 **DeFabio Spine and Sports Rehab, LLC**

***Chiropractic Acupuncture Nutrition***

308 Springfield Avenue Berkeley Heights, NJ 07922 • 908-771-0220 • 908-771-0114

**CONFIDENTIAL PATIENT INFORMATION**

|  |  |
| --- | --- |
| **Patient Information** | **Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | State \_\_\_\_\_\_\_\_\_\_\_\_\_ | Zip \_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_ | Work Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ | Cell Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ |
| E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Preferred Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Marital Status: 🞏 S 🞏 M 🞏 W 🞏 D | Ethnicity \_\_\_Hispanic/Latino \_\_\_Non-Hispanic/Latino  |
| Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gender \_\_\_\_M \_\_\_\_F | \_\_\_\_Left Handed \_\_\_\_Right Handed  |
| Smoking status \_\_Never \_\_Former \_\_Current \_\_How much? \_\_\_\_\_\_\_\_ | SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary MD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer/School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employer/School Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone Number \_\_\_-\_\_\_-\_\_\_\_ |
|  |
| **Reason For Today’s Visit** |
| List present complaints and injuries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How long have you had this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does it bother you occasionally/frequently/constantly?  |
| Who else have you seen for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What did they recommend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |

**Pain Scale**



**Patient Signature for Consent to evaluate and treat today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DeFabio Spine and Sports Rehab, LLC**

**2020 Insurance Information and Assignment Authorization**

|  |
| --- |
| **Patient’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Patient’s Social Security # \_\_\_/\_\_\_/\_\_\_ Insurance Company** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|

|  |  |
| --- | --- |
| **InsuInsurance Policy #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Group #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 |
|  |  |
| **Assignment Authorization and Agreement** |

I agree to provide the office with any **information, initial or follow up referral forms** prior to seeing the Doctor that are necessary for treatment or payment and

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance

 companies. Payments should be payable and mailed to:

DeFabio Spine & Sports Rehab, LLC

308 Springfield Avenue

Berkeley Heights, NJ 07922

2. I understand this if this office receives more than their fees, the office will pay any credit balances to me, the patient.

3. I authorize the office to release any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

4. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**

5. A photo copy of this form shall be as valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

**Patient’s Notice of Privacy Practices**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge I was offered a copy of DeFabio Spine & Sports Rehab’s Notice of Privacy Practices, with complete understanding and I had all my questions answered to my satisfaction.

I am authorizing DeFabio Spine & Sports Rehab, LLC to have my name displayed in the office in the form of a ‘sign-in sheet’ and a ‘patient referral sign’.

 🞏 Yes 🞏 No

I may be contacted in the following manner:

🞏 E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ via defabiochiropractic@gmail.com, a non-encrypted server

🞏 Best telephone number to contact me \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 OK to leave a detailed message 🞏 Leave a message with a call back number only

🞏 I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_access to release my health records

 Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

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**Payment Policy**

To pay your balance once your insurance company has processed your visit, a current credit card needs to be on file with authorization of payment. Once the insurance claim is processed your credit card will be charged the balance and an itemized receipt will be mailed to you.

Payment Authorization

I hereby authorize DeFabio Chiropractic Associates to automatically charge my credit card for:

1 The allowable balance due after my insurance payments are made.

1. For insurance payments sent directly to me.
2. For my co-payment when due.
3. For non-covered services.
4. Missed appointment fee.

A copy of the itemized statement and credit card receipt will be provided for your records.

Would you like a copy of your receipts?

□Yes □No

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_\_\_

MC Visa #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_

 CVS\_\_\_

Am Ex #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_

 CVS\_\_\_

**All information is confidential and secure.**