

Patient Information

Today's Date _____

Name _____ SS# _____

Address _____ Male _____ Female _____

City _____ State _____ Zip _____ Marital Status M S W D

Date of Birth _____ Age _____ Home # _____ Work # _____

Number of Children _____ Mobile/Cell # _____ (may we call you on any of these numbers? _YES_NO)

Occupation _____ Employer _____

Work Address _____ Work Phone _____

Spouse's Name _____ Occupation _____

Employer _____ Work Phone _____

Nearest Relative not living with You _____

Address _____ Phone _____

Insurance Information: Insured Name: _____ ID # _____

Carrier Name: _____ Contact # _____

*Please provide the office with your ID cards for verification purposes.

Referred By _____

Have you ever suffered from? Yes or No

- | | | | |
|-----------------|-------------------|---------------------|-----------------------|
| Dizziness _____ | Asthma _____ | Tuberculosis _____ | Sinus Trouble _____ |
| Arthritis _____ | Anemia _____ | Headaches _____ | Cancer _____ |
| Backaches _____ | Neuritis _____ | Heart Trouble _____ | Digestive Order _____ |
| Diabetes _____ | Nervousness _____ | | |

Purpose of This Appointment _____

Other Doctors Seen for This Condition _____

Has a Physician Treated You for Health Condition in the Past Year? Yes _____ No _____

Describe _____

Payment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Joseph P. Hornberger, M.S., D.C., P.A., will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Joseph P. Hornberger, M.S., D.C. P.A., will be credited to my account upon receiving. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. Furthermore, I hereby voluntarily consent to examination, diagnostic treatment and/or Chiropractic care by Hornberger Chiropractic Center, its physicians and employees as explained to me by the attending physician and whomever he may designate as his assistant. I am aware that the science of Chiropractic/Medicine is not an exact science and that any procedure has an inherent risk. I acknowledge that no guarantees have been made to me as a result of any treatment or examination in the office.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Information Taken By _____ Date _____

Full Legal Name: _____ DOB: ___/___/___

PATIENT HISTORY

Complete each section as accurately as possible as it will become a permanent part of your record. If a question is not applicable, please leave blank.

PAST MEDICAL HISTORY: Place an (X) if it applies and describe, i.e. year, joints injured, months treated, residuals, etc.

None Operation _____ Auto Accident _____
 Work Accident _____ Illness _____ Other _____

Describe: _____

FAMILY HISTORY: Place an (X) if any family member (father, mother, brother, sister) has suffered from any of the following:

Tuberculosis Epilepsy Arthritis Gout
 Hypertension Diabetes Mental Illness Stroke
 Migraines Cancer Kidney Disease Heart Attack
 Spinal Disorders Allergies Other

List Other: _____

PERSONAL HISTORY: Place an (X) if it applies and describe if necessary.

Single Married Divorced Separated Widow/Widower
 # children Employed Spouse **DRINKING:** Alcohol per day Caffeine per day
EXERCISE: no. of times weekly daily **SMOKING:** packs per day

Describe below: Congenital Medications Disease Other

SYSTEM REVIEW: Place an (X) next to the symptoms you now have.

<u>Genito-Urinary System</u>	<u>Gastro-Intestinal System</u>	<u>Nervous System</u>	<u>Eyes, Ears, Nose/Throat</u>
<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Numbness	<input type="checkbox"/> Eye Strain
<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Vomiting Food	<input type="checkbox"/> Fainting	<input type="checkbox"/> Eye Inflammation
<input type="checkbox"/> Scanty Urination	<input type="checkbox"/> Bloody Stool	<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Discolored Urine	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Loss of feeling	<input type="checkbox"/> Ear pain
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Headaches	<input type="checkbox"/> Ear Noises
<input type="checkbox"/> Other	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Confusion	<input type="checkbox"/> Ear Discharge
	<input type="checkbox"/> Difficult Chewing	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Hearing loss
<u>CARDIO-VASCULAR</u>	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Muscle Jerking	<input type="checkbox"/> Nose Pain
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Depression	<input type="checkbox"/> Nose Bleeding
<input type="checkbox"/> Coughing Phlegm	<input type="checkbox"/> Difficult Swallowing	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nose Discharge
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Breathing
<input type="checkbox"/> Pain over heart	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Other	<input type="checkbox"/> Sore gums
<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Excessive thirst		<input type="checkbox"/> Dental problems
<input type="checkbox"/> Lung problems	<input type="checkbox"/> Constipation		<input type="checkbox"/> Sore mouth
<input type="checkbox"/> Difficult Breathing	<input type="checkbox"/> Weight Trouble		<input type="checkbox"/> Sore throat
<input type="checkbox"/> Rapid Heartbeat	<input type="checkbox"/> Nausea		<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Black Stool		<input type="checkbox"/> Speech difficulty
<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Other		<input type="checkbox"/> Other
<input type="checkbox"/> Blood Pressure			
<input type="checkbox"/> Other			

OTHER: _____

PATIENT SIGNATURE: _____ DATE: ___/___/___

*HONRBERGER CHIROPRACTIC CENTER
JOSEPH P. HORNBERGER, M.S., D.C., P.A.
1180 S. BENEVA RD
SARASOTA, FL 34232

List the Doctor(s) You Have Seen Previously for This Injury in Order of Occurrence:

Doctor #1 _____

Address _____

Treatment Received _____ How Long Treated _____

What Were the Results _____

Were You Referred to Another Doctor: Yes _____ No _____

Who Were You Referred to _____

Doctor #2 _____

Address _____

Treatment Received _____ How Long Treated _____

What Were the Results _____

Were You Referred to Another Doctor: Yes _____ No _____

Who Were You Referred to _____

Doctor #3 _____

Address _____

Treatment Received _____ How Long Treated _____

What Were the Results _____

Were You Referred to Another Doctor: Yes _____ No _____

Who Were You Referred to _____

List Any and All Prior Injuries or Accidents (Auto, Work Related, Etc.)

1. Type of Injury _____

Date It Occurred _____ Resulting Injuries _____

2. Type of Injury _____

Date It Occurred _____ Resulting Injuries _____

3. Type of Injury _____

Date It Occurred _____ Resulting Injuries _____

HORNBERGER CHIROPRACTIC CENTERS

Joseph P. Hornberger, M.S., D.C., P.A.

1180 Beneva Rd. South
Sarasota, FL 34232

(941) 3662440
Fax: (941) 955-3336

Dear Patient:

I would like to take this opportunity to first welcome you to our office.

This letter will help you understand our front desk procedure with all patients – this procedure is called the *“one stop system”*. This means that you will only have to stop at the front desk only one time during your visit at our office. Traditionally a patient usually checks in at the front desk and then after seeing the doctor checks out to reschedule, pay for their visit, etc.

Our process is to be more efficient at the time of check in where you would sign in, schedule your future appointment/s and pay for your visit at that time. This means you will not have to check back at the front desk when you finish your adjustment and/or therapy.

What this means is that you will be paying for services, re-scheduling, and be self-directed to an adjusting room prior to seeing the doctor. The doctor will then direct you to the therapy room, massage therapist, and/or x-ray if needed based on your needs prior to you leaving the office after your adjustment. *We do believe that this process will save you more time.*

I truly appreciate your cooperation and participation in helping us maintain a stress relief environment.

I would be more than happy to discuss any questions regarding this policy – please do not hesitate to speak with me personally.

Thank you,

Dr. Joseph P. Hornberger, M.S., D.C., P.A.

PATIENT SIGNATURE: _____ DATE: _____

HORNBERGER CHIROPRACTIC CENTERS

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1180 Beneva Rd. South
Sarasota, FL 34232

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Fax: (941) 955-3336

Dear Patient:

Based on the Florida Statute 460.413, please be advised that your medical forms and x-ray films are a permanent record of our office for a maximum of 4 years.

If you will need to request the films that were processed in our office there will be a minimum charge of \$6.00 per copy. The x-ray technician will be more than happy to advise you in advance of the total cost.

The office policy: Payment must be made prior to duplicating the films and the waiting period for processing would be no longer than 24 – 36 hours.

PATIENT/GUARDIAN SIGNATURE DATE SIGNED

.....
Permission to leave recorded scheduling messages at your designated phone number.

Compliance to the doctor's recommendations is of paramount importance in realizing maximum benefits from your care in our office. With your consideration and permission we will phone to remind you of missed or changed appointment schedules. Messages would be a reminder to phone Dr. Hornberger at our office concerning your appointment. Permission to follow this important procedure is granted by you with your signature.

PATIENT SIGNATURE

DATE

RELEASE OF PATIENT RECORDS AUTHORIZATION

I hereby authorize Joseph P. Hornberger, M.S.,D.C.,P.A. (HORNBERGER CHIROPRACTIC CENTER) to release a copy of my patient records or x-rays containing protected health information to

_____. This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Patient's or Patient's Legal Representative's Signature

Patient's Date of Birth

Date Signed

Specific description of information to be disclosed:

ASSIGNMENT OF BENEFITS FORM

Pursuant to Florida Statute 627.736(5) and the applicable insurance policy, the undersigned patient hereby assigns the benefits of insurance and any and all rights and causes of action available under the policy of Health insurance with _____ Insurance Company are payable to **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** to receive payment, in full, for services rendered to the undersigned and which are payable under the plan provisions of the policy of Health insurance provided by _____ Insurance company.

As prescribed by Florida Statute 627.730-627.741, all payments shall be overdue if not paid within 30 days (thirty) after the insurer is furnished written notice of the fact of a covered loss and the amount of same. All overdue payments shall bear simple interest at the rate of ten percent (10%) per annum.

By virtue of this assignment, the undersigned directs that all payments should be issued **solely** in the provider's name and forwarded directly to the office of **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.**

In the event of dispute involving payment of my physician's bill, in order to maximize the benefits available under my policy coverage, and to continue to receive necessary treatment while the dispute is being resolved, I request the company adhere to the following. Assuming there is coverage remaining at the time company receives the physician's bill and the company fails to pay **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** the full amount of the treatment bill submitted, to avoid the exhaustion of coverage while this provider pursues its right under this assignment, I authorize and direct the insurance company, to set aside and place in escrow, an amount equal to the full amount of any such reduction and to hold that amount in escrow until the dispute is resolved in the appropriate forum.

It is acknowledged and agreed that in the event I have a wage loss claim, that **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** assignment takes precedence.

Further, I authorize and direct my insurance company to provide **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** and/or their attorney, an updated copy of the Master Document Plan.

It is agreed that this assignment will remain in full force until 48 hours after **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** receives written notice that it is being revoked. It is specifically agreed that any such revocation of this assignment will not apply to any treatment or associated expenses incurred on or before appropriate notice of revocation is received by **Dr. Joseph P Hornberger, M.S.,D.C.,P.A.** The undersigned agrees to pay any applicable deductible or co-payment not covered by the available health insurance coverage. Further, the undersigned agrees to pay all outstanding balances in excess of the available coverage limits.

Patient Signature

Date

The undersigned hereby accepts the above assignment of Insurance benefits, including any and all causes of action available to the above-mentioned patient under said policy provided by _____ Insurance company for bills and expenses for services provided to this patient. The insurance company should make any and all payments for such bills and expenses solely to me, and sent the payment directly to my office.

Dr. Joseph P Hornberger, M.S.,D.C.,P.A.

Date