Dr. David N. Block Family Chiropractor-Patient Information

Name(First, Middle, Last)____Date_________

Address(no PO boxes)________________________City________________State_____Zip________

Home phone________________Work phone_________________ Cell phone_________________

Social Security # ________________ E-mail address___________________________________

Age ______Birthdate ______/______/______ Sex M / F Status M S W D No.Children_______

Height: ______ feet _____inches Weight: ________lbs

Occupation ______________________Employer ______________________Years Employed_____

Work Address______________________City__________________State_____ Zip____________

Spouse's Name_____________Occupation___________ Employer ___________ S.S.#________

Primary Insurance Plan Name_______________________ID#___________Group#___________

Policy Holder's Name________ _________Relationship to policy holder:Spouse___Child___Self___

Policy Holder's Birthdate __________

Secondary Insurance Plan Name __________________ ID# _____________ Group #________

Is your condition due to an auto accident? Yes____No____ If yes, what state? ______

Is your condition work related?Yes__No__ Is your condition related to another accident? Yes__No__

What is your deductible________________ Was it met? Yes ____ No ____ Unsure ____

Immediate Family under care in this clinic______________________________________

I understand that the above patient is a minor and I personally guarantee payment for all charges related to:

*(patient name)*____*Name of guarantor:* ____________________

*Signature of guarantor:*____*Date:*______________________________

With my signature below, I authorize the assignment of insurance benefits directly to Dr. David N. Block.

Patient/Guarantor Signature: ____________________________________Date:______________

Authorization for Care, Insurance Assignment & Fees Please read and sign

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. I understand that Dr. David N. Block Family Chiropractic will prepare any necessary documents to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. David N. Block Family Chiropractic will be credited to my account on receipt (insurance assignment of benefits). However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment as well as collection manager/attorney's fees of 33.3% and any and all related costs of collection, including filing fees, should such action become necessary. Interest rate on unpaid balances is the greater of 1.65% per month or $5.00 per month and begins from the time an account has been considered delinquent. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I also authorize the doctor to bill any unpaid balance to my credit card if it was used previously in the office to pay for services rendered, to obtain a credit report if deemed necessary and verify my employment should that information be needed in the collection of unpaid balances.

I hereby authorize the doctor to provide for me manual adjustments to my spine and therapy. The patient also agrees that he/she is responsible for all bills incurred at this office including interest on unpaid balances. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnoses.

Patient Name____ Date____________________

Patient Signature ____ Date____________________

Guardian/Spouse/or Guarantor's Name Authorizing Care______________________________Date:_________

Guardian/Spouse/or Guarantor's Signature Authorizing Care___________________________Date:__________

AUTHORIZATION FOR TEXT MESSAGING

(SMS COMMUNICATIONS)

Patient Name ____ Date of Birth: _________________

I understand that:

- Text messages are inherently unsecure because they are transmitted over a public network onto a personal telephone and as such there are inherent risks in using this type of communication. Information texted to me could be received and read by an unauthorized third party.
- It is my responsibility to keep my mobile number up to date with Block Family Chiropractic.
- I should not send PHI (Protected Health Information) or ePHI to Block Family Chiropractic in a text message because of the unsecure nature of text messages.
- I may be charged for text messages by my wireless carrier.
- This Authorization is voluntary and I have the right to refuse to sign it.
- Treatment will not be conditional on whether I sign this Authorization.
- By signing this form, I am allowing Block Family Chiropractic to send text messages to the following mobile number: _____________________ for the following:
- Block Family Chiropractic will not send PHI (Protected Health Information) in a text message.
- If I sign this authorization, I may revoke (cancel or opt out) it later, at any time, by test message, phone call, or email address.
- My wireless carrier is: AT&T Sprint T-Mobile Verizon Other:__________

Signature(s

Patient signature ____ Date ______________________

Sign below if you are a personal representative of the patient.

Representative signature_____________________________________ Date ______________________

Print Name ____ Relationship to Patient _______________