CHIP SHEMANSKY, D.C.
24830 BURNT PINE DR STE3
BONITA SPRINGS FL 34134

PH (239) 948-5727
FAX (888) 657-4642
Gulfshorechiropractic.com

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CHIROPRACTIC CLINICS

Confidential Patient Case History Form

Personal Injury Questionnaire

Patient Name: _____Nickname:_____

SS#: _____D.O.B:_____/_____/_____ Age:_____ Marital Status (Please, Circle): S M D W

Emergency Contact Name & Phone #: _____

Primary Auto policy holder name: _____ Date of Birth: _____

Auto Insurance_____ Policy #_____Claim# _____

Adjuster's Name_____ Number: _____EXT. _____

Driver/Other Vehicle_____ Ins. Co. _____Policy #_____

Have you retained an attorney? () Yes ( )No Attorney name & number:_____

Address: _____City: _____ State: ___

Zip: _____Northern Address (if applicable):_____

City:_____ State:_____Zip:_____ Employer:_____

Occupation:_____ Work #:_____Cell #:_____

Home:_____E-mail:_____

May we have your permission to send you text messages regarding appointment reminders, promotions, and deals?

(Please, Circle) Yes No

Height:_____ Weight:_____ How often do you exercise?_____

Do you smoke? Yes____ No____ Family Medical History: _____

Medication Intake:_____

Medical Condition(s) Currently Being Treated For: _____

List Surgical Operations and When:_____

Primary Care Physician: _____ Name of Physician: _____

Last Physical: _____ Most Recent Bone Density

Test:_____

Have you ever had Chiropractic Care? Yes____ No____ Home Treatments: _____

Have you had treatment for your current condition recently or in the past? (Please, Circle) Yes No

Past Diagnostic Tests: X-rays_____ MRI_____ CT Scan_____ Other_____

Findings:_____

Women Only: Do you have any reason to believe that you may be pregnant? (Please, Circle) Yes No

NATURE OF ACCIDENT:

1. Date of Accident _____ City/State: _____Time of Day_____

2. Were you: ( ) driver ( ) passenger ( ) front seat ( ) back seat

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3. What type of vehicle were you in? _____ Other vehicle? _____

4. Number of people in your vehicle? _____ Other vehicle? _____

5. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

6. What direction was the other vehicle headed? ( )North ( )East ( )South ( )West

on (name of street) _____

7. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

8. What was the approximate speed at the time of the impact? Your vehicle _____mph Other vehicle _____mph

9. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long_____

10. Were police notified? ( ) Yes ( ) No

11. What was the weather at the time of the collision? ( ) Dry ( ) Wet ( ) Icy

12. Was your vehicle in: ( ) park ( ) neutral ( ) in gear ( ) moving ( ) stopped *Were your brakes being applied? Y N

13. Was your vehicle shoved: ( ) forward ( ) backward ( ) sideways You were shoved? _____

14. Did your seat have a head restraint (headrest)? ( ) Yes ( ) No, if Yes, what was the position ( ) low ( ) midposition ( )high

15. Did your head ride over the headrest? ( ) Yes ( ) No

16. Did any other part of your body hit the interior of the vehicle? ( ) Yes ( ) No, If yes specify: ( ) side door ( ) steering-

wheel ( ) dashboard ( ) windshield ( ) side window ( ) other: _____

17. Which part of your body? ( ) chest ( ) head ( ) chin ( ) face ( ) R L knee ( ) R L shoulder ( ) R L hand ( ) other

18. Were you holding on to the steering wheel? ( ) Yes ( ) No *Did you brace your arms against the dash? ( ) Yes ( ) No

19. Did you brace your legs against the floorboard? ( ) Yes ( ) No

20. In your own words, please describe accident: _____

_____

_____

_____

21. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No.

If yes, please describe in detail: _____

_____

22. Please describe how you felt:
a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident:_____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

23. What are your PRESENT complaints and symptoms? _____

24. Where/when were you taken after the accident? Name of hospital? _____

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25. Any medication or medical supplies given? _____

26. Did you have any X-rays taken at the hospital? ( ) Yes ( ) No

Diagnosis: _____

27. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctor's name and treatment received: _____

28. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse

29. Do you have any congenital (from birth) factors which relate to this problem?

( )Yes ( )No. If yes, please describe: _____

30. Do you have any previous illnesses which relate to this case? ( )Yes ( )No.

If yes please describe: _____

31. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

32. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

O Headache	**O** Irritability	**O** Numbness in Toes	**O** Face Flushed	**O** Cold Feet
O Neck Pain	**O** Chest Pain	**O** Shortness of Breath	**O** Buzzing in Ears	**O** Cold Hands
O Neck Stiff	**O** Dizziness	**O** Fatigue	**O** Loss of Balance	**O** Stomach Upset
O Sleeping Problems	**O** Head seems Too Heavy	**O** Depression	**O** Fainting	**O** Constipation
O Back Pain	**O** Pins & Needles in Arms	**O** Lights bother eyes	**O** Loss of Smell	**O** Cold Sweats
O Nervousness	**O** Pins & Needles in Legs	**O** Loss of Memory	**O** Loss of Taste	**O** Fever
O Tension	**O** Numbness in Fingers	**O** Ears Ring	**O** Diarrhea	**O** Vision/Focus

Symptoms Other Than Above _____

_____

Radiation of Pain? Leg_____ Knee_____ Foot_____ Shoulder_____ Other_____

Other Symptoms: Burning_____ Tingling_____ Numbness_____ Shooting_____ Dizziness/Vertigo_____

Pain worse when: Sitting___ Standing___ Rising from Chair___ Lying Down___ Walking___ Other_____

Pain better with: Sitting___ Standing___ Walking___ Resting___ Medication___ Ice___ Heat___ Activity___

33. Have you lost time from work as a result of this accident? ( )Yes ( )No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? ( )Yes ( )No. If yes, please state type of compensation you are receiving:_____

34. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No. If yes, please describe, in detail:

_____

35. Other pertinent information we've missed or you think is important: _____

_____

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Patient Signature: _____ **Date**: _____/_____/_____

How were you referred to our office?

✓ Please, place a checkmark next to applicable answer.

- ☐ Google
- ☐ Website
- ☐ Facebook
- ☐ Instagram
- ☐ Twitter
- ☐ Youtube
- ☐ Pinterest
- ☐ Word of mouth
- ☐ Article or blog post
- ☐ Other (please, specify) _____

Payment Is DueAt The Time Services Are Rendered

Our practice is acutely aware of the escalating healthcare costs and we are doing everything feasible to help lower them through increased efficiency. Recent changes in health benefits have resulted in larger patient co-pays, deductibles and coinsurance. It is costly and inefficient to send patients a bill/statement or to call the Insurance Company to verify your coverage. Our staff is happy to assist you in determining if you are in or out of network and will try to assist you in estimating what portion of our fees is your responsibility; however, this will NOT be a guarantee of coverage, and or payment. Due to the high volume in our office we might ask you to please verify your chiropractic coverage.

Because insurance companies commonly misquote benefits and deductible status, we request that you assist us in helping to reduce billing costs by completing the credit/debit card authorization below. By signing the authorization, you can be assured that your credit card will be charged only for those fees that your insurance company has determined that you owe. We honor all contractual obligations with insurance companies with which we participate, so you will never be charged for any amounts in excess of those that are allowed. You will be contacted via phone to be informed of the amount that will be charged to your credit card. The amount charged to your credit card will equal the amount shown on your EOB (Explanation of Benefits). If account has balance due to office for **which I am legally responsible, including co-pays, deductibles, coinsurance, non-covered charges, supplements, supplies, or missed payment at the time of appointment** the credit card will be charged.

Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay or coinsurance for the services rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly

Patient Name_____ **Card Holder** _____
Credit/Debit Card # _____-_____-_____-_____ **CVV #** _____ **Zip**_____
Expiration (MM/YY) _____/_____ **Address #**_____ **MC Visa Disc Amex**

I CLEARLY UNDERSTAND THE FINANCIAL AGREEMENT AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO MY INSURANCE AND OR DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE FFLHS TO CHARGE MY CC. **I hereby agree that if this office is required to institute a legal action to collect any past due balance upon my account, I shall be responsible for attorney's fees and costs of suit incurred by this office for said legal action.**

_____ _____
Signature of patient Date

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Financial Policy Notice

All insurance companies must follow the federal regulations of the Centers for Medicare & Medicaid Services. Please note that federal law supersedes state law. The Medicare and Medicaid definitions for treatment are as follows:

Maintenance Therapy/Wellness Care/Supported Care: "is not considered to be medically reasonable or necessary under the Medicare/Medicaid program, and is therefore, **NOT PAYABLE**. Maintenance therapy is defined as a treatment plan that seeks to prevent diseases, promote health, and prolong and enhance the quality of life; or therapy is performed to maintain or prevent deterioration of a chronic condition. **When further clinical improvements cannot reasonably be expected from continuous ongoing care and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered MAINTENANCE THERAPY and is, therefore, NOT medically necessary."**

Chronic Condition: "a patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment, (as is the case with an acute condition), but where the continued therapy can be expected to result in some function improvement. **Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatments is considered maintenance therapy and is NOT COVERED**." Although we can stabilize the condition to an extent, but residual pain may still remain.

Acute Condition: "a patient's condition is considered acute when it is expected to significantly improve or be resolved with treatment."

Exacerbated or Aggravated: "an increase in severity of a disease or any of the signs or symptoms. This is typically due to significant irritation or flare up of the patient's complaints without a specific incident." (This may be secondary to performing the activities of daily living. i.e. you woke up feeling this way, bent over to pick something up, stumbled walking down the street, which gives you the right to hurt and allows you the right to be re-evaluated and ordered additional treatment).

New Patient: "is one who has NOT received any professional services from a physician, another physician of the same specialty who belongs to the same group practice within the past 3 years." (If you've been treated by Dr. Shemansky before but have not been treated by him within the last 3 years, the law requires Dr. Shemansky to evaluate you as a new patient again in order to go through any medical changes within that time period in which you were not being treated).

Re-Evaluation: Medicare/Medicaid and Private insurance companies **REQUIRE** us to re-evaluate you, order a treatment plan, and then discharge you from care (**a start & finish to treatment MUST BE established**). An existing patient will be re-examined when a new symptom/injury occurs, or the patient's previous symptom(s) becomes exacerbated and/or aggravated so a treatment plan can be established showing the care you are going to receive is medically necessary to satisfy Medicare guidelines. 90 days is the maximum before a re-evaluation is due again.

In an effort to maintain compliance with various state & federal regulations, managed care and preferred provider agreements; as well as billing & coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

a. We are a participating provider in your health plan.
b. You are covered by a State of Federal Program with a mandated fee schedule.
c. Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2012, our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By:_____ Date:_____

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Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for muscular-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: **Soreness**: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments. **Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare. **Fractures/Join Injury**: I further understand that in isolated cases underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. **Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve and brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death. **Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

- I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
- I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
- I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to m consent to these procedures, I hereby affix my signature to this authorization for this treatment.

Signature of Patient:_____ Date: _____

Signature of Witness: _____Date: _____

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I,_____, hereby authorize Gulfshore Chiropractic Clinics to use and/or disclose to your insurance (Please, print name) _____ following specific protected health information: progress notes, X-ray notes, and any other requested correspondence.
2. I understand that this authorization is valid until patients' treatment is completed.
3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, statements, and anything else necessary for your care.
4. I acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand the revocation of this authorization will not have an affect on disclosure occurring prior to the execution of the revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that I, my health care, and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

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11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. This authorization is valid on _____/_____/_____, the date I have signed below.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

Witness:_____

Notice of Receipt of Privacy Notice

Protecting the privacy of your Personal Health Information ("PHI") is important to us. Our privacy notice details how information about you may be used and disclosed and how you can get access to that information.

By selecting I authorize being contacted for practice reminders by:
Mail _____; Email_____; at email address
_____;
Telephone numbers; including Text and or Voicemail at: _____(put phone # if different from personal information section)

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS. List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

_____ _____
Date Signed Witness

OFFICE POLICIES

Cash Patient: (No insurance coverage) Payment is due at the time of service is rendered. Once you have become an established patient, other options such as payment plans, etc. may be discussed.

Insurance Coverage: In today's insurance climate there are numerous and varied insurance coverage's. It is necessary for us to have a ***copy of your insurance card*** prior to accepting your insurance benefits. We will call your insurance company to verify your coverage. ***You will be considered a cash patient until your benefits can be determined***. Co-payments must be paid at the time of service. Deductibles (if out of network) must be paid at the time of service until met. Many times coverage varies from what is printed on your insurance card. We will make every effort to determine your coverage prior to your treatment or examination and discuss such in detail.

- ***Your insurance policy is an ***agreement between you and your insurance company***. Your help in obtaining benefits is very important. In other words, you have more influence with your company than we do. Ultimately, services rendered to you are your responsibility, regardless of your insurance company.
- Referral from Primary Care Physician: Some HMO's and PPO's require a referral from your Primary Care Physician to receive chiropractic benefits. It is your responsibility to contact your Primary Care Physician and get such a referral if one is necessary. Dr. Chip Shemansky will gladly speak with your physician and help with this referral.

Workers Compensation: We do accept Workers Compensation cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. **By Law**, your employer and our office are bound to certain time frames for filing claims under Workers Compensation.

Personal Injury Cases: We will accept Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will call your insurance company and verify your coverage. We will discuss your coverage with you in detail and whenever possible prior to treatment or examination.

Financial Policy:
There are **many varied types of financial arrangements** that are available to our patients. These range from cash patients, payment plans, and partial insurance coverage to full insurance coverage. Workers Compensation, Auto Insurance, and Medicare are also some of the other options. It can be quite complicated at times. Regardless of the arrangements made, your participation and cooperation is necessary and very important. Please, make certain to read all of your office and financial policies and ask any questions you may have. We do not want to discontinue your treatment because of a problem. **Please, keep the lines of communication open**.

(IF COLLECTION PROCEDURES ARE NECESSARY A 30% FEE WILL BE ADDED)
Missed Appointments:
The outcome of your treatment program is based on a number of factors such as; severity of your condition, age, lifestyle, type of work, keeping scheduled appointments, and other aspects. **Keeping scheduled appointments** is one of the most important factors and is the one factor that is totally out of our control. We understand that situations arise that are unforeseen and cause you to reschedule an occasional appointment. ***If you need treatment and don't receive it, your treatment results will suffer***. Please, notify us ASAP if you cannot keep a scheduled appointment. ***Second missed appointment without prior notification will result in a $50 no-show charge***. Our goal is to help you get well as quickly as possible. Your cooperation is a necessity.

Cancelled Appointments:
If you cancel your appointment the day of you will be charged a **$25 cancellation fee**, unless cancellation reason is justified. Our goal is to help you get well as quickly as possible. Your time is important as well as the time we set aside for your specific treatment. Last minute cancellations affect our office greatly as we have turned away other patients who require care. Please, be respectful of your time and ours. Your cooperation is a necessity.

Estimated Treatment Time:
It is impossible to predict the exact length of time your treatment will take. For the best outcome, be sure to follow all of our recommendations. Dr. Chip Shemansky will thoroughly explain your condition prior to starting treatment. He will give you his professional opinion on how long it will take to treat your condition and answer any questions you may have. Good communication is important to us. We want you to understand your condition and treatment.

Referrals:
Most of our "new patients" come to out office by word-of-mouth. Your referrals are welcomed, expected and are the "life blood" of this practice. Help us help others. Please, spread the word about chiropractic experiences and the service you received at this

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office. If you are happy with us, tell others and if you're not, tell us. If there is some way we can serve you better, please let us know. One of our goals is to continue to improve our service.

I, have read through and understand the Office Policies for Gulfshore Chiropractic Clinics. I also understand that I will ultimately be responsible for services rendered regardless of my insurance coverage, cancellation and/if any missed or cancelled appointment fees, as outlined above.

Patient Signature: _____ Date: _____

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AUTHORIZATIONS & RELEASES

Assignment of Benefits & ERISA ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Print Name:_____

Signature:_____Date:_____

Health Insurance Claim Form
In order for Shemansky Chiropractic, P.A. dba "Gulfshore Chiropractic Clinics" to submit claims to the insurance company, we must have patients sign the statements below. If not signed, Gulfshore Chiropractic Clinics, will assume you will be a cash patient.
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.

_____ _____
Signature of patient Date

Insured's or authorized person's signature. I authorize payment of medical benefits to the undersigned physician or supplier or services described below.

_____ _____
Signature of patient Date

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND Insurer and Patient Please Read the Following in its Entirety I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted.

In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____Date: _____

Patient's Signature: _____

(Please Print) (If patient is a minor, signature of parent/guardian)

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Confidential Patient Case History Form

Personal Injury Questionnaire

Patient Name: _____Nickname:_____

SS#: _____D.O.B:_____/_____/_____ Age:_____ Marital Status (Please, Circle): S M D W

Emergency Contact Name & Phone #: _____

Primary Auto policy holder name: _____ Date of Birth: _____

Auto Insurance_____ Policy #_____Claim# _____

Adjuster's Name_____ Number: _____EXT. _____

Driver/Other Vehicle_____ Ins. Co. _____Policy #_____

Have you retained an attorney? () Yes ( )No Attorney name & number:_____

Address: _____City: _____ State: ___

Zip: _____Northern Address (if applicable):_____

City:_____ State:_____Zip:_____ Employer:_____

Occupation:_____ Work #:_____Cell #:_____

Home:_____E-mail:_____

May we have your permission to send you text messages regarding appointment reminders, promotions, and deals?

(Please, Circle) Yes No

Height:_____ Weight:_____ How often do you exercise?_____

Do you smoke? Yes____ No____ Family Medical History: _____

Medication Intake:_____

Medical Condition(s) Currently Being Treated For: _____

List Surgical Operations and When:_____

Primary Care Physician: _____ Name of Physician: _____

Last Physical: _____ Most Recent Bone Density

Test:_____

Have you ever had Chiropractic Care? Yes____ No____ Home Treatments: _____

Have you had treatment for your current condition recently or in the past? (Please, Circle) Yes No

Past Diagnostic Tests: X-rays_____ MRI_____ CT Scan_____ Other_____

Findings:_____

Women Only: Do you have any reason to believe that you may be pregnant? (Please, Circle) Yes No

NATURE OF ACCIDENT:

1. Date of Accident _____ City/State: _____Time of Day_____

2. Were you: ( ) driver ( ) passenger ( ) front seat ( ) back seat

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3. What type of vehicle were you in? _____ Other vehicle? _____

4. Number of people in your vehicle? _____ Other vehicle? _____

5. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

6. What direction was the other vehicle headed? ( )North ( )East ( )South ( )West

on (name of street) _____

7. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

8. What was the approximate speed at the time of the impact? Your vehicle _____mph Other vehicle _____mph

9. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long_____

10. Were police notified? ( ) Yes ( ) No

11. What was the weather at the time of the collision? ( ) Dry ( ) Wet ( ) Icy

12. Was your vehicle in: ( ) park ( ) neutral ( ) in gear ( ) moving ( ) stopped *Were your brakes being applied? Y N

13. Was your vehicle shoved: ( ) forward ( ) backward ( ) sideways You were shoved? _____

14. Did your seat have a head restraint (headrest)? ( ) Yes ( ) No, if Yes, what was the position ( ) low ( ) midposition ( )high

15. Did your head ride over the headrest? ( ) Yes ( ) No

16. Did any other part of your body hit the interior of the vehicle? ( ) Yes ( ) No, If yes specify: ( ) side door ( ) steering-

wheel ( ) dashboard ( ) windshield ( ) side window ( ) other: _____

17. Which part of your body? ( ) chest ( ) head ( ) chin ( ) face ( ) R L knee ( ) R L shoulder ( ) R L hand ( ) other

18. Were you holding on to the steering wheel? ( ) Yes ( ) No *Did you brace your arms against the dash? ( ) Yes ( ) No

19. Did you brace your legs against the floorboard? ( ) Yes ( ) No

20. In your own words, please describe accident: _____

_____

_____

_____

21. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No.

If yes, please describe in detail: _____

_____

22. Please describe how you felt:
a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident:_____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

23. What are your PRESENT complaints and symptoms? _____

24. Where/when were you taken after the accident? Name of hospital? _____

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25. Any medication or medical supplies given? _____

26. Did you have any X-rays taken at the hospital? ( ) Yes ( ) No

Diagnosis: _____

27. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctor's name and treatment received: _____

28. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse

29. Do you have any congenital (from birth) factors which relate to this problem?

( )Yes ( )No. If yes, please describe: _____

30. Do you have any previous illnesses which relate to this case? ( )Yes ( )No.

If yes please describe: _____

31. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

32. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

O Headache	**O** Irritability	**O** Numbness in Toes	**O** Face Flushed	**O** Cold Feet
O Neck Pain	**O** Chest Pain	**O** Shortness of Breath	**O** Buzzing in Ears	**O** Cold Hands
O Neck Stiff	**O** Dizziness	**O** Fatigue	**O** Loss of Balance	**O** Stomach Upset
O Sleeping Problems	**O** Head seems Too Heavy	**O** Depression	**O** Fainting	**O** Constipation
O Back Pain	**O** Pins & Needles in Arms	**O** Lights bother eyes	**O** Loss of Smell	**O** Cold Sweats
O Nervousness	**O** Pins & Needles in Legs	**O** Loss of Memory	**O** Loss of Taste	**O** Fever
O Tension	**O** Numbness in Fingers	**O** Ears Ring	**O** Diarrhea	**O** Vision/Focus

Symptoms Other Than Above _____

_____

Radiation of Pain? Leg_____ Knee_____ Foot_____ Shoulder_____ Other_____

Other Symptoms: Burning_____ Tingling_____ Numbness_____ Shooting_____ Dizziness/Vertigo_____

Pain worse when: Sitting___ Standing___ Rising from Chair___ Lying Down___ Walking___ Other_____

Pain better with: Sitting___ Standing___ Walking___ Resting___ Medication___ Ice___ Heat___ Activity___

33. Have you lost time from work as a result of this accident? ( )Yes ( )No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? ( )Yes ( )No. If yes, please state type of compensation you are receiving:_____

34. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No. If yes, please describe, in detail:

_____

35. Other pertinent information we've missed or you think is important: _____

_____

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Patient Signature: _____ **Date**: _____/_____/_____

How were you referred to our office?

✓ Please, place a checkmark next to applicable answer.

- ☐ Google
- ☐ Website
- ☐ Facebook
- ☐ Instagram
- ☐ Twitter
- ☐ Youtube
- ☐ Pinterest
- ☐ Word of mouth
- ☐ Article or blog post
- ☐ Other (please, specify) _____

Payment Is DueAt The Time Services Are Rendered

Our practice is acutely aware of the escalating healthcare costs and we are doing everything feasible to help lower them through increased efficiency. Recent changes in health benefits have resulted in larger patient co-pays, deductibles and coinsurance. It is costly and inefficient to send patients a bill/statement or to call the Insurance Company to verify your coverage. Our staff is happy to assist you in determining if you are in or out of network and will try to assist you in estimating what portion of our fees is your responsibility; however, this will NOT be a guarantee of coverage, and or payment. Due to the high volume in our office we might ask you to please verify your chiropractic coverage.

Because insurance companies commonly misquote benefits and deductible status, we request that you assist us in helping to reduce billing costs by completing the credit/debit card authorization below. By signing the authorization, you can be assured that your credit card will be charged only for those fees that your insurance company has determined that you owe. We honor all contractual obligations with insurance companies with which we participate, so you will never be charged for any amounts in excess of those that are allowed. You will be contacted via phone to be informed of the amount that will be charged to your credit card. The amount charged to your credit card will equal the amount shown on your EOB (Explanation of Benefits). If account has balance due to office for **which I am legally responsible, including co-pays, deductibles, coinsurance, non-covered charges, supplements, supplies, or missed payment at the time of appointment** the credit card will be charged.

Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay or coinsurance for the services rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly

Patient Name_____ **Card Holder** _____
Credit/Debit Card # _____-_____-_____-_____ **CVV #** _____ **Zip**_____
Expiration (MM/YY) _____/_____ **Address #**_____ **MC Visa Disc Amex**

I CLEARLY UNDERSTAND THE FINANCIAL AGREEMENT AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO MY INSURANCE AND OR DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE FFLHS TO CHARGE MY CC. **I hereby agree that if this office is required to institute a legal action to collect any past due balance upon my account, I shall be responsible for attorney's fees and costs of suit incurred by this office for said legal action.**

_____ _____
Signature of patient Date

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Financial Policy Notice

All insurance companies must follow the federal regulations of the Centers for Medicare & Medicaid Services. Please note that federal law supersedes state law. The Medicare and Medicaid definitions for treatment are as follows:

Maintenance Therapy/Wellness Care/Supported Care: "is not considered to be medically reasonable or necessary under the Medicare/Medicaid program, and is therefore, **NOT PAYABLE**. Maintenance therapy is defined as a treatment plan that seeks to prevent diseases, promote health, and prolong and enhance the quality of life; or therapy is performed to maintain or prevent deterioration of a chronic condition. **When further clinical improvements cannot reasonably be expected from continuous ongoing care and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered MAINTENANCE THERAPY and is, therefore, NOT medically necessary."**

Chronic Condition: "a patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment, (as is the case with an acute condition), but where the continued therapy can be expected to result in some function improvement. **Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatments is considered maintenance therapy and is NOT COVERED**." Although we can stabilize the condition to an extent, but residual pain may still remain.

Acute Condition: "a patient's condition is considered acute when it is expected to significantly improve or be resolved with treatment."

Exacerbated or Aggravated: "an increase in severity of a disease or any of the signs or symptoms. This is typically due to significant irritation or flare up of the patient's complaints without a specific incident." (This may be secondary to performing the activities of daily living. i.e. you woke up feeling this way, bent over to pick something up, stumbled walking down the street, which gives you the right to hurt and allows you the right to be re-evaluated and ordered additional treatment).

New Patient: "is one who has NOT received any professional services from a physician, another physician of the same specialty who belongs to the same group practice within the past 3 years." (If you've been treated by Dr. Shemansky before but have not been treated by him within the last 3 years, the law requires Dr. Shemansky to evaluate you as a new patient again in order to go through any medical changes within that time period in which you were not being treated).

Re-Evaluation: Medicare/Medicaid and Private insurance companies **REQUIRE** us to re-evaluate you, order a treatment plan, and then discharge you from care (**a start & finish to treatment MUST BE established**). An existing patient will be re-examined when a new symptom/injury occurs, or the patient's previous symptom(s) becomes exacerbated and/or aggravated so a treatment plan can be established showing the care you are going to receive is medically necessary to satisfy Medicare guidelines. 90 days is the maximum before a re-evaluation is due again.

In an effort to maintain compliance with various state & federal regulations, managed care and preferred provider agreements; as well as billing & coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

a. We are a participating provider in your health plan.
b. You are covered by a State of Federal Program with a mandated fee schedule.
c. Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2012, our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By:_____ Date:_____

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Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for muscular-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: **Soreness**: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments. **Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare. **Fractures/Join Injury**: I further understand that in isolated cases underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. **Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve and brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death. **Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

- I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
- I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
- I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to m consent to these procedures, I hereby affix my signature to this authorization for this treatment.

Signature of Patient:_____ Date: _____

Signature of Witness: _____Date: _____

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I,_____, hereby authorize Gulfshore Chiropractic Clinics to use and/or disclose to your insurance (Please, print name) _____ following specific protected health information: progress notes, X-ray notes, and any other requested correspondence.
2. I understand that this authorization is valid until patients' treatment is completed.
3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, statements, and anything else necessary for your care.
4. I acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand the revocation of this authorization will not have an affect on disclosure occurring prior to the execution of the revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that I, my health care, and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

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11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. This authorization is valid on _____/_____/_____, the date I have signed below.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

Witness:_____

Notice of Receipt of Privacy Notice

Protecting the privacy of your Personal Health Information ("PHI") is important to us. Our privacy notice details how information about you may be used and disclosed and how you can get access to that information.

By selecting I authorize being contacted for practice reminders by:
Mail _____; Email_____; at email address
_____;
Telephone numbers; including Text and or Voicemail at: _____(put phone # if different from personal information section)

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS. List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

_____ _____
Date Signed Witness

OFFICE POLICIES

Cash Patient: (No insurance coverage) Payment is due at the time of service is rendered. Once you have become an established patient, other options such as payment plans, etc. may be discussed.

Insurance Coverage: In today's insurance climate there are numerous and varied insurance coverage's. It is necessary for us to have a ***copy of your insurance card*** prior to accepting your insurance benefits. We will call your insurance company to verify your coverage. ***You will be considered a cash patient until your benefits can be determined***. Co-payments must be paid at the time of service. Deductibles (if out of network) must be paid at the time of service until met. Many times coverage varies from what is printed on your insurance card. We will make every effort to determine your coverage prior to your treatment or examination and discuss such in detail.

- ***Your insurance policy is an ***agreement between you and your insurance company***. Your help in obtaining benefits is very important. In other words, you have more influence with your company than we do. Ultimately, services rendered to you are your responsibility, regardless of your insurance company.
- Referral from Primary Care Physician: Some HMO's and PPO's require a referral from your Primary Care Physician to receive chiropractic benefits. It is your responsibility to contact your Primary Care Physician and get such a referral if one is necessary. Dr. Chip Shemansky will gladly speak with your physician and help with this referral.

Workers Compensation: We do accept Workers Compensation cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. **By Law**, your employer and our office are bound to certain time frames for filing claims under Workers Compensation.

Personal Injury Cases: We will accept Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will call your insurance company and verify your coverage. We will discuss your coverage with you in detail and whenever possible prior to treatment or examination.

Financial Policy:
There are **many varied types of financial arrangements** that are available to our patients. These range from cash patients, payment plans, and partial insurance coverage to full insurance coverage. Workers Compensation, Auto Insurance, and Medicare are also some of the other options. It can be quite complicated at times. Regardless of the arrangements made, your participation and cooperation is necessary and very important. Please, make certain to read all of your office and financial policies and ask any questions you may have. We do not want to discontinue your treatment because of a problem. **Please, keep the lines of communication open**.

(IF COLLECTION PROCEDURES ARE NECESSARY A 30% FEE WILL BE ADDED)
Missed Appointments:
The outcome of your treatment program is based on a number of factors such as; severity of your condition, age, lifestyle, type of work, keeping scheduled appointments, and other aspects. **Keeping scheduled appointments** is one of the most important factors and is the one factor that is totally out of our control. We understand that situations arise that are unforeseen and cause you to reschedule an occasional appointment. ***If you need treatment and don't receive it, your treatment results will suffer***. Please, notify us ASAP if you cannot keep a scheduled appointment. ***Second missed appointment without prior notification will result in a $50 no-show charge***. Our goal is to help you get well as quickly as possible. Your cooperation is a necessity.

Cancelled Appointments:
If you cancel your appointment the day of you will be charged a **$25 cancellation fee**, unless cancellation reason is justified. Our goal is to help you get well as quickly as possible. Your time is important as well as the time we set aside for your specific treatment. Last minute cancellations affect our office greatly as we have turned away other patients who require care. Please, be respectful of your time and ours. Your cooperation is a necessity.

Estimated Treatment Time:
It is impossible to predict the exact length of time your treatment will take. For the best outcome, be sure to follow all of our recommendations. Dr. Chip Shemansky will thoroughly explain your condition prior to starting treatment. He will give you his professional opinion on how long it will take to treat your condition and answer any questions you may have. Good communication is important to us. We want you to understand your condition and treatment.

Referrals:
Most of our "new patients" come to out office by word-of-mouth. Your referrals are welcomed, expected and are the "life blood" of this practice. Help us help others. Please, spread the word about chiropractic experiences and the service you received at this

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office. If you are happy with us, tell others and if you're not, tell us. If there is some way we can serve you better, please let us know. One of our goals is to continue to improve our service.

I, have read through and understand the Office Policies for Gulfshore Chiropractic Clinics. I also understand that I will ultimately be responsible for services rendered regardless of my insurance coverage, cancellation and/if any missed or cancelled appointment fees, as outlined above.

Patient Signature: _____ Date: _____

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AUTHORIZATIONS & RELEASES

Assignment of Benefits & ERISA ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Print Name:_____

Signature:_____Date:_____

Health Insurance Claim Form
In order for Shemansky Chiropractic, P.A. dba "Gulfshore Chiropractic Clinics" to submit claims to the insurance company, we must have patients sign the statements below. If not signed, Gulfshore Chiropractic Clinics, will assume you will be a cash patient.
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.

_____ _____
Signature of patient Date

Insured's or authorized person's signature. I authorize payment of medical benefits to the undersigned physician or supplier or services described below.

_____ _____
Signature of patient Date

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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND Insurer and Patient Please Read the Following in its Entirety I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted.

In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____Date: _____

Patient's Signature: _____

(Please Print) (If patient is a minor, signature of parent/guardian)

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Confidential Patient Case History Form

Personal Injury Questionnaire

Patient Name: _____Nickname:_____

SS#: _____D.O.B:_____/_____/_____ Age:_____ Marital Status (Please, Circle): S M D W

Emergency Contact Name & Phone #: _____

Primary Auto policy holder name: _____ Date of Birth: _____

Auto Insurance_____ Policy #_____Claim# _____

Adjuster's Name_____ Number: _____EXT. _____

Driver/Other Vehicle_____ Ins. Co. _____Policy #_____

Have you retained an attorney? () Yes ( )No Attorney name & number:_____

Address: _____City: _____ State: ___

Zip: _____Northern Address (if applicable):_____

City:_____ State:_____Zip:_____ Employer:_____

Occupation:_____ Work #:_____Cell #:_____

Home:_____E-mail:_____

May we have your permission to send you text messages regarding appointment reminders, promotions, and deals?

(Please, Circle) Yes No

Height:_____ Weight:_____ How often do you exercise?_____

Do you smoke? Yes____ No____ Family Medical History: _____

Medication Intake:_____

Medical Condition(s) Currently Being Treated For: _____

List Surgical Operations and When:_____

Primary Care Physician: _____ Name of Physician: _____

Last Physical: _____ Most Recent Bone Density

Test:_____

Have you ever had Chiropractic Care? Yes____ No____ Home Treatments: _____

Have you had treatment for your current condition recently or in the past? (Please, Circle) Yes No

Past Diagnostic Tests: X-rays_____ MRI_____ CT Scan_____ Other_____

Findings:_____

Women Only: Do you have any reason to believe that you may be pregnant? (Please, Circle) Yes No

NATURE OF ACCIDENT:

1. Date of Accident _____ City/State: _____Time of Day_____

2. Were you: ( ) driver ( ) passenger ( ) front seat ( ) back seat

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3. What type of vehicle were you in? _____ Other vehicle? _____

4. Number of people in your vehicle? _____ Other vehicle? _____

5. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

6. What direction was the other vehicle headed? ( )North ( )East ( )South ( )West

on (name of street) _____

7. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

8. What was the approximate speed at the time of the impact? Your vehicle _____mph Other vehicle _____mph

9. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long_____

10. Were police notified? ( ) Yes ( ) No

11. What was the weather at the time of the collision? ( ) Dry ( ) Wet ( ) Icy

12. Was your vehicle in: ( ) park ( ) neutral ( ) in gear ( ) moving ( ) stopped *Were your brakes being applied? Y N

13. Was your vehicle shoved: ( ) forward ( ) backward ( ) sideways You were shoved? _____

14. Did your seat have a head restraint (headrest)? ( ) Yes ( ) No, if Yes, what was the position ( ) low ( ) midposition ( )high

15. Did your head ride over the headrest? ( ) Yes ( ) No

16. Did any other part of your body hit the interior of the vehicle? ( ) Yes ( ) No, If yes specify: ( ) side door ( ) steering-

wheel ( ) dashboard ( ) windshield ( ) side window ( ) other: _____

17. Which part of your body? ( ) chest ( ) head ( ) chin ( ) face ( ) R L knee ( ) R L shoulder ( ) R L hand ( ) other

18. Were you holding on to the steering wheel? ( ) Yes ( ) No *Did you brace your arms against the dash? ( ) Yes ( ) No

19. Did you brace your legs against the floorboard? ( ) Yes ( ) No

20. In your own words, please describe accident: _____

_____

_____

_____

21. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No.

If yes, please describe in detail: _____

_____

22. Please describe how you felt:
a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident:_____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

23. What are your PRESENT complaints and symptoms? _____

24. Where/when were you taken after the accident? Name of hospital? _____

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25. Any medication or medical supplies given? _____

26. Did you have any X-rays taken at the hospital? ( ) Yes ( ) No

Diagnosis: _____

27. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctor's name and treatment received: _____

28. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse

29. Do you have any congenital (from birth) factors which relate to this problem?

( )Yes ( )No. If yes, please describe: _____

30. Do you have any previous illnesses which relate to this case? ( )Yes ( )No.

If yes please describe: _____

31. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

32. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

O Headache	**O** Irritability	**O** Numbness in Toes	**O** Face Flushed	**O** Cold Feet
O Neck Pain	**O** Chest Pain	**O** Shortness of Breath	**O** Buzzing in Ears	**O** Cold Hands
O Neck Stiff	**O** Dizziness	**O** Fatigue	**O** Loss of Balance	**O** Stomach Upset
O Sleeping Problems	**O** Head seems Too Heavy	**O** Depression	**O** Fainting	**O** Constipation
O Back Pain	**O** Pins & Needles in Arms	**O** Lights bother eyes	**O** Loss of Smell	**O** Cold Sweats
O Nervousness	**O** Pins & Needles in Legs	**O** Loss of Memory	**O** Loss of Taste	**O** Fever
O Tension	**O** Numbness in Fingers	**O** Ears Ring	**O** Diarrhea	**O** Vision/Focus

Symptoms Other Than Above _____

_____

Radiation of Pain? Leg_____ Knee_____ Foot_____ Shoulder_____ Other_____

Other Symptoms: Burning_____ Tingling_____ Numbness_____ Shooting_____ Dizziness/Vertigo_____

Pain worse when: Sitting___ Standing___ Rising from Chair___ Lying Down___ Walking___ Other_____

Pain better with: Sitting___ Standing___ Walking___ Resting___ Medication___ Ice___ Heat___ Activity___

33. Have you lost time from work as a result of this accident? ( )Yes ( )No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? ( )Yes ( )No. If yes, please state type of compensation you are receiving:_____

34. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No. If yes, please describe, in detail:

_____

35. Other pertinent information we've missed or you think is important: _____

_____

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Patient Signature: _____ **Date**: _____/_____/_____

How were you referred to our office?

✓ Please, place a checkmark next to applicable answer.

- ☐ Google
- ☐ Website
- ☐ Facebook
- ☐ Instagram
- ☐ Twitter
- ☐ Youtube
- ☐ Pinterest
- ☐ Word of mouth
- ☐ Article or blog post
- ☐ Other (please, specify) _____

Payment Is DueAt The Time Services Are Rendered

Our practice is acutely aware of the escalating healthcare costs and we are doing everything feasible to help lower them through increased efficiency. Recent changes in health benefits have resulted in larger patient co-pays, deductibles and coinsurance. It is costly and inefficient to send patients a bill/statement or to call the Insurance Company to verify your coverage. Our staff is happy to assist you in determining if you are in or out of network and will try to assist you in estimating what portion of our fees is your responsibility; however, this will NOT be a guarantee of coverage, and or payment. Due to the high volume in our office we might ask you to please verify your chiropractic coverage.

Because insurance companies commonly misquote benefits and deductible status, we request that you assist us in helping to reduce billing costs by completing the credit/debit card authorization below. By signing the authorization, you can be assured that your credit card will be charged only for those fees that your insurance company has determined that you owe. We honor all contractual obligations with insurance companies with which we participate, so you will never be charged for any amounts in excess of those that are allowed. You will be contacted via phone to be informed of the amount that will be charged to your credit card. The amount charged to your credit card will equal the amount shown on your EOB (Explanation of Benefits). If account has balance due to office for **which I am legally responsible, including co-pays, deductibles, coinsurance, non-covered charges, supplements, supplies, or missed payment at the time of appointment** the credit card will be charged.

Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay or coinsurance for the services rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly

Patient Name_____ **Card Holder** _____
Credit/Debit Card # _____-_____-_____-_____ **CVV #** _____ **Zip**_____
Expiration (MM/YY) _____/_____ **Address #**_____ **MC Visa Disc Amex**

I CLEARLY UNDERSTAND THE FINANCIAL AGREEMENT AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO MY INSURANCE AND OR DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE FFLHS TO CHARGE MY CC. **I hereby agree that if this office is required to institute a legal action to collect any past due balance upon my account, I shall be responsible for attorney's fees and costs of suit incurred by this office for said legal action.**

_____ _____
Signature of patient Date

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Financial Policy Notice

All insurance companies must follow the federal regulations of the Centers for Medicare & Medicaid Services. Please note that federal law supersedes state law. The Medicare and Medicaid definitions for treatment are as follows:

Maintenance Therapy/Wellness Care/Supported Care: "is not considered to be medically reasonable or necessary under the Medicare/Medicaid program, and is therefore, **NOT PAYABLE**. Maintenance therapy is defined as a treatment plan that seeks to prevent diseases, promote health, and prolong and enhance the quality of life; or therapy is performed to maintain or prevent deterioration of a chronic condition. **When further clinical improvements cannot reasonably be expected from continuous ongoing care and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered MAINTENANCE THERAPY and is, therefore, NOT medically necessary."**

Chronic Condition: "a patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment, (as is the case with an acute condition), but where the continued therapy can be expected to result in some function improvement. **Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatments is considered maintenance therapy and is NOT COVERED**." Although we can stabilize the condition to an extent, but residual pain may still remain.

Acute Condition: "a patient's condition is considered acute when it is expected to significantly improve or be resolved with treatment."

Exacerbated or Aggravated: "an increase in severity of a disease or any of the signs or symptoms. This is typically due to significant irritation or flare up of the patient's complaints without a specific incident." (This may be secondary to performing the activities of daily living. i.e. you woke up feeling this way, bent over to pick something up, stumbled walking down the street, which gives you the right to hurt and allows you the right to be re-evaluated and ordered additional treatment).

New Patient: "is one who has NOT received any professional services from a physician, another physician of the same specialty who belongs to the same group practice within the past 3 years." (If you've been treated by Dr. Shemansky before but have not been treated by him within the last 3 years, the law requires Dr. Shemansky to evaluate you as a new patient again in order to go through any medical changes within that time period in which you were not being treated).

Re-Evaluation: Medicare/Medicaid and Private insurance companies **REQUIRE** us to re-evaluate you, order a treatment plan, and then discharge you from care (**a start & finish to treatment MUST BE established**). An existing patient will be re-examined when a new symptom/injury occurs, or the patient's previous symptom(s) becomes exacerbated and/or aggravated so a treatment plan can be established showing the care you are going to receive is medically necessary to satisfy Medicare guidelines. 90 days is the maximum before a re-evaluation is due again.

In an effort to maintain compliance with various state & federal regulations, managed care and preferred provider agreements; as well as billing & coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

a. We are a participating provider in your health plan.
b. You are covered by a State of Federal Program with a mandated fee schedule.
c. Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2012, our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By:_____ Date:_____

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Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for muscular-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: **Soreness**: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments. **Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare. **Fractures/Join Injury**: I further understand that in isolated cases underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. **Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve and brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death. **Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

- I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
- I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
- I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to m consent to these procedures, I hereby affix my signature to this authorization for this treatment.

Signature of Patient:_____ Date: _____

Signature of Witness: _____Date: _____

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I,_____, hereby authorize Gulfshore Chiropractic Clinics to use and/or disclose to your insurance (Please, print name) _____ following specific protected health information: progress notes, X-ray notes, and any other requested correspondence.
2. I understand that this authorization is valid until patients' treatment is completed.
3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, statements, and anything else necessary for your care.
4. I acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand the revocation of this authorization will not have an affect on disclosure occurring prior to the execution of the revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that I, my health care, and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

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11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. This authorization is valid on _____/_____/_____, the date I have signed below.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

Witness:_____

Notice of Receipt of Privacy Notice

Protecting the privacy of your Personal Health Information ("PHI") is important to us. Our privacy notice details how information about you may be used and disclosed and how you can get access to that information.

By selecting I authorize being contacted for practice reminders by:
Mail _____; Email_____; at email address
_____;
Telephone numbers; including Text and or Voicemail at: _____(put phone # if different from personal information section)

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS. List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

_____ _____
Date Signed Witness

OFFICE POLICIES

Cash Patient: (No insurance coverage) Payment is due at the time of service is rendered. Once you have become an established patient, other options such as payment plans, etc. may be discussed.

Insurance Coverage: In today's insurance climate there are numerous and varied insurance coverage's. It is necessary for us to have a ***copy of your insurance card*** prior to accepting your insurance benefits. We will call your insurance company to verify your coverage. ***You will be considered a cash patient until your benefits can be determined***. Co-payments must be paid at the time of service. Deductibles (if out of network) must be paid at the time of service until met. Many times coverage varies from what is printed on your insurance card. We will make every effort to determine your coverage prior to your treatment or examination and discuss such in detail.

- ***Your insurance policy is an ***agreement between you and your insurance company***. Your help in obtaining benefits is very important. In other words, you have more influence with your company than we do. Ultimately, services rendered to you are your responsibility, regardless of your insurance company.
- Referral from Primary Care Physician: Some HMO's and PPO's require a referral from your Primary Care Physician to receive chiropractic benefits. It is your responsibility to contact your Primary Care Physician and get such a referral if one is necessary. Dr. Chip Shemansky will gladly speak with your physician and help with this referral.

Workers Compensation: We do accept Workers Compensation cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. **By Law**, your employer and our office are bound to certain time frames for filing claims under Workers Compensation.

Personal Injury Cases: We will accept Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will call your insurance company and verify your coverage. We will discuss your coverage with you in detail and whenever possible prior to treatment or examination.

Financial Policy:
There are **many varied types of financial arrangements** that are available to our patients. These range from cash patients, payment plans, and partial insurance coverage to full insurance coverage. Workers Compensation, Auto Insurance, and Medicare are also some of the other options. It can be quite complicated at times. Regardless of the arrangements made, your participation and cooperation is necessary and very important. Please, make certain to read all of your office and financial policies and ask any questions you may have. We do not want to discontinue your treatment because of a problem. **Please, keep the lines of communication open**.

(IF COLLECTION PROCEDURES ARE NECESSARY A 30% FEE WILL BE ADDED)
Missed Appointments:
The outcome of your treatment program is based on a number of factors such as; severity of your condition, age, lifestyle, type of work, keeping scheduled appointments, and other aspects. **Keeping scheduled appointments** is one of the most important factors and is the one factor that is totally out of our control. We understand that situations arise that are unforeseen and cause you to reschedule an occasional appointment. ***If you need treatment and don't receive it, your treatment results will suffer***. Please, notify us ASAP if you cannot keep a scheduled appointment. ***Second missed appointment without prior notification will result in a $50 no-show charge***. Our goal is to help you get well as quickly as possible. Your cooperation is a necessity.

Cancelled Appointments:
If you cancel your appointment the day of you will be charged a **$25 cancellation fee**, unless cancellation reason is justified. Our goal is to help you get well as quickly as possible. Your time is important as well as the time we set aside for your specific treatment. Last minute cancellations affect our office greatly as we have turned away other patients who require care. Please, be respectful of your time and ours. Your cooperation is a necessity.

Estimated Treatment Time:
It is impossible to predict the exact length of time your treatment will take. For the best outcome, be sure to follow all of our recommendations. Dr. Chip Shemansky will thoroughly explain your condition prior to starting treatment. He will give you his professional opinion on how long it will take to treat your condition and answer any questions you may have. Good communication is important to us. We want you to understand your condition and treatment.

Referrals:
Most of our "new patients" come to out office by word-of-mouth. Your referrals are welcomed, expected and are the "life blood" of this practice. Help us help others. Please, spread the word about chiropractic experiences and the service you received at this

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office. If you are happy with us, tell others and if you're not, tell us. If there is some way we can serve you better, please let us know. One of our goals is to continue to improve our service.

I, have read through and understand the Office Policies for Gulfshore Chiropractic Clinics. I also understand that I will ultimately be responsible for services rendered regardless of my insurance coverage, cancellation and/if any missed or cancelled appointment fees, as outlined above.

Patient Signature: _____ Date: _____

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AUTHORIZATIONS & RELEASES

Assignment of Benefits & ERISA ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Print Name:_____

Signature:_____Date:_____

Health Insurance Claim Form
In order for Shemansky Chiropractic, P.A. dba "Gulfshore Chiropractic Clinics" to submit claims to the insurance company, we must have patients sign the statements below. If not signed, Gulfshore Chiropractic Clinics, will assume you will be a cash patient.
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.

_____ _____
Signature of patient Date

Insured's or authorized person's signature. I authorize payment of medical benefits to the undersigned physician or supplier or services described below.

_____ _____
Signature of patient Date

CHIP SHEMANSKY, D.C.
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ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND Insurer and Patient Please Read the Following in its Entirety I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted.

In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____Date: _____

Patient's Signature: _____

(Please Print) (If patient is a minor, signature of parent/guardian)

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Confidential Patient Case History Form

Personal Injury Questionnaire

Patient Name: _____Nickname:_____

SS#: _____D.O.B:_____/_____/_____ Age:_____ Marital Status (Please, Circle): S M D W

Emergency Contact Name & Phone #: _____

Primary Auto policy holder name: _____ Date of Birth: _____

Auto Insurance_____ Policy #_____Claim# _____

Adjuster's Name_____ Number: _____EXT. _____

Driver/Other Vehicle_____ Ins. Co. _____Policy #_____

Have you retained an attorney? () Yes ( )No Attorney name & number:_____

Address: _____City: _____ State: ___

Zip: _____Northern Address (if applicable):_____

City:_____ State:_____Zip:_____ Employer:_____

Occupation:_____ Work #:_____Cell #:_____

Home:_____E-mail:_____

May we have your permission to send you text messages regarding appointment reminders, promotions, and deals?

(Please, Circle) Yes No

Height:_____ Weight:_____ How often do you exercise?_____

Do you smoke? Yes____ No____ Family Medical History: _____

Medication Intake:_____

Medical Condition(s) Currently Being Treated For: _____

List Surgical Operations and When:_____

Primary Care Physician: _____ Name of Physician: _____

Last Physical: _____ Most Recent Bone Density

Test:_____

Have you ever had Chiropractic Care? Yes____ No____ Home Treatments: _____

Have you had treatment for your current condition recently or in the past? (Please, Circle) Yes No

Past Diagnostic Tests: X-rays_____ MRI_____ CT Scan_____ Other_____

Findings:_____

Women Only: Do you have any reason to believe that you may be pregnant? (Please, Circle) Yes No

NATURE OF ACCIDENT:

1. Date of Accident _____ City/State: _____Time of Day_____

2. Were you: ( ) driver ( ) passenger ( ) front seat ( ) back seat

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3. What type of vehicle were you in? _____ Other vehicle? _____

4. Number of people in your vehicle? _____ Other vehicle? _____

5. What direction were you headed? ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

6. What direction was the other vehicle headed? ( )North ( )East ( )South ( )West

on (name of street) _____

7. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

8. What was the approximate speed at the time of the impact? Your vehicle _____mph Other vehicle _____mph

9. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long_____

10. Were police notified? ( ) Yes ( ) No

11. What was the weather at the time of the collision? ( ) Dry ( ) Wet ( ) Icy

12. Was your vehicle in: ( ) park ( ) neutral ( ) in gear ( ) moving ( ) stopped *Were your brakes being applied? Y N

13. Was your vehicle shoved: ( ) forward ( ) backward ( ) sideways You were shoved? _____

14. Did your seat have a head restraint (headrest)? ( ) Yes ( ) No, if Yes, what was the position ( ) low ( ) midposition ( )high

15. Did your head ride over the headrest? ( ) Yes ( ) No

16. Did any other part of your body hit the interior of the vehicle? ( ) Yes ( ) No, If yes specify: ( ) side door ( ) steering-

wheel ( ) dashboard ( ) windshield ( ) side window ( ) other: _____

17. Which part of your body? ( ) chest ( ) head ( ) chin ( ) face ( ) R L knee ( ) R L shoulder ( ) R L hand ( ) other

18. Were you holding on to the steering wheel? ( ) Yes ( ) No *Did you brace your arms against the dash? ( ) Yes ( ) No

19. Did you brace your legs against the floorboard? ( ) Yes ( ) No

20. In your own words, please describe accident: _____

_____

_____

_____

21. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No.

If yes, please describe in detail: _____

_____

22. Please describe how you felt:
a. DURING the accident: _____

b. IMMEDIATELY AFTER the accident:_____

c. LATER THAT DAY: _____

d. THE NEXT DAY: _____

23. What are your PRESENT complaints and symptoms? _____

24. Where/when were you taken after the accident? Name of hospital? _____

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25. Any medication or medical supplies given? _____

26. Did you have any X-rays taken at the hospital? ( ) Yes ( ) No

Diagnosis: _____

27. Have you been treated by another doctor since the accident? ( ) Yes ( ) No. If yes, please list doctor's name and treatment received: _____

28. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse

29. Do you have any congenital (from birth) factors which relate to this problem?

( )Yes ( )No. If yes, please describe: _____

30. Do you have any previous illnesses which relate to this case? ( )Yes ( )No.

If yes please describe: _____

31. Have you ever been involved in an accident before? ( )Yes ( )No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received. _____

_____

32. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

O Headache	**O** Irritability	**O** Numbness in Toes	**O** Face Flushed	**O** Cold Feet
O Neck Pain	**O** Chest Pain	**O** Shortness of Breath	**O** Buzzing in Ears	**O** Cold Hands
O Neck Stiff	**O** Dizziness	**O** Fatigue	**O** Loss of Balance	**O** Stomach Upset
O Sleeping Problems	**O** Head seems Too Heavy	**O** Depression	**O** Fainting	**O** Constipation
O Back Pain	**O** Pins & Needles in Arms	**O** Lights bother eyes	**O** Loss of Smell	**O** Cold Sweats
O Nervousness	**O** Pins & Needles in Legs	**O** Loss of Memory	**O** Loss of Taste	**O** Fever
O Tension	**O** Numbness in Fingers	**O** Ears Ring	**O** Diarrhea	**O** Vision/Focus

Symptoms Other Than Above _____

_____

Radiation of Pain? Leg_____ Knee_____ Foot_____ Shoulder_____ Other_____

Other Symptoms: Burning_____ Tingling_____ Numbness_____ Shooting_____ Dizziness/Vertigo_____

Pain worse when: Sitting___ Standing___ Rising from Chair___ Lying Down___ Walking___ Other_____

Pain better with: Sitting___ Standing___ Walking___ Resting___ Medication___ Ice___ Heat___ Activity___

33. Have you lost time from work as a result of this accident? ( )Yes ( )No. If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? ( )Yes ( )No. If yes, please state type of compensation you are receiving:_____

34. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No. If yes, please describe, in detail:

_____

35. Other pertinent information we've missed or you think is important: _____

_____

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Patient Signature: _____ **Date**: _____/_____/_____

How were you referred to our office?

✓ Please, place a checkmark next to applicable answer.

- ☐ Google
- ☐ Website
- ☐ Facebook
- ☐ Instagram
- ☐ Twitter
- ☐ Youtube
- ☐ Pinterest
- ☐ Word of mouth
- ☐ Article or blog post
- ☐ Other (please, specify) _____

Payment Is DueAt The Time Services Are Rendered

Our practice is acutely aware of the escalating healthcare costs and we are doing everything feasible to help lower them through increased efficiency. Recent changes in health benefits have resulted in larger patient co-pays, deductibles and coinsurance. It is costly and inefficient to send patients a bill/statement or to call the Insurance Company to verify your coverage. Our staff is happy to assist you in determining if you are in or out of network and will try to assist you in estimating what portion of our fees is your responsibility; however, this will NOT be a guarantee of coverage, and or payment. Due to the high volume in our office we might ask you to please verify your chiropractic coverage.

Because insurance companies commonly misquote benefits and deductible status, we request that you assist us in helping to reduce billing costs by completing the credit/debit card authorization below. By signing the authorization, you can be assured that your credit card will be charged only for those fees that your insurance company has determined that you owe. We honor all contractual obligations with insurance companies with which we participate, so you will never be charged for any amounts in excess of those that are allowed. You will be contacted via phone to be informed of the amount that will be charged to your credit card. The amount charged to your credit card will equal the amount shown on your EOB (Explanation of Benefits). If account has balance due to office for **which I am legally responsible, including co-pays, deductibles, coinsurance, non-covered charges, supplements, supplies, or missed payment at the time of appointment** the credit card will be charged.

Please note at ALL visits there will be a fee collected; whether it be, deductible, co-pay or coinsurance for the services rendered at the time of service. If for some reason we have collected a larger amount than needed, your account will be credited accordingly

Patient Name_____ **Card Holder** _____
Credit/Debit Card # _____-_____-_____-_____ **CVV #** _____ **Zip**_____
Expiration (MM/YY) _____/_____ **Address #**_____ **MC Visa Disc Amex**

I CLEARLY UNDERSTAND THE FINANCIAL AGREEMENT AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED TO MY INSURANCE AND OR DIRECTLY TO ME AND THAT I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE FFLHS TO CHARGE MY CC. **I hereby agree that if this office is required to institute a legal action to collect any past due balance upon my account, I shall be responsible for attorney's fees and costs of suit incurred by this office for said legal action.**

_____ _____
Signature of patient Date

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Financial Policy Notice

All insurance companies must follow the federal regulations of the Centers for Medicare & Medicaid Services. Please note that federal law supersedes state law. The Medicare and Medicaid definitions for treatment are as follows:

Maintenance Therapy/Wellness Care/Supported Care: "is not considered to be medically reasonable or necessary under the Medicare/Medicaid program, and is therefore, **NOT PAYABLE**. Maintenance therapy is defined as a treatment plan that seeks to prevent diseases, promote health, and prolong and enhance the quality of life; or therapy is performed to maintain or prevent deterioration of a chronic condition. **When further clinical improvements cannot reasonably be expected from continuous ongoing care and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered MAINTENANCE THERAPY and is, therefore, NOT medically necessary."**

Chronic Condition: "a patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment, (as is the case with an acute condition), but where the continued therapy can be expected to result in some function improvement. **Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatments is considered maintenance therapy and is NOT COVERED**." Although we can stabilize the condition to an extent, but residual pain may still remain.

Acute Condition: "a patient's condition is considered acute when it is expected to significantly improve or be resolved with treatment."

Exacerbated or Aggravated: "an increase in severity of a disease or any of the signs or symptoms. This is typically due to significant irritation or flare up of the patient's complaints without a specific incident." (This may be secondary to performing the activities of daily living. i.e. you woke up feeling this way, bent over to pick something up, stumbled walking down the street, which gives you the right to hurt and allows you the right to be re-evaluated and ordered additional treatment).

New Patient: "is one who has NOT received any professional services from a physician, another physician of the same specialty who belongs to the same group practice within the past 3 years." (If you've been treated by Dr. Shemansky before but have not been treated by him within the last 3 years, the law requires Dr. Shemansky to evaluate you as a new patient again in order to go through any medical changes within that time period in which you were not being treated).

Re-Evaluation: Medicare/Medicaid and Private insurance companies **REQUIRE** us to re-evaluate you, order a treatment plan, and then discharge you from care (**a start & finish to treatment MUST BE established**). An existing patient will be re-examined when a new symptom/injury occurs, or the patient's previous symptom(s) becomes exacerbated and/or aggravated so a treatment plan can be established showing the care you are going to receive is medically necessary to satisfy Medicare guidelines. 90 days is the maximum before a re-evaluation is due again.

In an effort to maintain compliance with various state & federal regulations, managed care and preferred provider agreements; as well as billing & coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

a. We are a participating provider in your health plan.
b. You are covered by a State of Federal Program with a mandated fee schedule.
c. Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

As part of our compliance plan, as of January 1, 2012, our office will be unable to extend any type of discounts other than those listed above.

Acknowledged By:_____ Date:_____

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Informed Consent to Chiropractic Treatment

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for muscular-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows: **Soreness**: I am aware that, like exercise, it is common to experience muscle soreness in the first few treatments. **Dizziness**: Temporary symptoms like dizziness and nausea can occur but are relatively rare. **Fractures/Join Injury**: I further understand that in isolated cases underlying physical defects, deformities or pathologies, like weak bones from osteoporosis, may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. **Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve and brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death. **Physical Therapy Burns**: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Tests have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results

- I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
- I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
- I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to m consent to these procedures, I hereby affix my signature to this authorization for this treatment.

Signature of Patient:_____ Date: _____

Signature of Witness: _____Date: _____

PATIENT AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I,_____, hereby authorize Gulfshore Chiropractic Clinics to use and/or disclose to your insurance (Please, print name) _____ following specific protected health information: progress notes, X-ray notes, and any other requested correspondence.
2. I understand that this authorization is valid until patients' treatment is completed.
3. I understand that the purpose or use of the disclosure I am granting: Thank you cards, phone calls, statements, and anything else necessary for your care.
4. I acknowledge that this authorization is voluntary.
5. The following is/are other criteria or limitations that I make regarding this authorization:

_____

_____

6. I understand that the office will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that this authorization may be revoked by the authorizer, in writing, at any time in accordance with the attached authorization revocation procedure. I also understand the revocation of this authorization will not have an affect on disclosure occurring prior to the execution of the revocation.
8. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.
9. I understand that I, my health care, and payment for my healthcare will not be affected if I do not sign this form.
10. I understand that I may see and copy the information described in this form, if I ask for it, and that I will get a copy of this form after I sign it.

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11. This form was completely filled in before I signed it. I certify that all of my questions were answered to my satisfaction and that I understand this authorization form and all of its contents.
12. This authorization is valid on _____/_____/_____, the date I have signed below.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

Witness:_____

Notice of Receipt of Privacy Notice

Protecting the privacy of your Personal Health Information ("PHI") is important to us. Our privacy notice details how information about you may be used and disclosed and how you can get access to that information.

By selecting I authorize being contacted for practice reminders by:
Mail _____; Email_____; at email address
_____;
Telephone numbers; including Text and or Voicemail at: _____(put phone # if different from personal information section)

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS. List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____

_____

By signing the lines below I authorize the doctor to personally discuss with me products that may benefit my health or condition. I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices.

_____ _____
Patient Name (Printed) Signature of Patient

_____ _____
Signature of Legal Guardian Relationship to Patient

_____ _____
Date Signed Witness

OFFICE POLICIES

Cash Patient: (No insurance coverage) Payment is due at the time of service is rendered. Once you have become an established patient, other options such as payment plans, etc. may be discussed.

Insurance Coverage: In today's insurance climate there are numerous and varied insurance coverage's. It is necessary for us to have a ***copy of your insurance card*** prior to accepting your insurance benefits. We will call your insurance company to verify your coverage. ***You will be considered a cash patient until your benefits can be determined***. Co-payments must be paid at the time of service. Deductibles (if out of network) must be paid at the time of service until met. Many times coverage varies from what is printed on your insurance card. We will make every effort to determine your coverage prior to your treatment or examination and discuss such in detail.

- ***Your insurance policy is an ***agreement between you and your insurance company***. Your help in obtaining benefits is very important. In other words, you have more influence with your company than we do. Ultimately, services rendered to you are your responsibility, regardless of your insurance company.
- Referral from Primary Care Physician: Some HMO's and PPO's require a referral from your Primary Care Physician to receive chiropractic benefits. It is your responsibility to contact your Primary Care Physician and get such a referral if one is necessary. Dr. Chip Shemansky will gladly speak with your physician and help with this referral.

Workers Compensation: We do accept Workers Compensation cases. Communication with your employer is very important. Notify us immediately if you feel your case should be filed under Workers Compensation. **By Law**, your employer and our office are bound to certain time frames for filing claims under Workers Compensation.

Personal Injury Cases: We will accept Personal Injury cases. We must receive all insurance information prior to accepting your auto insurance as payment. We will call your insurance company and verify your coverage. We will discuss your coverage with you in detail and whenever possible prior to treatment or examination.

Financial Policy:
There are **many varied types of financial arrangements** that are available to our patients. These range from cash patients, payment plans, and partial insurance coverage to full insurance coverage. Workers Compensation, Auto Insurance, and Medicare are also some of the other options. It can be quite complicated at times. Regardless of the arrangements made, your participation and cooperation is necessary and very important. Please, make certain to read all of your office and financial policies and ask any questions you may have. We do not want to discontinue your treatment because of a problem. **Please, keep the lines of communication open**.

(IF COLLECTION PROCEDURES ARE NECESSARY A 30% FEE WILL BE ADDED)
Missed Appointments:
The outcome of your treatment program is based on a number of factors such as; severity of your condition, age, lifestyle, type of work, keeping scheduled appointments, and other aspects. **Keeping scheduled appointments** is one of the most important factors and is the one factor that is totally out of our control. We understand that situations arise that are unforeseen and cause you to reschedule an occasional appointment. ***If you need treatment and don't receive it, your treatment results will suffer***. Please, notify us ASAP if you cannot keep a scheduled appointment. ***Second missed appointment without prior notification will result in a $50 no-show charge***. Our goal is to help you get well as quickly as possible. Your cooperation is a necessity.

Cancelled Appointments:
If you cancel your appointment the day of you will be charged a **$25 cancellation fee**, unless cancellation reason is justified. Our goal is to help you get well as quickly as possible. Your time is important as well as the time we set aside for your specific treatment. Last minute cancellations affect our office greatly as we have turned away other patients who require care. Please, be respectful of your time and ours. Your cooperation is a necessity.

Estimated Treatment Time:
It is impossible to predict the exact length of time your treatment will take. For the best outcome, be sure to follow all of our recommendations. Dr. Chip Shemansky will thoroughly explain your condition prior to starting treatment. He will give you his professional opinion on how long it will take to treat your condition and answer any questions you may have. Good communication is important to us. We want you to understand your condition and treatment.

Referrals:
Most of our "new patients" come to out office by word-of-mouth. Your referrals are welcomed, expected and are the "life blood" of this practice. Help us help others. Please, spread the word about chiropractic experiences and the service you received at this

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office. If you are happy with us, tell others and if you're not, tell us. If there is some way we can serve you better, please let us know. One of our goals is to continue to improve our service.

I, have read through and understand the Office Policies for Gulfshore Chiropractic Clinics. I also understand that I will ultimately be responsible for services rendered regardless of my insurance coverage, cancellation and/if any missed or cancelled appointment fees, as outlined above.

Patient Signature: _____ Date: _____

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AUTHORIZATIONS & RELEASES

Assignment of Benefits & ERISA ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits.

I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Print Name:_____

Signature:_____Date:_____

Health Insurance Claim Form
In order for Shemansky Chiropractic, P.A. dba "Gulfshore Chiropractic Clinics" to submit claims to the insurance company, we must have patients sign the statements below. If not signed, Gulfshore Chiropractic Clinics, will assume you will be a cash patient.
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.

_____ _____
Signature of patient Date

Insured's or authorized person's signature. I authorize payment of medical benefits to the undersigned physician or supplier or services described below.

_____ _____
Signature of patient Date

CHIP SHEMANSKY, D.C.
24830 BURNT PINE DR STE3
BONITA SPRINGS FL 34134

PH (239) 948-5727
FAX (888) 657-4642
Gulfshorechiropractic.com

GULFSHORE
CHIROPRACTIC CLINICS

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND Insurer and Patient Please Read the Following in its Entirety I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider, including the right to file a law suit to seek payment of any unpaid PIP benefits, penalty, postage and/or interest. It is the intention of the provider to accept this assignment in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes over due interest payments and any potential claim for common law or statutory bad faith. The undersigned directs the insurer to pay the health care provider directly.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted. Please send a copy of any scheduled defense examinations or examination under oath to this provider.

Release of information: I hereby authorize this provider to furnish an insurer, an insurer's intermediary, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer; obtain copies of all medical records, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider may produce my medical records to its attorney in connection with any pending lawsuits. The insurer is directed to keep the patient's medical records private and confidential and is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted.

In the event this provider's medical bills are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute.

Certification: I certify that: I have read and agree to the above.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____Date: _____

Patient's Signature: _____

(Please Print) (If patient is a minor, signature of parent/guardian)