DeFabio Spine and Sports Rehab, LLC

Chiropractic Nutrition Chronic Pain
308 Springfield Avenue Berkeley Heights, NJ 07922 • 908-771-0220 • 908-771-0114

CONFIDENTIAL PATIENT INFORMATION

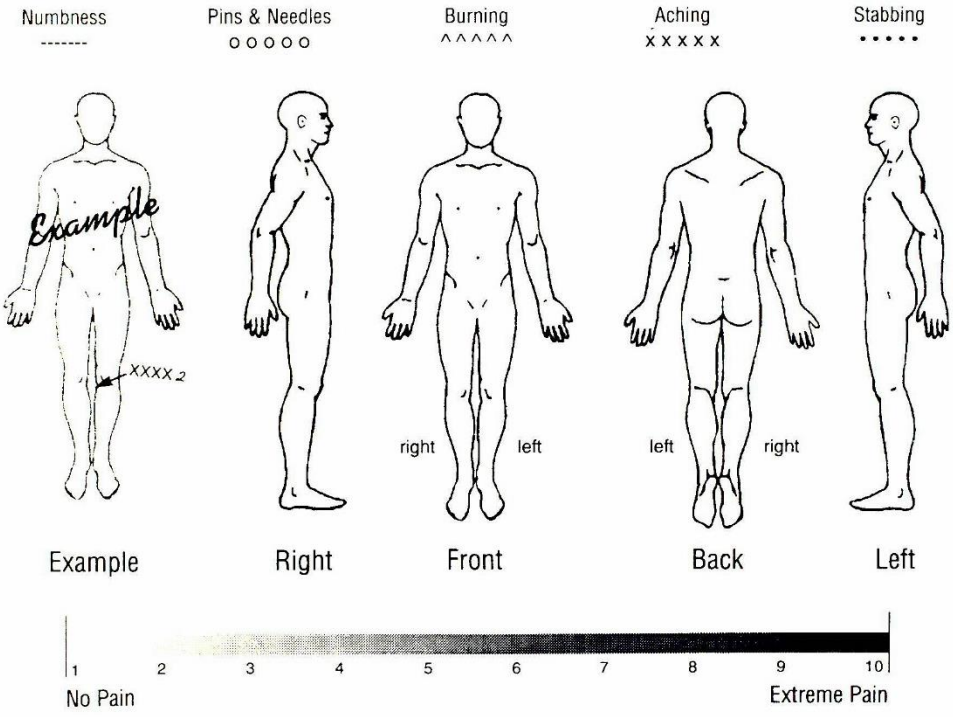
Patient Information **Today's Date _____**

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

2022 Insurance Information and Assignment Authorization

Patient's Name _____ **Date** _____

Patient's Social Security # __/___/___ Insurance Company _____

Insurance 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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2022 New Jersey Disclosure

New Jersey laws and the New Jersey Department of Health require healthcare providers to inform patients of the healthcare plan in which they participate and the facilities with which they are affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

A. Health Plans with which Our Practice participates:
   Medicare
B. Facility with which Our Practice affiliates:
   DeFabio Spine and Sports Rehab, LLC
   308 Springfield Avenue, Suite 1
   Berkeley Heights, New Jersey 07922
C. Licensed Associate Healthcare Providers:
   Donald C. DeFabio, DC
   Amanda Occhipinti, DAc., Dipl. Ac., FNS
   Slade Eigenmann, DC
   Michael Dispenziere, DC

I understand the healthcare professionals with whom I am seeking healthcare services is "out-of-network" and does not participate with my insurance plan.

I understand the amount or estimated amount of my healthcare services may be beyond my "in-network" deductible, copayment, or coinsurance and I am responsible for those charges.

I understand I may contact my health insurance plan or administrator for further consultation regarding the cost and reimbursement of my healthcare charges.

I, the undersigned patient, acknowledge receipt of this disclosure from my healthcare provider, read and understand its content. I wish to receive evaluation and treatment at DeFabio Spine and Sports Rehab, LLC with full notice of these disclosures. I certify I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures. I am not being coerced to sign this disclosure and I do so of my own free will.

Name: _____

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.
2 For insurance payments sent directly to me.
3 For my co-payment when due.
4 For non-covered services.
5 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___

<u>All information is confidential and secure.</u>