Cassista Chiropractic Office

Dr. Gerard Cassista

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General Information Form

Name_____ Date_____
Address_____
City_____ St____ Zip_____ Home (___)_____
Work (___)_____ Cell (___)_____
E-Mail _____ Social Security #____-____-____
Date of Birth___/___/___ Age____ Referred By_____
Occupation_____Employer_____
Marital Status S M DW Spouse's Name_____ # of children___
In Case of Emergency Contact_____
Relationship_____Phone #_____
Name of clubs/groups/organizations_____

Health Insurance Company_____

Name of Policy Holder_____ DOB ___/___/_____

Purpose of this appointment_____

Other symptoms you have felt:

___headaches	___chest pain	___constipation	___sleeping problems
___neck pain	___dizziness	___depression	___buzzing in ears
___midback pain	___fatigue	___ loss of balance	___tingling in fingers
___lowback pain	___fainting	___nervousness	___tingling in toes
___neck stiff	___irritability	___ears ringing	___numbness in toes/
___tension	___fever	___ cold sweats	___ fingers

Is this visit being submitted to an open claim for an auto, work or personal injury? Yes___ No___
(please notify staff if YES)

All patients need to check and read all that apply:

______**CASH:** Patients are required to pay at the time of each visit. We accept cash, checks, Visa, MasterCard and Discover.

______**GENERAL INSURANCE:** Patients are responsible for payment at the time of each visit. Patients are responsible for deductibles, co-payments, non-covered services, and referrals if required. Non- contracted services will **not** be submitted to insurance companies and are the sole responsibility of the patient.

______**BLUE CROSS/BLUE SHIELD OF MASS.** The doctor in this office is a participating Blue Cross/Blue Shield provider. When verification has been completed, we will accept assignment as specified by Blue cross/Blue Shield for you particular plan. Patients are responsible for all deductibles, co-payments and non-covered services. I understand that any service the doctor is not contracted for will be paid by me. Non-covered services will **not** be submitted to Blue Cross/Blue Shield.

______**MEDICARE:** The doctor in this office is a participating Medicare provider. Medicare recipients must present their enrollment cards at the onset of treatment. Medicare requires a $135 annual deductible to be paid before services are covered. In compliance with the Federal MAAC regulations, the fee for a spinal manipulation has been set at $40.00. Spinal Manipulation is the only service covered by Medicare. If the patient does not have a second insurance or the second insurance does not cover the treatment, the patient will be required to pay a co-payment. Patients are responsible for any non-covered services.

Any inquires from your insurance company to you directly that are not completed may result in NON-PAYMENT to us. Therefore all services will be billed to you for full payment. (Pt. initials) ________

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I understand and agree that all fees for professional services rendered in my behalf are my personal responsibility and are due and payable at the time services are rendered. I understand that any fees not paid by the insurance company will be paid directly by me upon notification. I hereby authorize and direct Dr. Gerard Cassista of Cassista Chiropractic to release all medical information necessary to process this claim.

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I herby authorize and direct the insurance carrier to pay all benefits, which may be due to me according to the policy, directly to Dr. Gerard Cassista of Cassista Chiropractic Office to be applied towards my account.

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I have read the above information. I understand and agree to the above.

Signature____**Date**________

Patients (parent or guardian)

Are you here today for a work related accident? Yes___ No ___

Date of Accident____/____/_____ **Claim #**_____

Have you missed any work due to the accident? Yes_____ No _____

Dates missed_____

Workman Compensation info:

Name of Employer_____Phone(___)_____-

Address _____City_____St___Zip_____

Employer's Workman's Compensation Insurance Co.

Name of WC insurance co._____Phone(___)____-_____

Address of WC insurance co._____

Are you here for a CLAIM on a personal injury accident? Yes___No___

Date of Accident____/____/_____ **Claim #**_____

Have you missed work due to the accident? Yes_____ No_____

Date missed_____

Was an accident report filled out? Yes_____ No___**(we'll need a copy)**

Attorney Name:_____Phone (___)____-_____

Address:_____

Are you here today due to an auto accident? Yes___No ___

Date of Accident____/____/_____ **Claim #**_____

Have you missed work due to the accident? Yes_____ No_____

Dates missed_____

Name of Policyholder of the vehicle you were in:_____

Auto Ins. Company Name:_____Phone:(___)____-___

Address: _____

Adjustor Name:_____Phone(___)____-_____ ext._____

If you have an Attorney for this case, please give

Attorney Name:_____Phone:(___)____-____

Address: _____

WORKER'S COMPENSATION: Patients must report injury to employer within 3 to 5 days after injury. When the proper forms are filed, we will accept assignment as a work related case. If the patient's injury is found not to be work related and is denied by the insurance company and the Industrial Accident Board, the patient will be responsible for payment of his/her bill either through their medical insurance carrier or themselves.

AUTOACCIDENT: Patients are required to complete a Personal Injury Protection Form (PIP) When the proper forms are filed and verification has been completed, we will accept assignment for medical costs covered by your insurance. If an attorney is involved, you must sigh a lien which we will mail to you attorney. Patients are responsible for any non-covered services.

Patients Signature (parent or guardian)

Date
