



413 Alfred St
Biddeford, ME 04005
207-283-1168

Hi !

We are so glad that you have chosen our office to help you in your journey towards health and wellness in your life.

There are a few forms to complete prior to your arrival at the office. Please allow yourself 20-30 minutes to fill them out in their entirety so that we can have all the information needed to make a complete diagnosis.

The Health Profile form gives us information about your current health concerns as well as your health history. Please be as thorough as possible. The more information given to the doctor, the better equipped she is to understand the condition of your body and how best to treat your current health condition.

You will find additional forms which require your review and signature as well. Please bring all the completed forms to the office at your visit.

If for any reason you are unable to keep this appointment, please call our office as soon as possible.

Looking forward to meeting you.

Sincerely,

Dr. Ellie Rolnick
Wellness Chiropractor

Doreen M. Dube
New Patient Coordinator



Tel: (207) 283-1168
 Fax: (207) 282-5248
 Dr. Eleanor Rolnick
 413 Alfred St. Biddeford, Me 04005

CASE HISTORY HEALTH PROFILE

Personal Information

Full name:		Date:	
Address:			
Street	City	State	Zip
Home phone:		Work phone:	
Cell phone:		Email address:	
Best time/place to contact you:			
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Marital status: M S W D			
Occupation:			
Employer's name & address:		Spouse/guardian name:	
Spouse's Occupation/Employer:			
Name of person responsible for account:			
Do you have insurance that covers Chiropractic care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Insurance Company:			
Insurance Policy number:		Insurance Company phone number:	
Insurance Company address:			

Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General Health History".

Symptoms/Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = highly severe	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where? _____

Since the problem started is it: About the same? Getting better? Getting worse?

What have you done for this condition? Was it of benefit? _____

I **DO** or **DO NOT** have a family history of this or similar symptoms (Please explain): _____

Which activities aggravate your condition? _____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc? (i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

Is this condition interfering with any of the following:

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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What lesson(s) have you taken home from your healing process to date? _____

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Diet *Please use the following codes to label each of the food categories:*

D - Consume this daily

FD - Consume this a few times per day

W - Consume this weekly

FW - Consume this a few times per week

M - Consume this monthly

FM - Consume a few times per month (less than weekly)

O - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked vegetables	Canned Vegetables	Which specific type of diet do you follow, if any?	

Past Health History

Please mark the following conditions: **P**= Had in the past **C**= Currently have

Alcoholism ___	Allergy ___	Anemia ___	Arteriosclerosis ___	Multiple Sclerosis ___	Heart Attack ___
Back Pain ___	Cancer ___	Cold Sores ___	Constipation ___	Thyroid Problems ___	Depression ___
Diabetes ___	Diarrhea ___	Eczema ___	Emphysema ___	Irregular Periods ___	Gall Bladder Problems ___
Gout ___	Headaches ___	Asthma ___	Heart Disease ___	High Blood Pressure ___	HIV (Aids) ___
Epilepsy ___	Migraines ___	Malaria ___	Measles ___	Menstrual Cramps ___	Nervousness ___
Miscarriage ___	Arthritis ___	Mumps ___	Neck Pain ___	Low Blood Sugar ___	Rheumatic Fever ___
Pleurisy ___	Pneumonia ___	Polio ___	Neuritis ___	ringing in ears ___	Sinus Problems ___
Stroke ___	Convulsions ___	Measles ___	Tuberculosis ___	Venereal Disease ___	Whooping Cough ___

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

- 1. Physical stress (posture, couch potato, standing/sitting for long periods of time, sleep on stomach, computer work)
 - a. _____
 - b. _____
 - c. _____

- 2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/meds, alcohol, etc.)
 - a. _____
 - b. _____
 - c. _____

- 3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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Do you have any family members who have similar health issues? _____

Is there anything else you would like the doctor to know which has not been discussed? _____

Why are you here at this point in time? _____

I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____



AUTHORIZATION TO PAY PHYSICIAN

I hereby authorize the _____ Insurance Company to pay by check made out and mailed directly to:

Rolnick Chiropractic
413 Alfred St
Biddeford, Me 04005

the medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____ 20____

Signature of Policyholder

Witness

Signature of Claimant



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information (“PHI”) to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your PHI, and of other important matters about your PHI. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Pam Gaudette, C.C.C.A..

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of this
Office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your protected health information ("PHI"). We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

This Practice is committed to maintaining the privacy of your PHI, which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all PHI that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for addition copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, the Practice may use your health information in order to evaluate the performance of the Practice's personnel in providing care to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclose of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable assumption of your best interest in allowing a person to pick up nutritional supplements, orthopedic supports, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information to Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Adjustment Area: Certain healthcare information about you may be disclosed during a normal adjustment visit. This will be limited as much as possible and in the judgment of the treating doctor. Privacy is available when more detailed information needs to be discussed and can be requested by you at any time.

Appointment Reminder: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Sign-In Log: The Practice maintains a sign-in log for individuals seeking care in the office. The sign-in log is located in a position where staff can readily see who is seeking care in the office.

This information, which is limited to your signature, may be seen by and it accessible to, others who are seeking care or services in the Practice.

Facsimile Transmissions: The Practice may from time to time transmit information about you to insurers, other health care professionals and providers, and appropriate governmental agencies utilizing facsimile transmission.

Other Correspondence and Contact: The Practice may mail to you a birthday card, newsletter or other information from the practice to the address you have provided to us. We may call your home to check on you if we have not seen you for awhile (recalls).

The Practice may also use and/or disclose your PHI in the following instances:

De-identified Information: This is information that does not identify you and, even without your name, cannot be used to identify you.

Business Associate: To a business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

PATIENT RIGHTS

You have the right to:

Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

Request restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.

Amend your PHI as provided by law. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Receive an accounting of disclosures of your PHI as provided by law. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other

activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional request.

Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

Complain to the Practice or to the Secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

To file a question, complaint or request, you may contact the Practice's Privacy Officer, Pamela Gaudette, C.C.C.A., at 413 Alfred Street, Biddeford, Maine, 04005 or via email at contact@rolnickchiropractic.com.



EXPLANATION OF MEDICARE BENEFITS TO THE PATIENT

Medicare will cover CHIROPRACTIC ADJUSTMENTS ONLY. Allowed services will go towards your \$135.00 deductible if it has not already been met. Services will be allowed dependent on medical necessity. Medicare will not pay for maintenance or wellness care. You will be informed when and if your visits will no longer be covered and/or if your care is maintenance or wellness care.

Medicare will pay 80% of the allowable – recognized charges. They do not pay for exams, vitamins or other supplies, which might be used in a Chiropractic office. Examples of non-covered charges include exams, nutritional supplements, orthopedic supports, orthotics, the Creating Wellness System as well as other supplies not listed here.

The Standard Fee in this office is \$40.00 to \$50.00 per visit. We do accept assignment. This means that once your deductible has been met, we will wait for payment from Medicare. However, should the claim not be paid by your insurance, you would then be responsible for the visit. The fee charged by this office for a Medicare patient's Chiropractic Adjustment ranges from \$23.99 to \$43.35. We will bill Medicare for this service and they will pay us directly. Medicare will pay us between \$19.19 and \$34.68 per allowed visit. The remainder of between \$4.80 to \$8.67 will be due by the patient unless other arrangements have been made for assignment of a companion plan health insurance.

Again, as a service to our patients we will fill out and send in all necessary Medicare insurance forms. We will also submit and accept assignment to any companion plans other than Medicaid, as we do not participate with this particular insurance company. If a deductible needs to be met with your companion plan, it will be your responsibility to make this payment when we receive notification that it has not been met.

Upon my signature of the Explanation of Medicare Benefits to the Patient, I attest that things were explained to me to my understanding; I, being the patient. I also agree to and understand the conditions and services for which I am responsible for payment.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____

MEDICARE SECONDARY PAYOR QUESTIONNAIRE

Patient Name: _____ Date: _____

HIC # : _____

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions:

1. Is your injury/illness due to:

A. A work related accident/condition? _____ No _____ Yes

Name/address of Workers Compensation Plan: _____

Policy or ID #: _____

Accident Date: _____

B. A condition covered under the Federal Black Lung program?

_____ No _____ Yes

C. An automobile accident? _____ No _____ Yes

Name and address of auto insurance _____

Name of insured: _____

Policy or ID #: _____

Accident Date: _____

Accident Location: _____

D. The fault of another party? _____ No _____ Yes

Name/address of liability insurer _____

Name of insured: _____

Policy or ID #: _____

Accident Date: _____

Accident Location: _____

2. Are you eligible for coverage under the Veterans' Administration? _____ No _____ Yes

3. Are you employed ? _____ No, date of retirement: _____

_____ Yes, employer name and address: _____

Are there 20 or more employees? _____ No _____ Yes

Do you have Employer Group Health Plan Coverage? _____ No _____ Yes

Insurer name and address: _____

Policy #: _____ Group # _____

4. Is your spouse employed? No, date of retirement _____
 Yes, spouse's name: _____
Employer name and address: _____
Are there 20 or more employees? _____

Are you covered under your spouse's Employer Group Health Plan?
 No Yes, insurer name and address: _____
Policy# _____ Group # _____

5. Are you a dependent covered under a parent's/guardian's Employer Group Health Plan?
 No Yes, employer name and address: _____
Insurer's name and address: _____
Name of insured: _____
Policy # _____ Group # _____
Are there 100 or more employees? _____

6. Are you on Medicare because of a disability or ESRD? _____

Thank you for your cooperation in ensuring that your medical services will be billed to the proper insurer(s).

Date

Signature of beneficiary or guardian

Street address

City, State and Zip Code

Telephone Number

MEDICARE ASSIGNMENT FORM

THIS ASSIGNMENT FORM IS TO BE USED BY BOTH MASSACHUSETTS AND MAINE PROVIDERS AS VERIFICATION BY BENEFICIARIES THAT PAYMENTS CAN BE MADE DIRECTLY TO THE PROVIDER. THIS FORM REPLACES THE ASSIGNMENT CARDS USED IN THE PAST.

Beneficiary's Health Insurance Claim No : (Medicare Number)

Beneficiary's Last Name

First Initial

Provider No. **# 148897**
PROVIDER NAME: Rolnick Chiropractic
PROVIDER ADDRESS: 413 Alfred St
 Biddeford, ME 04005

I request that payment by the medical insurance program be made directly to this physician on any unpaid bills for services furnished to me by that physician.

I authorize release to SSA's carriers any information needed to process this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original.

Beneficiary's Address: _____

Beneficiary's Signature: _____

Date: _____

MEDICARE B

Privacy Act Authorization Form

Rolnick Chiropractic has requested access to certain information contained in your Medicare B files. In accordance with the Privacy Act of 1974, we cannot grant request without your written authorization.

If you wish the information disclosed to the above party, please sign the following authorization form and return it with the request.

Please be specific as to dates and description of services contained in the information you wish released.

We recommend that you make this authorization valid for a period of at least two months. Blanket authorization will not be acceptable.

I authorize **Rolnick Chiropractic** to inquire about and to be given the following information from my Medicare records.

Date of Service or other information

Control Number from Explanation
of Benefits

This authorization is valid from the date of _____ to _____ .

Date

Signature of Beneficiary

Health Insurance Number: _____