alcoholism ☐ heart disease ☐ mental illness
☐ thyroid disease ☐ high blood pressure ☐ stroke
☐ diabetes ☐ high cholesterol ☐ cancer (if so what kind: _____________)

Social History:
Do you use any tobacco products? (circle one) Yes No
How many cigarettes or cigars do you smoke per day? ______
Have you used tobacco products in the past? (circle one) Yes No
Do you drink alcohol? (circle one) Yes No
How many drinks in a week? ______
Do you use any of these recreational substances? (check all that apply)
☐ marijuana ☐ cocaine ☐ hallucinogens ☐ opioids ☐ steroids ☐ other: _________

Activities of Daily Living:
Which activities do you have **trouble** completing? (check all that apply)
☐ sitting ☐ bathing ☐ computer work ☐ rising from seated position
☐ standing ☐ walking ☐ getting dressed ☐ personal care (shaving, doing hair, etc.)
☐ bending ☐ running ☐ socializing ☐ concentrating
☐ eating ☐ writing ☐ climbing stairs ☐ picking up children
☐ lifting ☐ reading ☐ falling asleep ☐ playing with children
☐ driving ☐ squatting ☐ staying asleep ☐ playing sports

****

Complimentary Consultation Terms

I, **(signature)** ___________________________________ , consent to allow the provider to speak with me in order to determine if I am a good candidate for Regen Injection treatment and to determine if they are willing to accept my case. It is also my understanding that my first Regen consultation is at no charge. I understand that the consultation process does not establish me as a patient under the practitioners care and there is no physician-patient relationship or obligation.

Name (print): _________________________________
Signature: ___________________________________ **Date:** _____________________

****

Third Party Payer Information

Patient
Patient Name: ______________________________ Patient DOB: _______________
Patient Address: ____
City: _________________________________ State: __________ Zip: ____________
Primary Phone: _____________________ Mobile Phone: ______________________
Email: ____

Patient's Relationship to Policy Holder (circle one): self spouse child other

Policy Holder Insurance Information (if same as patient leave blank)
Insurance Name: __________________________________
Policy Holder Name: _______________________________ Group Name: _________________
Policy Holder ID#: _________________________________ Group Number: _______________
Policy Holder SSN: _________________________________

Secondary Insurance Information (if no secondary insurance leave blank)
Insurance Name:____ Group Name: __________________
Policy Holder Name: ______________________________________ Group Number: ________________
Policy Holder ID#: _______________________________________

Primary Care Physician: ____________________________ Phone Number: ____________
Preferred Pharmacy: _______________________________ Phone Number: ____________

** **OFFICE USE ONLY** **********************************

Primary Insurance Card (front)

Primary Insurance Card (back)

Secondary Insurance Card (front)

Secondary Insurance Card (back)

Special instructions/notes: ____

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer (contact info at the bottom of this document)

I. **How This Medical Practice May Use or Disclose Your Health Information**: This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

i. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

ii. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

iii. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

iv. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

v. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

vi. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

vii. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participate in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation that covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

viii. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

ix. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

x. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

xi. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

xii. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

xiii. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

xiv. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

xv. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

xvi. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

xvii. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

xviii. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

xix. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

xx. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

II. **When This Medical Practice May Not Use or Disclose Your Health Information**: Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

III. **Your Health Information Rights**

i. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

ii. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

iii. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

iv. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

v. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

vi. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

IV. **Changes to this Notice of Privacy Practices**: We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

V. **Complaints**: Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer:

Centered Physical Medicine & Chiropractic DBA
Centered Spine & Joint
4109 Mountain View Avenue Suite 400
Chattanooga, TN 37415
(423) 315-1690

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov
The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

I, (**print name**) __________________________________ agree to the terms in this Notice of Privacy Practices (HIPAA) document.

Signature: _____________________________________ **Date**: ___________________

Authorization and Assignment

Please initial next to each line that applies to you. Thank you.

____ **AUTHORIZATION TO RELEASE INFORMATION (*if applicable):*** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster, in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you of any consequence thereof.

____ **ASSIGNMENT OF PAYMENT (*if applicable*):** My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any money due to him/her on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay the difference if any, between the total amounts of his/her charges and the amount paid him/her by the attorney and/or insurance company. It is further understood that I, the undersigned, agree to pay the full amount of his/her charges, should my condition be such that is not covered by my policy or if for any other reason the insurance company and/or attorney refuses to pay my claim. Accepting assignment does not release the patient from the responsibility for their yearly deductible or for their co-payment on services provided by the clinic. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do so will result in collection action.

MEDICARE ASSIGNMENT (*if applicable*): I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration to its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

____**MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN):** If Medicare doesn't pay for the service listed (Examinations, radiographs (**x-rays), chiropractic adjustments, manual therapy, therapeutic exercise & rehabilitation, and regenerative medicine**), you may have to pay. Medicare does not pay for all procedures, even some care that you or your health care provider have good reason to think you need. What you need to know is; read this notice, so you can make an informed decision about your care and ask us any questions that you may have after reading this.

MEDICARE ONLY: Please initial only one box below that applies to your decision of Medicare Benefits.

_____I want the listed service above to get me better faster and have better likelihood of improvement. I may be asked to pay now, but I also want Medicare billed for an official decision on payment. I understand that if Medicare does not pay, I am responsible for payment, but I can appeal the decision by following directions on the Medicare Summary Notice (MSN). If Medicare does pay then, I will be refunded the payment I made to Centered Health & Wellness.

_____ I want the listed service above to get me better faster and have better likelihood of improvement, but do not bill Medicare. I am responsible for payment and by not billing I waive the right to appeal to Medicare.

_____ I do not want the services listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if Medicare would pay.

ACKNOWLEDGEMENT AND UNDERSTANDING: I hereby acknowledge;

A. That there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the doctor, or make other provisions for the protection of the interest of the doctor; or

B. If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the services of an attorney; then payment of services rendered by Centered Health & Wellness., will be made on a current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last statement, whichever comes first.

I, (**print name**) __________________________________ agree to the terms in this Authorization and Assignement document.

Signature: _____________________________________ **Date**: ___________________