

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 _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

**THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND
MAINTAINED FOR SIX YEARS.**

AUTHORIZATION TO OBTAIN PIP BENEFITS PAYOUT INFORMATION

NAME OF INSURER:
PIP POLICY NUMBER:
NAME OF INSURED:
DATE OF ACCIDENT:

I, _____, hereby authorize and direct _____
Name of insured Name of Insurer

to send to:

HORNBERGER CHIROPRACTIC CENTER
1180 Beneva Road So. Sarasota, FL. 34232
(941) 366-2440 or Fax 941 955-3336

an accounting of payouts made under all claims submitted for payment under the above
referenced policy relating to the automobile accident occurring on the above referenced date as
those payouts occur.

Signature of Insured

Date Signed

Address of Insured

LETTER OF PROTECTION

The purpose of this document is to provide a courtesy to our patient who requires services but is not able to afford the prescribed care. A patient receiving care in our facility is ultimately responsible for payment of services rendered, however, we will extend a courtesy of time if the patient cannot afford deductibles, reductions, or services in excess of the insurance coverage. This courtesy is extended to those patients who are compliant with recommendations and are injured due to the fault of another.

I, _____, (hereafter patient) hereby authorize my attorney, (hereafter attorney) to disburse direct to Joseph P. Hornberger, D.C., (hereafter doctor) any and all sums necessary to pay any outstanding balance due on the doctor's bill for care and treatment rendered to me, from any net proceeds recovered in my behalf by attorney as a result of any insurance contract claims or personal injury claims prepared and handled on my behalf by attorney for injury dated _____.

This letter is binding not only upon the above named attorney but any successor attorney(s) in the event that patient elects to change attorney during the pendency of said claims. A copy of **Assignment, Lien and Authorization** form on file with Joseph P. Hornberger, D.C. is enclosed for attorney file.

Doctor is hereby authorized to deliver copies of this letter of protection to my above named attorney or any successor attorney for his/her signature and acknowledgment. I hereby request and direct my attorney to sign this letter of protection acknowledging that he/she will abide by the terms of this letter of protection received in my behalf.

By signing below, I hereby acknowledge that the doctor's forbearance in the receipt of payment for medical services rendered even though some or all of said medical/dental services may be reimbursed by other available insurance benefits is good, valuable, and sufficient consideration for the promises contained herein from myself and attorney.

Dated this _____ day of _____, 20__.

Patient: _____ Witness: _____

By signature below, I acknowledge receipt of the above **ASSIGNMENT, LIEN AND AUTHORIZATION** issued to **JOSEPH P. HORNBERGER, D.C.**, by and agree to abide by the terms of this letter of protection.

I further agree to distribute funds received to Dr. Hornberger in accordance with these terms and applicable Florida law.

Dated this _____ day of _____, 20__.

Attorney At Law

ASSIGNMENT OF BENEFITS FORM

Pursuant to Florida Statue 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 automobile 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 Personal Injury Protection (PIP) and/or Medical Payments Coverage of the policy of automobile 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 PIP and Medical Payments coverage payment record as needed.

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 PIP and /or Medical Payments 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

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:

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



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were **actually rendered**. This means that those services have **already been provided**.

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above. This means that no person has initiated contact with me and/or persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

- A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
- B. I have **explained** the services rendered to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.
- C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately, and in a substantially complete manner**.
- D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Insured Person (patient receiving treatment) or Guardian of Insured Person:

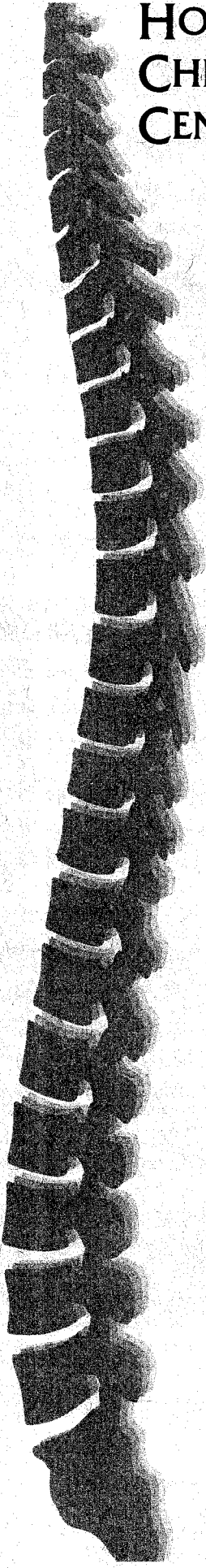
Name (<i>PRINT or TYPE</i>)	Signature	Date
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Licensed Medical Professional Rendering Treatment (*Signature by his or her own hand*):

Name (<i>PRINT or TYPE</i>)	Signature	Date
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Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.



**HORNBERGER
CHIROPRACTIC
CENTER**

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

“My signature on this document attests to the fact that the services set forth herein were actually rendered. The person rendering the medical services for which will be claimed has explained the services to me in detail.”

Dear Patient:

In accordance with the recent PIP changes effective 10/01/2003.

Please be advised that both you and the physician are required to sign a standard disclosure form which will be mailed to your automobile carrier.

You will also be required to sign your permanent patient record on each day of treatment.

Your signature will confirm that the services checked off on your travel card that the procedures indicated have been performed per your treatment schedule on a daily basis.

Spinal Manipulation	Electrical Muscle Stimulation
Intersegmental Traction	Ice or Heat
Ultrasound	Medical Massage
X-ray	Rehabilitative Exercise

The above procedure/policy has been explained to me and I fully understand this revised PIP policy/government regulated guideline.

PATIENT FULL SIGNATURE

FILED IN CHART

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 _____

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:

