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:_____

Patient Name_____ **DOB**_____

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.

Signature of Patient or Legal Representative_____ Date _____

If signed by legal representative, relationship to patient:_____

AUTHORIZATION FOR TEXT MESSAGING (SMS COMMUNICATIONS)

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 of Patient or Legal Representative_____ Date _____

If signed by legal representative, relationship to patient:_____

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment. Obtain payment from third-party payers. Conduct normal health care operations such as quality assessments and accreditation.

Signature of Patient or Legal Representative _____ Date _____

If signed by legal representative, relationship to patient:_____