BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

MEDICARE AND MY CHIROPRACTIC VISITS:

2022 Medicare annual deductible is $233.00.
You must meet your annual deductible before you start receiving reimbursement checks from Medicare.

- Patient Exam Fee: **$90.00** (to be charged at first visit only or if you have not been seen in over 2 years.)

- 2022 Medicare Manipulation Fee: average is **$43.60**(the ONLY treatment Medicare will cover at 80%. Patient will receive this reimbursement by check in the mail from Medicare directly).

- Therapies (Treatment other than the Manipulation of the Spine): **$15 per Therapy** (Medicare will NOT cover these services which is why we discount them significantly to the rate of $15 each – see Advanced Beneficiary Notice of Non Covered Services form.)

What if I have a supplemental insurance plan?

Our billing department at Barkalow Chiropractic & Physical Medicine will send all claims directly to Medicare. Once Medicare receives, approves, and processes your claims they will then submit them to your supplemental for possible additional coverage. You must still pay your patient responsibility at check out.

What are my estimated costs?

FIRST VISIT (or greater than 2 years):	FOLLOW UP VISITS:
EXAM: **$90.00** MANIP: **$43.60** THERAPIES: **$15.00 EACH** **Estimate: $153 - $168** (patient will get back a portion of this amount from Medicare)	2022 MANIPULATION (must be charged every appointment for MC to approve): **$43.60** THERAPIES: **$15.00 EACH** **Estimate: $63 - $93** (patient will get back a portion of this amount from Medicare)

Barkalow Chiropractic & Physical Medicine
550 Camino El Estero, Ste. 103
Monterey, CA 93940

BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

NEW PATIENT INTAKE

Patient Name:_____ Date:_____ Email:_____

Address_____ City_____ State_____ Zip_____

Telephone (Cell/home)_____ (work)_____ Birth Date_____ Last 4 SS#_____

Occupation_____ Employer_____ Marital Status_____

Spouse/Partner's name_____ Spouse/Partner's occupation_____

Emergency Contact_____ Phone_____ Number of children_____

Insurance Company_____ Primary insured name_____ Birth Date_____

Who can we thank for referring you to our office?_____

Please describe your main problem_____

When did it begin?_____ Is it getting better, worse, or staying the same (**circle one**)

Did it start as a result of: (Circle) Auto Accident, Workers Comp, Other _____

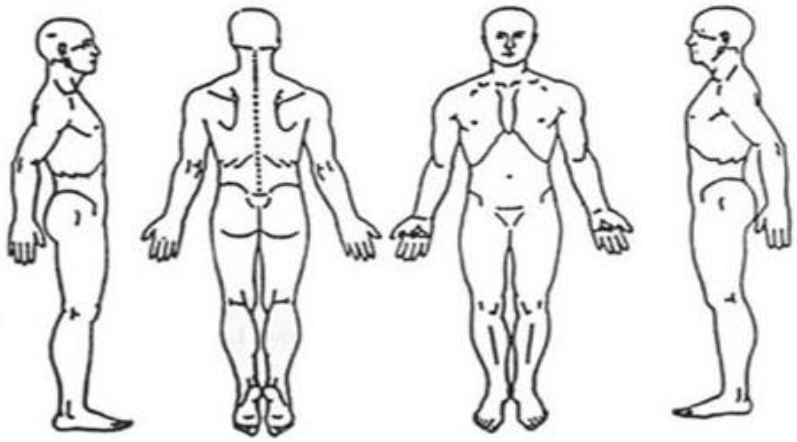
Describe activities that you cannot do because of the problem? _____

What aggravates your problem?_____ What relieves your problem?_____

Do your symptoms interfere with normal daily activities? Y / N Does it wake you at night? Y / N

How do you feel today (Circle): 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 **(0 = No pain, 10 = Unbearable pain**)

Circle and Label where your symptoms are located:
A =Ache, B = Burning, N = Numbness, P = Pins & Needles, S = Stabbing, O = Other



List all practitioners seen for this injury (MD, Chiropractor, Physical Therapy, etc.)_____
Have you ever experienced this condition before? Y / N When? _____
Have you been treated for any other condition in the past 3 years? Y / N If yes, describe_____
Have you seen: A Chiropractor for *any other* conditions? Y / N A Physical Therapist for *any other* conditions? Y / N If yes, please explain _____

Last physical exam_____Last blood test _____ Last Xray or MRI _____

Have you ever had: (circle)

Broken bones	Ear Aches	Numbness	Been hospitalized	Cancer
Allergies	Pacemaker	Been in an Auto Accident	Chest pain	Constipation
Jaw pain	Auto Accidents	High blood pressure	Bladder/bowel control	Shoulder pain
Been struck unconscious		Stroke	Digestive problems	Rib Pain
Diabetes	Loss of balance/Dizziness	Loss of taste	Pelvic / Groin pain	
Surgeries_____	Swelling of _____		Headaches	Incontinence (leakage)
Other_____	Fever		Hernia	Diastasis Recti

For Women:

Is there a chance that you are pregnant? Y / N If yes, do you have an OB or Midwife_____

Are you seeking care for a Pelvic Floor Dysfunction? Y / N If yes, please describe_____

Appointment and Cancellation Policy

I, _____, agree to the "No Show and Late Cancellation" policy at this office: I agree and understand this office policy that I will be charged **$35.00** if I do not give **24 hours notice to cancel or reschedule**.

_____ _____

Patient Signature / Guardian Signature Date

Financial Policy

I, _____, to the "Financial Policy" at this office: I agree and understand this office policy for Non-Insured, Medical Insurance, Medicare or Auto Insurance. I agree that I will be responsible for paying my bill if my insurance does not cover my treatments. I may request a copy my insurance verification form.

_____ _____

Patient Signature / Guardian Signature Date

Notice of Privacy Practices

I, _____, agree to the Privacy Notice that all my information is private and protected. By my way of signature, I provide my Doctor with my authorization and consent to disclose my protected health care information for purposes of treatment, payment and healthcare operation as described in the Privacy Notice (please see laminated form in the office). I may request a copy of this agreement to take home with me.

_____ _____

Patient Signature / Guardian Signature Date

Barkalow Chiropractic & Physical Medicine
550 Camino El Estero, Suite 103
Monterey, CA, 93940
(Ph) 831.655.3255 (F) 831.655.3443

BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

INFORMED CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures by Dr. Stephen Barkalow, Dr. Derek Barkalow and/or Dr. Dustin Nagai including various modes of physical therapy modalities some of which may be performed by other office or clinic personnel. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to the following:

- While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments

- There have been reported cases of injury to a vertebral artery following cervical spine adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may, on rare occasion, result in serious injury. **The possibility of such injuries resulting from cervical spinal adjustment is extremely remote.**

- There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interest. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and have been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatments is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge that I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of the Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor including spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

PATIENT SIGNATURE PATIENT PRINTED NAME

_____

DATE

BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

Electronic Health Records Intake Form

In compliance with Medicare requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB:__/__/_____ Gender (Circle One): Male/Female Preferred Language:

_____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): *American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)*
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): *Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer*

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **Check here if you DO NOT wish to have a copy of this form emailed to you after each visit.**

For office use only: Height: _____ Weight:_____ Blood Pressure:_____ /_____

Barkalow Chiropractic & Physical Medicine
550 Camino El Estero, Suite 103
Monterey, CA, 93940
(Ph) 831.655.3255 (F) 831.655.3443

A. Notifier: **STEPHEN BARKALOW, DC: 550 CAMINO EL ESTERO, STE 103; MONTEREY, CA 93940 • (831) 655-3255**

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Chiropractic maintenance care 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.** maintenance care below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
98940 CHIROPRACTIC MANIPULATION,1-2 AREAS 98941 CHIROPRACTIC MANIPULATION,3-4 AREAS 98942 CHIROPRACTIC MANIPULATION, 5 AREAS	MEDICARE DOES NOT PAY FOR CHIRPORACTIC *"MAINTENANCE CARE"*	$30.48 $43.60 $56.93

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.** maintenance care 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.** maintenance care 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**.**

□ **OPTION 2.** I want the **D.** maintenance care 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.** maintenance care 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: This supplier doesn't accept payment from Medicare for the item(s) listed in the table above. If I checked Option 1 above, I am responsible for paying the supplier's charge for the item(s) directly to the supplier. If Medicare does pay, Medicare will pay me the Medicare-approved amount for the item(s), and this payment to me may be less than the supplier's charge.

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:

 Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB

BARKALOW
CHIROPRACTIC & PHYSICAL MEDICINE

MEDICARE & NON-COVERED SERVICES

Here at ***Barkalow Chiropractic & Physical Medicine***, we are dedicated to providing you with the best healthcare possible, with the goal of you reaching your optimal health and function. For that reason, we will always recommend everything you need for the benefit of your condition and will not make recommendations based only on what your insurance covers.

The decision to proceed with care is always up to you, the patient, since your healthcare choices are a personal decision. With that in mind, this notice will help you understand what is covered by Medicare in a chiropractic office, and what may be your responsibility.

Medicare covers ONLY spinal manipulation ("adjustments") when the doctor feels they meet Medicare's requirement of "Medical Necessity". All other services that we deliver here in our office are *excluded* by Medicare because they are ordered and delivered by a *Chiropractor.* We will discount *non-covered therapies* at $15 each. (Examples of "non-covered therapies" below):

- Traction of Cervical & Lumbar Spine
- Myofascial Release
- Therapeutic Exercise
- Neuromuscular Re-Education
- Electric Muscle Stimulation

We are happy to have you among our practice. Please let us know if you have any questions.

Acknowledgment of Receipt

_____ _____

SIGNATURE DATE

_____

PRINTED NAME