A Better *Life* Chiropractic

Deanna Barbaro, D.C.

661 Goodlette Road North, Suite 108; 34102
Tel (239)263-3369 Fax (239) 263-8842
www.abetterlifechiropractic.com

Name: _____ Date of Birth: _____ Sex: M F

Home Tel: _____Cell: _____ Email Address: _____

How were you referred to our office? _____

□ **Full Time Resident** □ **Seasonal Resident** □ **Temporary Visitor, Leaving When**: _____

Local Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: Address: _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Occupation: _____

INSURANCE:

Auto Insurance Company/Worker's Comp Company: _____

Claim # _____ Agent's Name: _____ Tel : _____

Name on Policy (if other than self): _____

Workers' Comp: Employer Contact: _____Phone: _____

Attorney Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Nature of Accident: *(circle where appropriate)*

1. Date of accident: _____ Motor Vehicle Accident Work Accident/Injury

2. Were you: Driver Passenger Front Seat Back Seat Operating Machinery

3. Number of people in your vehicle: _____ Were you wearing seat belts? YES NO

4. What direction were ***you*** headed? North South East West ***Other vehicle?*** North South East West

Name of street/Intersection: _____

5. Were you struck from: Behind Front Left side Right side

6. ***Your vehicle*****:** Make/Model: _____ Approximate speed at time of impact: _____ mph

7. ***Other vehicle*****:** Make/Model: _____ Approximate speed at time of impact: _____ mph

8. Were you knocked unconscious? YES NO DAZED Were police notified? YES NO

Did you strike anything in vehicle at time of impact? YES NO What part of body? _____

9. POSITION: both hands on steering wheel? YES NO Foot on brake? YES NO Braced for impact? YES NO

At the time of impact, were you looking…: STRAIGHT AHEAD TO THE LEFT TO THE RIGHT DOWNWARD

10. In your own words, please describe the accident:_____

_____

_____

11. Please describe your pain, injuries and symptoms:

a. ***During*** the accident: _____

b. Immediately ***after*** the accident: _____

c. Later ***that*** day: _____

d. The ***next*** day: _____

12. Did you go to the hospital? YES NO Ambulance Private Transportation

Were you Admitted? YES NO _____ days Were any of these taken? X-rays MRI Cat Scan

Which hospital: _____

13. Have you been treated by another doctor since the accident? YES NO Diagnosis: _____

If yes, please list the doctor's name and phone: _____

14. ***Circle the symptoms you have noticed since the accident***: Please circle Left or Right when indicated

Neck Pain	Neck Stiff	Head Seems Too Heavy	Cold Sweats
Low Back Pain	Pins & Needles in Legs L / R	Numbness/Tingling Toes L / R	Feet Cold
Mid Back Pain	Rib Pain L / R	Chest Pain	Arm Pain L / R
Shoulder Pain L / R	Pins & Needles in Arms L / R	Numbness/Tingling Fingers L / R	Hands Cold
Leg Pain L / R	Hip Pain L / R	Knee Pain L / R	Ankle Pain L / R
Headache	Dizziness	Loss of Memory	Sleeping Problems
Fatigue	Nervousness	Tension	Irritability
Depression	Sensitivity to Light (Eyes)	Ears Ringing/Buzzing	Face Flushed
Fainting	Loss of Balance	Shortness of Breath	Fever
Loss of Smell	Loss of Taste	Upset Stomach	Diarrhea / Constipation

Symptoms other than listed above: _____

Rate your pain

Neck: (Scale 1-10) _____ Constant On/Off Sharp Achy Dull Stiff Stabbing Burning

Worse with: Sneezing/Coughing Activity Lying Resting Prolonged Position

Midback: (Scale 1-10) _____ Constant On/Off Sharp Achy Dull Stiff Stabbing Burning

Worse with: Sneezing/Coughing Activity Lying Resting Prolonged Position

Low Back (Scale 1-10) _____ Constant On/Off Sharp Achy Dull Stiff Stabbing Burning

Worse with: Sneezing/Coughing Activity Lying Resting Prolonged Position

15. Since the injury occurred, are your symptoms: Improving Getting Worse Same

16. Do you notice any ***activity restrictions*** *as a result of this injury*? YES NO

If yes, please describe in detail:_____

_____

17. Have you lost time from work as a result of this accident? YES NO last day worked: _____

18. Did you have any physical complaints/previous illness before the accident? YES NO

If yes, please describe in detail: _____

_____

CURRENT MEDICATIONS:

Medication Dosage	Medication Dosage
_____ _____	_____ _____
_____ _____	_____ _____
_____ _____	_____ _____
_____ _____	_____ _____

All first visit charges are payable when services are rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and ***All first visit charges are payable when services are rendered.***

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand A BETTER LIFE CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to A BETTER LIFE CHIROPRACTIC will be certified upon receipt. HOWEVER, I clearly understand and agree that I am personally responsible for payment. Interest in the amount of 18% per annual or 1.5% per month will be charged on your account if it becomes past due.

x_____ **_____**

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN **DATE**

In case of emergency, please notify: _____ _____

Name/Relation Tel #

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I HAVE READ A COPY OF **PATIENT NOTICE OF PRIVACY PRACTICES.** *(A Copy of A BETTER LIFE CHIROPRACTIC Notice of Privacy Practices included in this package of new patient intake forms)*

x_____ **_____**

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN **DATE**

HEALTH HISTORY

Check the following conditions that apply (past/present). Please add your comments to clarify the condition.

Musculo-Skeletal

__ *Neck Pain*
__ Shoulder/Arm/Hand Pain
__ Headaches/ Migraines
__ Jaw Pain/TMJ
__ *Mid Back Pain*
__ Chest/Rib/Abdominal Pain
__ *Low Back Pain*
__ Hip Pain
__ Sciatic Pain
__ Leg/foot pain
__ Problems Walking
__ Joint Stiffness/Swelling
__ Spasms/Cramps
__ Broken/Fractured bones
__ Strains/Sprains
__ Tendonitis
__ Bursitis
__ Arthritis
__ Osteoporosis
__ Scoliosis
__ Bone or Joint Disease
__ Other: _____

Circulatory and Respiratory

__ Dizziness
__ Shortness of Breath
__ Fainting
__ Cold Feet or Hands
__ Cold Sweats
__ Swollen Ankles
__ Pressure Sores
__ Varicose Veins
__ Blood Clots
__ Stroke
__ Heart Condition
__ Allergies
__ Sinus Problems
__ Asthma
__ High Blood Pressure
__ Low Blood Pressure
__ Lymphedema
__ Other: _____

Digestive

__ Nervous Stomach
__ Indigestion
__ Constipation
__ Intestinal Gas/Bleeding
__ Diarrhea
__ Diverticulitis
__ Irritable Bowel Syndrome
__ Crohn's Disease
__ Colitis
__ Adaptive Aids
__ Other: _____

Nervous System

__ Numbness/Tingling
__ Twitching of Face
__ Fatigue
__ Chronic Pain
__ Sleep Disorders
__ Ulcers
__ Paralysis
__ Epilepsy
__ Chronic Fatigue Syndrome
__ Multiple Sclerosis
__ Parkinson's Disease
__ Spinal Cord Injury
__ Other: _____

Skin

__ Rashes
__ Allergies
__ Athlete's Foot
__ Warts
__ Moles
__ Acne
__ Cosmetic Surgery
__ Other: _____

Reproductive System

__ Pregnancy:
____ Current _____ Previous

Date of Last Menstrual Cycle:

_____/_____/_____

__ PMS
__ Menopause
__ Pelvic Inflammatory Disease
__ Endometriosis
__ Hysterectomy
__ Fertility Concerns
__ Prostate Concerns

Other

__ Loss of Appetite
__ Forgetfulness
__ Confusion
__ Depression
__ Difficulty Concentrating
__ Drug Use _____
__ Alcohol Use _____
__ Nicotine Use _____
__ Caffeine Use _____
__ Hearing Impaired
__ Visually Impaired
__ Burning upon Urination
__ Bladder Infection
__ Eating Disorder
__ Diabetes
__ Fibromyalgia
__ Post/Polio Syndrome
__ Cancer
Type: _____
Date Diagnosed _____

Infectious Disease (Confidential)

__ HIV __ TB __ Hepatitis

Other congenital or acquired disease: _____

Prior Surgeries: _____

_____

Please list any additional comments regarding your health and well-being:

_____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform the health care provider of any changes in my status.

Patient Signature: _____ Date: _____
***Doctor* Signature**: _____ Date: _____

NECK INDEX

Patient Name _____ Date _____

*This questionnaire will give your provider information about how your **neck condition** affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity
☐0 I have no pain at the moment.
☐1 The pain is very mild at the moment.
☐2 The pain comes and goes and is moderate.
☐3 The pain is fairly severe at the moment.
☐4 The pain is very severe at the moment.
☐5 The pain is the worst imaginable at the moment.

Sleeping
☐0 I have no trouble sleeping.
☐1 My sleep is slightly disturbed (sleep loss 0-1 hour).
☐2 My sleep is mildly disturbed (1-2 hours).
☐3 My sleep is moderately disturbed (2-3 hours).
☐4 My sleep is greatly disturbed (3-5 hours).
☐5 My sleep is completely disturbed (5-7 hours).

Reading
☐0 I can read as much as I want with no neck pain.
☐1 I can read as much as I want with slight neck pain.
☐2 I can read as much as I want with moderate neck pain.
☐3 I cannot read as much because of moderate neck pain.
☐4 I can hardly read at all because of severe neck pain.
☐5 I cannot read at all because of neck pain.

Concentration
☐0 I can concentrate fully when I want with no difficulty.
☐1 I can concentrate fully with slight difficulty.
☐2 I have a fair degree of difficulty concentrating.
☐3 I have a lot of difficulty concentrating when I want.
☐4 I have a great deal of difficulty concentrating.
☐5 I cannot concentrate at all.

Headaches
☐0 I have no headaches at all.
☐1 I have slight headaches which come infrequently.
☐2 I have moderate headaches which come infrequently.
☐3 I have moderate headaches which come frequently.
☐4 I have severe headaches which come frequently.
☐5 I have headaches almost all the time.

Work
☐0 I can do as much work as I want.
☐1 I can only do my usual work but no more.
☐2 I can only do most of my normal work but no more.
☐3 I cannot do my usual work.
☐4 I can hardly do any work.
☐5 I cannot do any work at all.

Personal Care
☐0 I can look after myself normally without causing any extra pain.
☐1 I can look after myself normally, but it causes extra pain.
☐2 It is painful to look after myself and I am slow and careful.
☐3 I need some help but I manage most of my personal care.
☐4 I need help every day in most aspects of self-care.
☐5 I do not get dressed, I wash with difficulty and stay in bed.

Lifting
☐0 I can lift heavy objects without extra pain.
☐1 I can lift heavy objects but it causes extra pain.
☐2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
☐3 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
☐4 I can only lift very light weights.
☐5 I cannot lift or carry anything at all.

Driving
☐0 I can drive my car without any neck pain.
☐1 I can drive my car with slight neck pain.
☐2 I can drive my car with moderate neck pain.
☐3 I cannot drive my car as long as I want because of moderate neck pain.
☐4 I can hardly drive at all because of severe neck pain.
☐5 I cannot drive my car at all because of neck pain.

Recreation
☐0 I am able to engage in all my recreation activities without neck pain.
☐1 I am able to engage in all my recreation activities with some neck pain.
☐2 I am able to engage in most but not all my usual recreation activities because of neck pain.
☐3 I am only able to engage in a few of my usual recreation activities because of neck pain.
☐4 I can hardly do any recreation activities because of neck pain.
☐5 I cannot do any recreation activities at all.

BACK INDEX

Patient Name _____ Date _____

*This questionnaire will give your provider information about how your **back condition** affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

Pain Intensity

☐0 The pain comes and goes and is very mild.
☐1 The pain is mild and does not vary much.
☐2 The pain comes and goes and is moderate.
☐3 The pain is moderate and does not vary much.
☐4 The pain comes and goes and is very severe.
☐5 The pain is very severe and does not vary much.

Sleeping

☐0 I get no pain in bed.
☐1 I get pain in bed, doesn't prevent from sleeping well.
☐2 Due to pain normal sleep is reduced by less than 25%.
☐3 Due to pain normal sleep is reduced by less than 50%.
☐4 Due to pain normal sleep is reduced by less than 75%.
☐5 My pain prevents me from sleeping at all.

Sitting

☐0 I can sit in any chair as long as I want.
☐1 I can only sit in my favorite chair as long as I want.
☐2 Pain prevents me from sitting more than 1 hour.
☐3 Pain prevents me from sitting more than 1/2 hour.
☐4 Pain prevents me from sitting more than 10 minutes.
☐5 I avoid sitting because it increases pain immediately.

Personal Care (Washing or Dressing)

☐0 I do not have to change my way of washing or dressing in order to avoid pain.
☐1 I do not normally change my way of washing or dressing even though it causes some pain.
☐2 Personal care increases the pain but I manage not to change the way I do it.
☐3 Personal care increases the pain and I find it necessary to change the way I do it.
☐4 Because of the pain I am unable to do some washing and dressing without help.
☐5 Because of the pain I am unable to do any washing and dressing without help.

Social Life

☐0 My social life is normal and gives me no extra pain.
☐1 My social life is normal but increases the pain.
☐2 Pain has no significant effect on my social life apart from limiting my more energetic interests (dancing).
☐3 Pain has restricted my social life, I don't go out very often.
☐4 Pain has restricted my social life to my home.
☐5 I have hardly any social life because of the pain.

Standing

☐0 I can stand as long as I want without pain.
☐1 I have some pain while standing but it does not increase with time.
☐2 I can't stand longer than 1 hr without increasing pain.
☐3 I can't stand longer than 1/2 hour not increasing pain.
☐4 I can't stand longer than 10 min without increasing pain.
☐5 I avoid standing because it increases pain immediately.

Walking

☐0 I have no pain while walking.
☐1 I have some pain but it does not increase with distance.
☐2 I can't walk more than 1 mile without increasing pain.
☐3 I can't walk more than 1/2 mile not increasing pain.
☐4 I can't walk more than 1/4 mile not increasing pain.
☐5 I cannot walk at all without increasing pain.

Traveling

☐0 I get no pain while traveling.
☐1 I get some pain while traveling but none of my usual forms of travel make it worse.
☐2 I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
☐ 3 I get extra pain while traveling which causes me to seek alternate forms of travel.
☐ 4 Pain restricts all forms of travel except those done while lying down.
☐5 Pain restricts all my forms of travel.

Lifting

☐0 I can lift heavy weights without extra pain.
☐1 I can lift heavy weights but it causes extra pain.
☐2 Pain prevents from lifting heavy weights off the floor.
☐3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
☐4 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
☐5 I can only lift very light weights.

Changing Degree of Pain

☐0 My pain is rapidly getting better.
☐1 Pain fluctuates but overall is definitely getting better.
☐2 Pain seems to be getting better, improvement is slow.
☐3 My pain is neither getting better or worse.
☐4 My pain is gradually worsening.
☐5 My pain is rapidly worsening

ASSIGNMENT OF BENEFITS
and MEDICAL RELEASE

ASSIGNMENT OF BENEFITS

I, _____, hereinafter ASSIGNOR, hereby authorize
(Name of insured patient)

_____ to pay directly to Smardz Corporation .
(Name of Insurance Carrier) (Name of Medical Provider)

hereinafter ASSIGNEE, the medical benefits otherwise payable to me for their service, but not to exceed the changes of those services. I hereby ASSIGN to ASSIGNEE any benefits or causes of action under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by ASSIGNEE. This ASSIGNMENT OF BENEFITS is given in exchange for ASSIGNEE agreeing to await payment from the above named insurance carrier for all payments due and payable pursuant to the ASSIGNOR'S contract of insurance. This ASSIGNMENT OF BENEFITS is IRREVOCABLE unless subsequent revocation is in writing and agreed to by both parties.

MEDICAL RELEASE

This document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me, to release true copies of same to ASSIGNEE or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the ASSIGNEE herin. A photocopy of this document shall be as binding as an original signature page.

The undersigned ASSIGNOR by these presents does give and grant the said ASSIGNEE as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the ASSIGNOR might or could personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

IN WITTNESS WHEREOF the undersigned ASSIGNOR and ASSIGNEE have hereunto set their hands, this _____ day of _____, 20__.

_____
Patient's Signature (ASSIGNOR)

_____
Authorized Representative of ASSIGNEE
(Smardz Corporation)

_____
Patient's Name (Please Print Clearly)

DOCTOR'S LIEN

TO: Attorney / Insurance Carrier

_____

_____

_____

Doctor

Dr. Deanna Barbaro Smardz Corp
A BETTER LIFE CHIROPRACTIC
2228 North Tamiami Trail
Naples, FL 34103
Tel : (239) 263-3369
Fax: (239) 263-8842

RE: Patient records and doctor's lien

I do hereby authorize the above doctor to furnish you, my attorney / insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred / began on _____.

I hereby give a lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney / insurance carrier, to pay directly to said doctor such sums as may be due and owing him for services rendered me, and to withhold such sums from such settlement, claim, judgement, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: _____ Authorized Signature: _____

NOTICE: Please date, sign and return one copy to doctor's office at once.

Keep one copy for your record.
Reply envelope attached.

A BETTER LIFE CHIROPRACTIC
661 Goodlette Road Suite 108; Naples, FL 34102
Tel (239)263-3369 Fax (239) 263-8842

Dr. Deanna Barbaro
Chiropractor

INSURANCE PATIENTS

**** PLEASE NOTE ****

While our office makes every effort to obtain coverage information, unfortunately, we cannot guarantee that your insurance will pay benefits. This is due to the fact that insurance companies NEVER guarantee benefits until they review the file.

This office does discount the PPO "contracted discounted amount" from the final payable patient portion.

However, we are not responsible for disputed amounts which fall outside the contracted PPO allowed amount.

Please realize it is the responsibility of each patient to contact his/her employer or benefits office for details of personal coverage. While we do make every effort to ensure your benefits, insurance coverage disputes are not the responsibility of our office.

Insurance coverage is a contract between the patient and the insurance company. All charges incurred are the responsibility of the patient.

Please review your Explanation of Benefits received from insurance to review payment on services.

Signature: _____ Date: _____

Please only fill out the highlighted areas

A Better Life Chiropractic
661 Goodlette Rd N #108
Naples, FL 34102
(239) 263-3369

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.	

A BETTER LIFE CHIROPRACTIC
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Dr. Deanna Barbaro
Chiropractor

TERMS OF ACCEPTANCE

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those for findings, we will recommend that you seek the services of all health care providers who specializes in that area.

Chiropractic has only one goal. It is important that each patient understand both the *objective* and the *method* that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express it's maximum health potential.

Regardless of what a disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.

_____ _____
Signature Date

PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Deanna Barbaro of A Better Life Chiropractic to use and disclose **PROTECTED HEALTH INFORMATION (PHI)** about me to carry out **TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO).**
I have the right to review the Notice of Privacy Practices prior to signing this consent. A Better Life Chiropractic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Deanna Barbaro, A Better Life Chiropractic, 661 Goodlette Road North, Suite 108; Naples, FL 34102 or send an email to cris@ablchiro.com.
With this consent, A Better Life Chiropractic **may call me, may email me, may mail** my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

By signing this form, I am consenting to A Better Life Chiropractic's use and disclosure of my Protected Health Information (PHO) to carry out Treatment, Payment and Health care operations (TPO).
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, or later revoke it, A Better Life Chiropractic may decline to provide treatment to me.**

_____ _____
Signature of Patient or Legal Guardian Date

A BETTER LIFE CHIROPRACTIC
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Dr. Deanna Barbaro
Chiropractor

Dear Patients:

Massage therapy is a separate entity within our office. A minimum of 24 hours advanced cancellation is required. If notification is not received within this time period, you will be responsible for fees charged to our office.

Full massage session fees will apply if you are late for your appointment.

No future massage appointments will be scheduled if you have an outstanding bill for massage fees.

I understand the above stated massage cancellation policy:

Signature: _____

Print Name: _____

Date: _____

MASSAGE THERAPY CLIENT WAIVER *Client Name* _____

I do hereby consent to having Massage Therapy performed by the therapists of A Better Life Chiropractic, Dr. Deanna Barbaro. I understand treatment may include *various massage techniques* involving movements of joints and soft tissues. I am aware that it is common to experience *muscle soreness* within the first few treatments. I do understand that underlying pathology, perhaps unknown to me or the therapist may render me more susceptible to injury. I further understand that **I will inform the therapist if any unusual physical discomfort occurs during or after treatment.**

I do understand that some of the therapy methods used in the office generate *heat*, such as hot stones, hot towels, hot shells and can rarely cause burn. **During treatment I will inform the therapist my level of temperature comfort to avoid burns.** I freely assume any risk on my chosen treatment.

Please initial each statement, then sign and date below:

_____ I understand that massage therapy and bodywork are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.

_____ I understand that the bodywork practitioner does not diagnose illness, disease or any other physical or mental disorder. The practitioner does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. It has been made very clear that massage therapy and bodywork are not substitutes for medical examination or diagnosis and that it is recommended that I see a medical practitioner for any physical ailment that I may have.

_____ I understand that services offered today, and in the future are not a substitute for medical care and that any information provided by the therapist is for educational purposes only and is not diagnostically prescriptive in nature.

_____ I have stated all my known medical conditions on the Client Information Form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.

_____ I realize it is solely my responsibility to keep the bodywork practitioner updated on any changes in my physical health and I understand that **A Better Life Chiropractic and Dr. Deanna Barbaro** shall not be liable should I fail to do so.

_____ I understand that all massage therapy and bodywork offered is *strictly non-sexual*.

_____ By signing this release, I hereby waive and release **A Better Life Chiropractic** and its staff, massage therapists and bodywork practitioners from any and all liability, past, present and future relating to massage therapy and bodywork.

Treatment Results:

I do understand there are beneficial effects associated with massage therapy including, but not limited to, decrease pain, improved mobility, reduced muscle spasm as well as relaxing effects. However, I do understand that massage therapy is not an exact science and I acknowledge that *no guarantee has been made to me regarding the outcome of this care.* Over all I do agree with the treatment and am responsible for my decision to have massage therapy.

Client Signature _____ Date _____

PATIENT REQUEST FOR RECORDS

DATE:_____

RECORDS TO BE SENT FROM:

_____ ATTENTION:_____

(DOCTOR/HOSPITAL)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TEL (___) _____-_____ FAX (___) _____-_____

I hereby authorize the release of my _____ or copies of such and request that they are transferred to:

DR DEANNA BARBARO / A BETTER LIFE

ATTENTION: RECORDS **ADDRESS:** 661 GOODLETTE ROAD NORTH UNIT 108

CITY: NAPLES **STATE:** FL **ZIP:** 34116

TEL (239) 263-3369 **FAX** (239)263-8842

Email: OFFICE@ABETTERLIFECHIROPRACTIC.COM

PATIENT NAME: _____ FILE _____ DOB:_____

_____

PATIENT SIGNATURE