

# **HORNBERGER CHIROPRACTIC CENTER**

Dr. Joseph P. Hornberger, M.S., D.C.  
1180 So Beneva Road  
Sarasota, FL. 34232  
(941) 366-2440

## **MEDICARE POLICY**

Our billing policy in regards to Medicare is as follows:

We are a non-participating provider meaning that we do not accept Medicare direct re-imbusement(s).

All Medicare patients pay for their total bill at the time of service.

Our insurance staff will mail in your claims to Medicare in your behalf on a weekly basis. All information noted on your claim form is based on what you have provided our office. You are responsible to notify us of any changes.

We do not nor will we guarantee that Medicare and/or supplemental carrier will pay your claims. We will furnish all the necessary information as long as you have signed your HIPPA release form.

Please do not let Medicare or your insurance coverage dictate the treatment you need to correct and maintain YOUR health.

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

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 \_\_\_\_\_

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 \_\_\_\_\_

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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 \_\_\_\_\_



**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:

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

# 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

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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: \_\_\_\_\_