DeFabio Spine and Sports Rehab, LLC

Chiropractic Nutrition Chronic Pain

308 Springfield Avenue Berkeley Heights, NJ 07922 • (P) 908-771-0220 • (F) 908-771-0114

CONFIDENTIAL PATIENT INFORMATION

Patient Information **Today's Date** _____

Patient Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Home Phone (___)____-_____ Work Phone (___)____-_____ Cell Phone (___)____-_____

E-mail _____ Preferred Language _____

Marital Status: ☐ S ☐ M ☐ W ☐ D Ethnicity ___Hispanic/Latino ___Non-Hispanic/Latino

Race _____ Gender ____M ____F ____Left-Handed ____Right-Handed

Smoking status __Never __Former __Current __How much? _____ Social Security# _____-____-_____

Referred By _____ Primary MD _____

Employer/School _____ Occupation _____

Employer/School Address _____

Emergency Contact _____ Emergency Contact Phone Number (___) _____-_____

Reason For Today's Visit

List present complaints and injuries _____

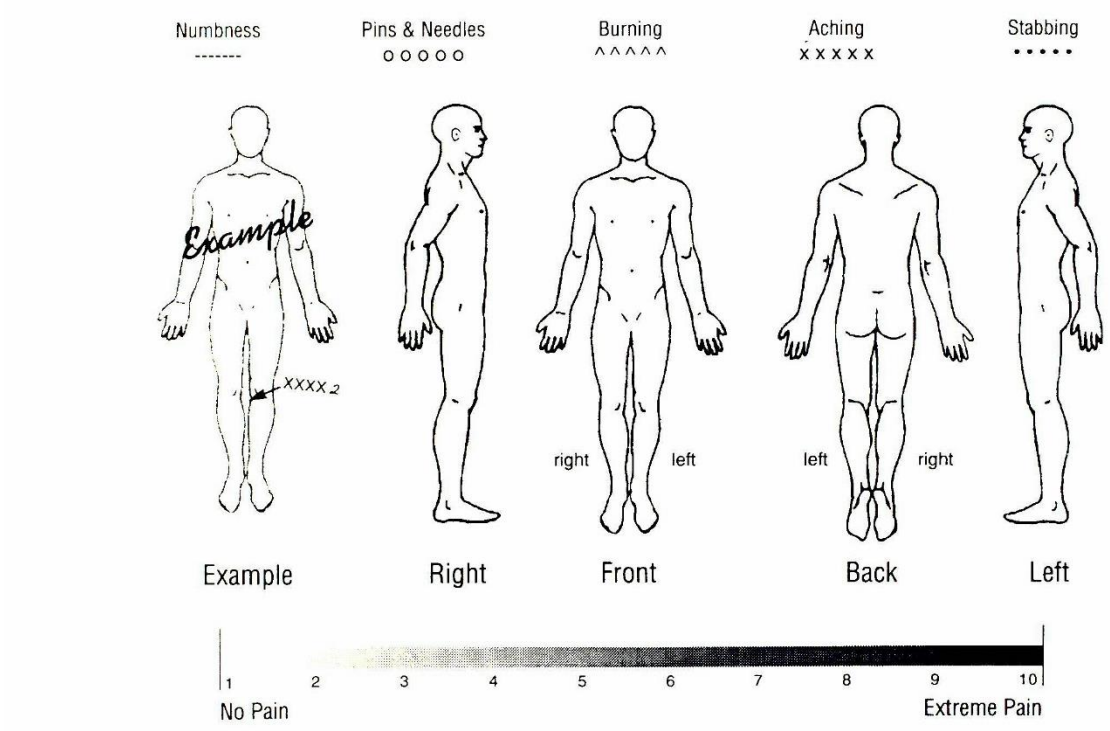
_____

How long have you had this condition? _____ Does it bother you occasionally/frequently/constantly?

Who else have you seen for this condition? _____

What did they recommend? _____

Pain Scale



Patient Signature for Consent to evaluate and treat today:_____

DeFabio Spine and Sports Rehab, LLC

2024 Insurance Information and Assignment Authorization

Patient's Name _____ **Date** _____

Patient's Social Security # __/___/___ Insurance Company _____

Insurance Policy # _____ **Group #** _____

Assignment Authorization and Agreement

I agree to provide the office with any **information, initial or follow up referral forms** prior to seeing the Doctor that are necessary for treatment or payment and

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable and mailed to:

   DeFabio Spine & Sports Rehab, LLC
   308 Springfield Avenue
   Berkeley Heights, NJ 07922

2. I understand this if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.
4. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**
5. A photocopy of this form shall be as valid as the original.

_____ _____

Patient's Signature Date

Patient's Notice of Privacy Practices

I, _____, acknowledge I was offered a copy of DeFabio Spine & Sports Rehab's Notice of Privacy Practices, with complete understanding and I had all my questions answered to my satisfaction.

I am authorizing DeFabio Spine & Sports Rehab, LLC to have my name displayed in the office in the form of a 'sign-in sheet' and a 'patient referral sign'.

☐ Yes ☐ No

I may be contacted in the following manner:

☐ E-mail address_____ via defabiochiropractic@gmail.com, a non-encrypted server

☐ Best telephone number to contact me _____

☐ OK to leave a detailed message ☐ Leave a message with a call back number only

☐ I authorize _____access to release my health records

Relationship to patient: _____

_____ _____

Patient's Signature Date

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2024 New Jersey Disclosure

New Jersey laws and the New Jersey Department of Health require healthcare providers to inform patients of the healthcare plan in which they participate and the facilities with which they are affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

A. Health Plans with which Our Practice participates:
   Medicare / Blue Cross Blue Shield
B. Facility with which Our Practice affiliates:
   DeFabio Spine and Sports Rehab, LLC
   308 Springfield Avenue, Suite 1
   Berkeley Heights, New Jersey 07922
C. Licensed Associate Healthcare Providers:
   Christopher J. DeFabio, DC
   Donald C. De Fabio, DC

I understand the healthcare professionals with whom I am seeking healthcare services is "out-of-network" and does not participate with my insurance plan.

I understand the amount or estimated amount of my healthcare services may be beyond my "in-network" deductible, copayment, or coinsurance and I am responsible for those charges.

I understand I may contact my health insurance plan or administrator for further consultation regarding the cost and reimbursement of my healthcare charges.

I, the undersigned patient, acknowledge receipt of this disclosure from my healthcare provider, read and understand its content. I wish to receive evaluation and treatment at DeFabio Spine and Sports Rehab, LLC with full notice of these disclosures. I certify I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures. I am not being coerced to sign this disclosure and I do so of my own free will.

Name: _____

Signature: _____

Date: ____/____/____

Photograph, Video & Written Testimonial Consent and Release Form

Purpose of the Release: The purpose of this release is to give your permission to DeFabio Spine & Sports Rehab, LLC (hereinafter referred to as **the practice**) to use your information (photographic/video/testimonial) for the practice's own advertising, publicity, educational and promotional purposes.

You agree as follows:

1. Your Photography/ Video/ Written Testimonial: This includes all items and/or information you provide to and/or let the practice record for example, quotes attributable to you, your voice, video footage, photos, etc.).
2. You understand and agree that **the practice** has the unrestricted right to:
   (a) Reproduce, copy, modify, create derivatives of, or use the photograph/video/testimonial and
   (b) Use your name in connection with photographs/video/testimonials as **the practice** may choose, and
   (c) Display, distribute, send or broadcast the photograph/video/testimonial by any means or method.

You give **the practice** your permission to use your photograph/video/ testimonial for the purpose of creating, publishing and distributing promotional, educational, advertising and publicity materials**. The practice** shall be the copyright owner of all published materials and all extensions and renewals of such copyright. You agree that no promotional idea or document containing the use of the published material needs to be submitted to you for approval.

3. The terms of this permission shall begin on the date you have signed below.
4. You agree to waive all rights and release **the practice** form, and shall not sue **the practice** or take any legal action against **the practice** for, any claim or cause of action, whether now known or unknown, including without limitations, for defamation, invasion of right to privacy, publicity, or personality, commercial misappropriation of name or likeness or any similar matter, or based upon or relating to the use and exploitation of the photograph/video/testimonial.

Authorization to use and disclose health information for marketing purposes

I authorize **the practice** to use and disclose my health information for marketing as follows.

1. Description of health information that may be used and/or disclosed: I authorize **the practice** to use and disclose my protected health information; specifically, information about the condition for which **the practice** treated me and the outcomes of that treatment, and all information described above.
2. Authorized recipients of my health information for **the practices** own advertising, publicity, educational, and promotional purposes, and the outcomes of that treatment, and all information to any recipients of **the practices** advertising, publicity, educational, promotional material.
3. I understand that I have the right to revoke this authorization prior to the expiration date shown below. I may revoke this authorization by writing to **the practice's** privacy officer at the following address.

   _____ (Compliance Officer), _____ (Email) _____ (Tel.)
4. I understand that the information disclosed under this authorization may potentially be re-disclosed by the recipients. The federal privacy rules may do not protect my health information from re-disclosure by recipients under this authorization.
5. I understand that I may decline to sign this authorization. **The practice** may not refuse to treat me if I do not sign this authorization.
6. This authorization shall expire 10 years from the date shown below.

   I have read this release, understand it, and am signing it voluntarily. I understand that any consideration received is full and fair for purposes described above for the use of the photograph/video/testimonial. By my signature, I represent that I am at least eighteen years of age and am competent to execute this authorization and agree to permit the disclosures permitted by this authorization.

_____
Patient Printed Name

_____
Patient Signature

_____
Date

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Payment Policy

To pay your balance once your insurance company has processed your visit, a current credit card needs to be on file with authorization of payment. Once the insurance claim is processed your credit card will be charged the balance and an itemized receipt will be mailed to you.

Payment Authorization

I hereby authorize DeFabio Chiropractic Associates to automatically charge my credit card for:

1. The allowable balance due after my insurance payments are made.
2. For insurance payments sent directly to me.
3. For my co-payment when due.
4. For non-covered services.
5. Missed Appointment fee.

A copy of the itemized statement and credit card receipt will be provided for your records.

Would you like a copy of your receipts?

□Yes □No

Name_____ Date_____

Signature_____ Zip Code: _____

MC Visa #_____ Expiration Date____
CVS___

Am Ex #_____ Expiration Date____
CID ___

All information is confidential and secure.