DELICATO CHIROPRACTIC, P.C.
NEW PRIVATE PATIENT INSURANCE INFORMATION

(Please Print clearly)

Patients Name: _____

Insured's Name: _____

Insured's Social Security No. _____ Insured's Date of Birth: _____

Insured's Employer: _____

Insurance Company (Name, Address, Telephone No.): _____

_____

Policy No.: _____ Group No.: _____

Category: _____ Effective Date: _____

Is There a Secondary Insurance ☐ Yes ☐ No

Insurance Company (Name, Address, Telephone No.): _____

_____

_____

ATTORNEY INFORMATION:

Name: _____

Address: _____

Phone No. _____

I understand and agree that health and accident insurance policies are an arrangement between the Insurance Carrier and myself. Furthermore, I understand that Delicato Chiropractic P.C. will prepare everything necessary to assist me in making collection from the Insurance Company, and that any amount authorized for payment to Delicato Chiropractic, P.C. will be credited to my account. I authorize the release of any medical information necessary to process my claim. I recognize that I am responsible to Delicato Chiropractic, P.C. for whatever amounts of the bill, for services rendered, up to the entire amount, that my insurance does not cover.

PATIENTS' SIGNATURE: X _____ DATE: _____

CONFIDENTIAL PATIENT INFORMATION

(Please Print clearly)

Name: _____ Social Security No.: _____

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

Sex: ☐ Male ☐ Female Age_____ Birthdate: _____ Marital Status: M S W D

No. of Children _____ Spouses Name: _____ Referred by: _____

Home Telephone No.: _____ Work Telephone No.: _____

Employer (Name and Address: _____

_____ Occupation: _____

HEALTH INFORMATION

Have You Had Previous Chiropractic Care?: ☐ Yes ☐ No

Main Complaint: _____

_____

Other Complaints: _____

_____

How Long Have You Had This Condition?: _____

Have You Had Similar Conditions in the Past?: _____

Does The Condition Effect Your Work?: ☐ Yes ☐ No

Does This Condition Effect Your Family or Social Life?: ☐ Yes ☐ No

What Aggravates This Condition?: _____

_____

Other Doctors Seen For This Condition: _____

_____

Are You Taking Medication?: _____

What Helps Your Symptoms?: _____

_____

Have You Had Surgery, Falls or Accidents?:

When? _____ Please Describe: _____

_____

Date of Last Physical: _____

Is This Condition Due to:

A. Work Related Injury ☐ Yes ☐ No

B. Automobile Accident ☐ Yes ☐ No

DO YOU SUFFER FROM?:

	YES	NO
Headaches	☐	☐
Neck Pain	☐	☐
Arm/Shoulder Pain	☐	☐
Back Pain	☐	☐
Hip or Leg Pain	☐	☐
Abdominal Pain	☐	☐
Sinus Trouble	☐	☐
Heart Trouble	☐	☐
Palpitations	☐	☐
Circulatory Trouble	☐	☐
Low Blood Pressure	☐	☐
High Blood Pressure	☐	☐
Female Problems	☐	☐
Prostate Disorder	☐	☐
Bladder Problems	☐	☐
Kidney Problems	☐	☐
Lung Disorder	☐	☐
Bronchial Disorder	☐	☐
Constipation	☐	☐
Loose Stool	☐	☐
Diabetes	☐	☐
Swollen Joints	☐	☐
Insomnia	☐	☐
Dizziness	☐	☐
Numbness	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Fatigue	☐	☐
Anemia	☐	☐
Poor Memory	☐	☐
Hot Flashes	☐	☐

PATIENTS COMMENTS: _____

_____

_____

PATIENTS SIGNATURE: X _____ DATE: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED X DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED X

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Fold

Fold

NUCC Instruction Manual available at: www.nucc.org

Mfd. by Medical Arts Press

Call toll-free: 1-800-328-2179

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

#14710 - Medical Arts Press

Use with Envelope #14145 (gummed) or #14146 (self-seal)

- § 2302. Authority to issue
- § 2305. Attendance required pursuant to subpoena; possession of books, records, documents or papers
- § 2306. Hospital records; medical records of department or bureau of a municipal corporation or of the state

- New York Civil Practice Law and Rules, Article 31 Disclosure
  - § 3101. Scope of disclosure
  - § 3102. Method of obtaining disclosure
  - § 3103. Protective orders
  - Rule 3107. Notice of taking oral questions
  - Rule 3108. Written questions; when permitted
  - Rule 3109. Notice of taking deposition on written questions
  - Rule 3111. Production of things at the examination
  - Rule 3118. Demand for address of party or of person who possessed and assigned cause of action or defense
  - Rule 3120. Discovery and production of documents and things for inspection, testing, copying or photographing
  - § 3121. Physical or mental examination
  - Rule 3122. Objection to disclosure, inspection or examination; compliance
  - § 3123. Admissions as to matters of fact, papers, documents and photographs
  - Rule 3124. Failure to disclose; motion to compel disclosure
  - Rule 3125. Place where motion to compel disclosure made
  - § 3126. Penalties for refusal to comply with order or to disclose
  - § 3130. Use of interrogatories
  - § 3131. Scope of interrogatories
  - Rule 3132. Service of interrogatories
  - Rule 3133. Service of answers or objections to interrogatories
- New York Civil Practice Law and Rule, Article 45, Evidence
  - § 4504. Physician, dentist, podiatrist, chiropractor and nurse
  - Rule 4518. Business records
  - Rule 4532-a. Admissibility of graphic, numerical, symbolic or pictorial representations of medical or diagnostic tests in personal injury actions
  - § 4548. Privileged communications; electronic communication thereof

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

- This Notice is in effect as of ___/___/___.

By signing below, I certify that I have received and reviewed this notice and all of my questions have been answered to my satisfaction in language that I can understand.

_____
Name of Individual (Printed)

X _____
Signature of Individual

_____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):

_____
Relationship

Date Signed: ____/____/____

Witness:_____