

Chiropractic, Acupuncture & Massage Center
Dr. Amir Ahmadiyar, D.C.
Your Back to Health Choice for All Ages

Authorization to Pay Physician

I hereby authorize _____ Insurance Company to pay by check and mail directly to:

Greater Falls Church Chiropractic Center
6521 Arlington Boulevard, Suite 100
Falls Church, VA 22042

Ashburn Chiropractic Center
44121 Harry Byrd., Suite 145
Ashburn, VA 20147

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above named address for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Print Name

Date

Signature

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

DR. AMIR AHMADIYAR, D.C.

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Confidential Health History

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Female: _____ Male

SS#: _____ Driver's License #: _____

Employer: _____ Type of Work: _____

Employment Status: _____ Full Time _____ Part Time _____ Not Employed _____ Retired _____

Marital Status: _____ Single _____ Married _____ Widowed: _____ Divorced _____ Separated: _____

Name of Spouse: _____ Spouse SS#: _____

Spouse Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

****Referred to this office by: _____

PLEASE CIRCLE TYPE OF PATIENT:

SELF PAY INSURANCE AUTO ACCIDENT WORKER'S COMP

HEALTH INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder: Self Spouse Other _____

ID#: _____

Group #: _____

Policy Holder's Name: _____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

Secondary Insurance: _____

Policy Holder: Self Spouse Other _____

ID#: _____

Group #: _____

Policy Holder's Name: _____

Date of Birth: _____

SS #: _____

Sex: _____ Male _____ Female

I understand and agree that health and accident insurance policies are an arrangement between insurance carriers and my self. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized should be paid directly to the Doctor's Office will be credited to me account on receipt. However, I clearly understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In the event my account is past due for 60 days from the date of service, and is turned over to an attorney for collection, I will also be liable for attorney's fees in the amount 1/3 of the principal balance, plus court costs.

PATIENT'S SIGNATURE: _____ **DATE:** _____

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Designation of Authorized Representative

I _____, do hereby designate Dr. Amir Ahmadiyar/ Dr. James Geer of Greater Falls Church Chiropractic Center to full extent permissible under the Employee Retirement Income Security Act of 1974 (“ERISA”) and as provided in 29 CFR 2560-503-1(b)4 to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other healthcare expense(s) incurred as a result of the services I receive from the above named doctor. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical plan reimbursement and to pursue any other applicable remedies.

Patient’s Name

Patient’s Signature

Date

CHIROPRACTIC, ACUPUNCTURE & MASSAGE CENTER

Dr. Amir Ahmadiyar, D.C.

Notice of Practices Acknowledgement

I understand that, under the Health insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third party payers.

*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Greater Falls Church Chiropractic & Acupuncture Center

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Patient's Name: _____ Medicare # (HICN): _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, Medicare probably will not pay for:

1. Massage
2. Acupuncture
3. Traction
4. Electrical Stim
5. Moist Heat
6. X-rays
7. Supplies and Vitamins
8. Any modalities not mentioned with the exception of spinal manipulation

The purpose of this form is to help you make an informed choice whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: \$**_____), in case you have to pay for them yourself or through insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. SIGN AND DATE YOUR CHOICE

<p>_____ OPTION 1 YES. I want to receive these items or services.</p> <p>I understand that Medicare will not decide to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund me of any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeals Medicare's decision.</p>	
_____ DATE	_____ Signature of patient or guardian
<p>_____ OPTION 2 NO. I have decided not to receive these items or services</p> <p>I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.</p>	
_____ DATE	_____ Signature of patient or guardian

Greater Falls Church Chiropractic Center

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ABOUT MEDICARE COVERAGE

The government's Medicare program only pays Doctors of Chiropractic (DCs) for limited services. If your needed Chiropractic Adjustment (manipulation treatment) meets Medicare's rules, they will usually pay for it. There are three categories of Medicare services; 1) non-covered 2) always covered, and 3) perhaps covered.

NON-COVERED

According to existing Medicare law, most of the available services in our office are NON-COVERED. Hopefully, the U.S Congress will change that someday and treat Doctors of Chiropractic like all other doctors. Until then:

Examples of Non-Covered Services

All Services Other than Chiropractic Adjustments:

- Office Visits – to evaluate and manage, re-evaluate, advise or counsel
- Physiotherapy – such as massage, traction, electrical stimulation, neuromuscular re-education, etc.
- X-rays, Laboratory, Supplies, Vitamins, etc.

Various Chiropractic Adjustments:

- Adjustment on the area other than the spine (to the shoulder, arm, leg, etc.)
- Maintenance Care – you are stable and not making any more improvement
- Wellness care – to promote better health.

NON-Covered items will appear on your insurance claim form. They will show as a Medicare NON-Covered service like this: "72010-GY". The "72010" code is for an x-ray. The "-GY" code means that it is not-covered, allowing your service to go through the Medicare system. After denial by Medicare, it can then go on to your other insurance. If you have Medigap insurance (also known as Medicare Secondary or Supplemental insurance) they will pay according to the terms of your contract

ALWAYS COVERED

A typical example of a Medicare COVERED service (or clinically needed) is when you are in much pain due to a bad spinal condition. You should also expect Medicare to cover and pay for your rehabilitation as long as you are improving. When you have a COVERED Chiropractic spinal adjustment (manipulation treatment), it will be shown on your Medicare claim form and payment reports as either "98940", "98941", or "98942".

PERHAPS COVERED

Your Chiropractic Adjustment must be clinically needed according to Medicare. If Medicare thinks that your condition is not "Medically Necessary" they won't pay. If we know or believe that Medicare will not pay for your Chiropractic Adjustment due to any rules that they might have, we will let you know. We will give you a special Medicare form known as the Advance Beneficiary Notice (ABN).

STATEMENT OF UNDERSTANDING

I understand that I am personally financially responsible for all Medicare NON-covered services. I also understand that there could be times when my chiropractic adjustments might not be covered. If so, my doctor will let me know. I am also responsible for any annual deductibles or applicable copayments as required by Medicare

Signature of patient or person acting on patient's behalf

Date

LONG-TERM AUTHORIZATION

You won't have to sign again during this time period. This authorization can be revoked upon your written request.

Patient Name: _____ Medicare # (HICN): _____

Provider Name: _____

Provider Address : _____

Authorization Period: From : _____ 200__ To: _____ 200__ (must be completed to be valid)

I request that payment under the medicare insurance program be made either to me or to the provider named above on any bills for services Furnished to me during the effective period of this authorization, and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers, or to any other payer for information needed to process claims. I further permit a copy of this authorization to be used in place of the original.

Signature of patient or person acting on patients behalf

Date

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to a payer, your health information on this form may be shared with the payer. Your health information which the payer sees will be kept confidential by the payer.

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Office Financial Policy

Please be informed of the following office financial policy:

_____ **I am a Cash/Self-Pay Patient**

- I am responsible for all charges incurred for my treatment during each of my visits.
- I will get a 10% discount fee if I pay for **10** consecutive visits in advance.
- Birthday Rule: I get a 50% discount if I bring my birthday postcard sent to me by the office on my birthday month.
- Complimentary Referral Rule: I get a choice of a free visit or a free ½ hour massage if I refer someone to the clinic and is seen by my doctor.

_____ **I am an Insurance/Medicare Patient**

- I am agreeing to pay my co-payment at the time of each service.
- I am responsible and will be billed for my insurance deductible and coinsurance as reflected on my EOB(Explanation of Benefits)
- I am responsible to obtain any referrals needed prior to my visit from my insurance company or primary care physician's office. If seen without a referral, I agree to be financially responsible for all charges incurred for all services rendered.
- Birthday Rule: My co-payment is waived at the time of service if I bring my birthday postcard sent to me by the office on my birthday month.
- Complimentary Referral Rule: I get a choice of a free ½ hour massage or my co-payment being waived for one visit if I refer someone to the clinic and is seen by my doctor.

Acknowledgement

- I understand that payment is expected when services are rendered unless other arrangements have been made.
- I understand that I will be financially responsible for the recommended care whether or no the anticipated results and benefits are achieved.
- I understand that I will be billed directly for the \$20 Fee for massage cancellation done less than 24 hours notice.
- In the event that my participation with my healthcare network is terminated, I wish to continue my treatment as a private paying patient and I would be personally responsible for the charges associated with my care.
- If outside collection services or attorneys are employed by this facility for the individual who disregards our office policy, he/she agrees to pay those charges, including court costs and attorney fees of 33+1/3% in the event this file is turned over to an attorney for collection.

Patient Name

Date

Signature