Wharfside
CHIROPRACTIC CENTER
Dr. Thomas C. McGillick, D.C.

2 Hollywood Blvd., Suite A
Forked River, NJ 08731
(609) 971-7722
Fax (609) 693-7623
(800) 447-1398

CONSENT FOR TREATMENT OF A MINOR

I, being the parent or guardian of _____,
a minor, the age of _____, do hereby consent, authorize, and request Dr. Thomas C. McGillick to administer such treatment deemed advisable, necessary, or requested on the above minor.

Signed: _____
Parent or Guardian *

Date: _____ Witness: _____

* Identification may be required

A. WHARFSIDE CHIROPRACTIC CENTER, INC.

B. Patient: **C. Identification Number:223631436**

Advance Beneficiary Notice of Non-coverage 2024 (ABN)

NOTE: If Medicare doesn't pay for **D. Therapies** below, you will 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 will not pay for the Therapy below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Therapies Muscle Stimulation Diathermy Stabilizer	Medicare will not pay any Therapies. When provided by a Doctor of Chiropractic.	$16.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Therapy.** 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.**_____ 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. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ 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.**_____ 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:

Traditional Medicare never will pay for any Therapies.

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:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

AUTHORIZATIONS AND RELEASES

NAME _____

Consent for Treatment

I, the undersigned, hereby authorize Dr. Thomas C. McGillick and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipts. I permit this office to endorse remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Patient's Signature _____ **Date**_____ **Witness** _____

Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my Insurance claim(s) and also certify that all Insurance information given to this clinic is correct and complete.

Patient's Signature _____ **Date**_____ **Witness** _____

Request for Payment of Benefits to Provider of Care

I hereby authorize the _____ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to Wharfside Chiropractic Center. The expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature _____ **Date**_____ **Witness** _____

X-RAY/Medical Records Release

I have requested the release of (Name) _____ which are a part of the records at (Facility) _____.

I hereby request and authorize you, your employees and agents to furnish the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information that may be requested relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future. Please forward to:

(Name) _____ (Address) _____

Patient's Signature _____ **Date**_____ **Witness** _____

Acknowledgement of Privacy Notice

I acknowledge that I have been told that the Notices of Privacy Practices for Wharfside Chiropractic Center is posted in the reception area. I have been offered a copy of the Notice of Privacy Practices and have ACCEPTED/DECLINED a copy.

Patient's Signature _____ **Date**_____ **Witness**_____

Name of Patient's Representative and Relationship (if applicable) _____

Health History

Please list any medication (including pain killers) you are taking: _____

_____

Please list any serious injuries or surgeries you have had in the last 10 years:

	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Other Serious Injuries		

Women: Are you pregnant? ☐ Y ☐ N If so, how far along? _____ Nursing? ☐ Y ☐ N

Medical Conditions

Have you ever had or do you currently have any of the following medical conditions?

- ☐ Heart Attack/Stroke
- ☐ Congenital Heart Defect
- ☐ Alcohol/Drug Abuse
- ☐ Fainting/Seizures/Epilepsy
- ☐ Shingles
- ☐ Psychiatric Problems
- ☐ Difficulty Breathing
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Frequent Neck Pain
- ☐ Jaw Pain
- ☐ Wrist Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Lower Back Problems
- ☐ Severe/Frequent Earaches
- ☐ Ringing in Ears
- ☐ Severe/Frequent Headaches
- ☐ Diabetes/Tuberculosis
- ☐ Dizziness
- ☐ Emphysema/Glaucoma
- ☐ Kidney Problems
- ☐ Artificial Bones/Joints
- ☐ Cancer
- ☐ HIV Positive/AIDS
- ☐ Ulcer/Colitis
- ☐ Gout
- ☐ Numbness, where? _____
- ☐ Tingling, where? _____
- ☐ Muscle Spasms, where? _____

Personal Habits

	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the chiropractor to help determine appropriate and healthful chiropractic treatment. If there is any change in my medical status, I will inform the chiropractor.

I authorize my insurance company to pay to the chiropractor or chiropractic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Soc. Sec.# _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birth Date _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birth Date _____ Soc. Sec.# _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person responsible employed by _____ Occupation _____

Business Address _____

Business Phone _____ Business Email _____

Insurance Company _____

Phone _____ Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Reason for Visit

Have you ever seen a chiropractor? ☐ Yes ☐ No If yes, when and why? _____

Your reason for *this* visit: _____

Please describe your current pain and its location: _____

When did symptoms begin (date)? _____ Have you had similar conditions in the past? _____

Is pain getting: ☐ Worse ☐ Better ☐ Same ☐ Comes and goes How often do you have this pain? _____

Have you been treated by a medical physician for this condition? _____

If so, when and where? _____

Activities or movements that are difficult/painful to perform: ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Lifting

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Tingling ☐ Numbness ☐ Cramping
☐ Stiffness ☐ Swelling ☐ Other _____

Is pain interfering with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Please complete both sides.