



Swan Lake Chiropractic

724 Pearl Street, Boulder, CO 80302 | 303.449.3103 | swanlakechiro.com

Welcome Medicare Patient

As you are a recipient of Medicare benefits, it is our desire to clarify to you how these benefits presently relate to chiropractic.

We are Medicare Providers with non-participating status.

AFTER a \$283 deductible (as of 1/1/2026) has been satisfied, Medicare will only pay for manual manipulation of the spine, related to active treatment, and will pay for 80% of the allowable amount for visits deemed eligible, up to 30 visits per calendar year.

Since we are non-participating providers, you will pay us directly at the time of the visit. As a courtesy to you, we will bill Medicare for all your visits. If you have a secondary insurance, Medicare will forward the claim to them and they will process the claim according to the benefits of that supplemental policy. Once processed, Medicare and your secondary will each issue you a check of any amount due to you.

Please understand that Medicare does not guarantee payment on submitted claims. Please understand also that we have no control over these laws. Let us know if we can help further clarify or explain anything relating to your Medicare benefits or your care here at Swan Lake Chiropractic.

What you can expect as a Medicare patient:

Please initial each line.

- Please alert us every time you have a new condition or your condition has changed.
- Medicare does NOT pay for Maintenance Care. It pays for spinal manipulation, as long as you're under active treatment for a current condition(s).
- Maintenance Care visits will be processed at a rate of \$50 for which you are responsible at the time of service.
- Medicare does NOT cover: Decompression Therapy (\$75), Initial new-patient examinations (\$82), Re-examinations (\$15-\$35), Extra-spinal (extremity) Adjustments (\$10).

Patient's Signature

Date



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Confidential Patient Case History

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Work Phone: _____ Who Referred you?: _____

Emergency Contact's Name & Phone: _____

What is/are your major complaints: _____

What do you think caused this condition?: _____

Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation: _____

Have you had this or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did it start: _____ Do any positions make it feel worse? <input type="checkbox"/> Yes <input type="checkbox"/> No Do any positions make it feel better? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this condition: <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Getting worse Is this condition interfering with your: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Other: _____ Have you been to a chiropractor before?: <input type="checkbox"/> Yes <input type="checkbox"/> No Last Adjustment: _____ Doctors or Therapists who have treated THIS condition: _____

Have you been in an accident or had any other significant injury which caused or contributes to your current condition? Yes No If yes, describe: _____

Hospitalizations, Surgeries, Auto or Work injuries: (include dates and treatments): _____

Do you have Spinal X-Rays or MRI's?: Yes No Dates: _____

Current Medications: _____

Birth trauma, childhood injuries, significant illnesses: _____

Activities you participated in ages 5-20: _____

What are your goals in seeking care for this condition?: _____

Hours per day sitting (work, car, leisure): _____

Times per week exercising ½ hour or more: _____

<p>PLEASE READ - Appointment Policy: Our time together is important. Please do your best to arrive on time for all your appointments. As we get to know your body and treatment priorities, your appointment time will decrease. <i>If you arrive more than 5 minutes late to our scheduled time together, we may have to reschedule your appointment for another time or day.</i></p> <p>Patient Initials: _____</p>
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Please check ALL that apply:

Musculo/Skeletal:

- Spinal pain greater than 3 weeks
- Hip pain
- Shoulder pain
- Foot pain
- Swollen or painful joints
- Arthritis
- Gout
- Osteoporosis
- Bursitis
- Fractured bones
- Muscle weakness or paralysis
- Numbness in arms, hands or fingers
- Pain in arms, hands or fingers
- Numbness in legs, feet or toes
- Pain in legs, feet or toes
- Numbness or pain in groin

Head

- Headaches
- Dizziness/poor balance
- Direct head trauma
- Memory loss
- Lost consciousness
- Poor coordination
- Trouble concentrating
- Seizures
- Tremor
- Jaw pain

Ears, Nose and Throat

- Loss of smell
- Swallowing problems
- Speech problems
- Sinus problems
- Hearing problems
- Ringing in ears
- Dental problems
- Wear glasses or contacts
- Glaucoma
- Light bothers eyes

- Intolerance to noise
- Speech difficulties
- "Clunk" sound with moving neck

Heart/Lung

- Heart disease or murmur
- Racing, pounding heart
- High blood pressure
- Low blood pressure
- High cholesterol
- Stroke
- Chest pain
- Asthma
- Allergies
- Shortness of breath
- Difficulty breathing
- Chronic cough

Urological

- Pain or blood with urination
- Leaking urine
- Urinating at night
- Loss of bladder or bowel control
- Kidney or bladder infection
- Kidney stones

Gastro-Intestinal

- Recurrent abdominal pain
- Diarrhea
- Acid Reflux
- Constipation
- Bloody or black stools
- Liver problems
- Gall bladder problems
- Ulcers
- Heartburn
- Hernia
- Hemorrhoids
- Nausea
- Vomited blood

Emotional/Stress

- Depression

- Sleep problems
- Anxiety
- Mood swings
- Apathy
- Nightmares
- Sleep disturbances
- Relationship difficulties
- Impaired comprehension
- Attention impairment
- Panic attacks
- Concentration difficulty
- Social withdrawal
- Reading problems

Misc.

- History of Cancer: _____
- Thyroid problems
- Anemia
- Bleeding or bruising tendency
- Unexplained weight loss or gain
- Night sweats
- Eczema
- Pain fails to improve with rest
- Varicose veins
- Ankle swelling
- Unusual fatigue
- Cold hands or feet
- Prostate problems
- Menstrual problems
- Diabetes
- Other: _____

Family History

- Cancer
- Musculo-skeletal conditions
- Ear/nose/throat conditions
- Heart/lung conditions
- Urological conditions
- Gastro-intestinal conditions
- Emotional Problems
- Diabetes
- Dementia/Alzheimer's

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment; and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the Doctors. The information in this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicate honestly with the Doctors and to notify them of any changes in my health status.

Patient's Signature: _____ Date: _____

Responsible Party's Signature, if patient is a minor: _____ Date: _____



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Please read our **PAYMENT GUIDELINES** and select one of the following options:

_____ **Self Pay Plan** – I, the patient, understand that I am responsible for all charges accrued from office visits. Payment is required when services are rendered. No third party is involved. A receipt or superbill can be generated for me to pursue my own reimbursement.

_____ **Medical Insurance Plan** – I hereby authorize the assignment of benefits to Swan Lake Chiropractic as well as the release of any medical information necessary for the payment of claims. I, the patient, am responsible for any co-pays or deductibles due at the time the services are rendered. If after 90 days Swan Lake Chiropractic is unsuccessful recovering monies from my insurance carrier, I understand that I am ultimately responsible for charges accrued from office visits, etc.

I have read and understand the payment policy of Swan Lake Chiropractic Health Centre as explained in the **PAYMENT GUIDELINES**. I also acknowledge that all charges incurred in this office are ultimately my responsibility.

Name: _____ Date: _____

Signature: _____

Please read our **NO-SHOW/LATE CANCELLATION** policy:

If a patient fails to appear at the time of their appointment and has not contacted our office **with at least 3 hours’ notice**, they will be considered a No Show. Because we understand life happens and obstacles come up that are beyond your control, we will not charge any fee for the first No Show. We will, however, contact you for a credit card number to keep on file so we have means of collecting a fee if it happens a second time.

Any patient who fails to appear at their appointment, who cancels/reschedules within a 3-hour period for a second time, or **who is more than 10 minutes late** for their appointment will be charged our full adjustment rate of \$60. This same charge will be applied for any subsequent No Shows. The fee will be charged immediately on the card on file.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. In such instances, please contact us before the appointment and we will waive the No Show fee when appropriate.

Signature: _____



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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have been notified of my option to receive a copy of this office's Notice of Privacy Practices and that this practice abides by those policies.

_____ (Signature)

_____ (Date)

_____ FOR OFFICE USE ONLY _____

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

- Individual refused to sign
- Communication barriers prohibited obtainment
- An emergency situation prevented us from obtainment
- Other (please specify):
