Greenberg Chiropractic LLC

REGISTRATION FORM

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐			
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Social Security #:	Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:	City:	State:	Zip Code:			
Home Phone:	Cell Phone:	Email:				
Occupation:	Employer:	Employer phone no.:				
Chose clinic because/referred to clinic by :						
Other family members seen here:						

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? ☐ Yes ☐ No					
Occupation:	Employer:	Employer address:	Employer phone no.:		
Is this patient covered by insurance? ☐ Yes ☐ No					
Name of Primary ins. and address:					
Subscriber's name (if different from above):	Subscriber's SS no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other		
Accident Date (if applicable):	State of Accident:	Adjuster's Name:			
Name of secondary ins. (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other		

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IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jonathan Greenberg DC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Greenberg Chiropractic, LLC

Chiropractic Case History

Name_____ _____ **Date**_____

1) Primary reason for seeking care?

_____

Location of complaint_____

Complaint began when and how? _____

Please circle the Quality of the complaint / pain: dull aching sharp shooting burning

Does this complaint /pain radiate or travel anywhere? _____

Do you have any numbness or tingling? _____

Grade intensity / severity of pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst possible pain)

How long has the complaint been present? _____

Does anything aggravate the complaint? _____

Does anything improve the complaint? _____

2) Previous treatments, medications, surgery, or care you've sought for your complaint_____

_____

3) Past health history:

A. Previous illnesses you have had _____

B. Previous injury or trauma _____

C. Medications _____

D. Surgeries _____

E. Family health history_____

Deaths in immediate family:

Cause of parents or siblings death	At age
_____	_____
_____	_____
_____	_____

Patient's Signature_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by Dr. Jonathan Greenberg and/or anyone working in this clinic authorized by Dr. Jonathan Greenberg.

I have had an opportunity to discuss with Dr. Greenberg and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes.

I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned chiropractic procedures. I intend this consent form to cover the entire course of treatment for my present condition.

TO BE COMPLETED BY PATIENT:

PRINT PATIENT'S NAME_____

SIGNATURE _____

DATE SIGNED_____

Section 7: Notice of Privacy Practices
Greenberg Chiropractic
Effective April 14, 2003

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. Greenberg Chiropractic is required by law to maintain the confidentiality of your health information. Greenberg Chiropractic realizes that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:
The following circumstances may require us to use or disclose your health information:
1. Treatment: to provide, coordinate or manage your health care and related services. Greenberg Chiropractic may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. Greenberg Chiropractic may use or disclosure protected health information about your treatment activities of another health care provider.

2. Payment: Greenberg Chiropractic may use or disclose protected health information so that Greenberg Chiropractic can bill and collect payment for the treatment and services provided to you. Before providing treatment or services, Greenberg Chiropractic may share details with your health plan concerning the services you are scheduled to receive for payment approval.

3. Health Care Operations: Greenberg Chiropractic may use or disclosure protected health information to allow us to improve the quality of care Greenberg Chiropractic provides and to reduce health care costs, which may include training programs for our staff.

4. Cooperating with outside legal entities

5. To public health authorities and health oversight agencies that are authorized by law to collect information.

6. Lawsuits and similar proceedings in response to a court or administrative order.

7. If required to do so by a law enforcement official.

8. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Greenberg Chiropractic will only make disclosures to a person or organization able to help prevent the threat.

9. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. To federal officials for intelligence and national security activities authorized by law.

11. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

12. For Workers Compensation and similar programs.

Your rights regarding your health information:
1. Communications. You can request that Greenberg Chiropractic communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that Greenberg Chiropractic contact you at home, rather than work. Greenberg Chiropractic will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that Greenberg Chiropractic restrict our disclosure of
your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. Greenberg Chiropractic is not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Official: Jennifer Hansen.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Official: Jennifer Hansen. You must provide us with a reason that supports your request for the amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our Privacy Official: Jennifer Hansen.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Official: Jennifer Hansen. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

In accordance with the standards of implementation specifications of 45 C.F.R. § 164.524, Provider may grant an individual access to inspect and obtain a copy of protected health information about the individual in a designated record set.
Greenberg Chiropractic ’s policy:

1. The designated record set that is subject to access by an individual is as follows:
    a. Medical Records
    b. Billing Records
2. The titles of the persons or offices responsible for receiving and processing requests for access by individuals are as follows:

Privacy Official: Jennifer Hansen
Greenberg Chiropractic also uses protected health information for the following reasons: (you may opt out of this authorization).
Special initial authorization is required and attached.
Marketing; internal referral board, testimonials, pictures on bulletin board, sending newsletters or information unrelated to healthcare and other marketing materials.

If you have any questions regarding this notice or our health information privacy policies, please contact:
Jennifer Hansen

You can reach the Privacy Official at:
Greenberg Chiropractic
2 S. Frontenac Ave.
Margate, NJ 08402
Phone number: 609-823-9300
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Greenberg Chiropractic

Effective: April 14, 2003
Initial Acknowledgement and Uses

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Greenberg Chiropractic. Our Notice of Privacy Practices provides information about how we may use and disclose you protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Jennifer Hansen.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Jennifer Hansen
You can reach the Privacy Official at:
Greenberg Chiropractic
2 S. Frontenac Ave.
Margate, NJ 08402
Phone number: 609-823-9300

Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____
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Staff complete only if NO signature is obtained, if it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

□ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices

□ Other: _____

Staff Signature: _____date: _____

GREENBERG CHIROPRACTIC NO SHOW AND CANCELLATION POLICY

Patients who do not keep their appointments or provide 24 hour notice of cancellation will be subject to a charge of $25.00. This fee will be applied after the second missed appointment or second failure to provide 24 hour notice of cancellation within a 12 month period. This is not a billable charge to any insurance company and is the responsibility of the patient. If a patient misses or cancels 3 times without proper notification, we reserve the right to dismiss that patient from the care of Greenberg Chiropractic.

GREENBERG CHIROPRACTIC FINANCIAL POLICY

Charges incurred for services rendered by the Greenberg Chiropractic are the patient's responsibility, regardless of insurance coverage. Assignment will be accepted for all insurance with which our practice participates. It is the patient's responsibility to provide this office with accurate insurance information, and to notify us of any changes in health insurance coverage. If you have questions on network status/participation with your insurance, it is your responsibility to contact the customer service number on your insurance card.

Patient responsibility: If your insurance has an office co-payment, co-insurance, or deductible that has not been satisfied, you must pay this at the time of your appointment.

Authorization: If your insurance company requires authorization to see a specialist, it is your responsibility to contact your primary care physician and request the authorization. Always check with your insurance before your appointment date and make sure the authorization has been approved. If no approved authorization is on file, you are responsible for the entire bill.

Billing: Know your insurance policy. You are responsible for any rejected claims, noncovered expenses, deductibles, co-insurance/co-payments. Our statements are sent monthly. Cash, check, money order or all major credit cards are acceptable means in which to pay the balance. If there remains an unpaid balance and we receive no payment or contact from the responsible party despite all our efforts to contact said party, then the account could be turned over to a collection agency or pursued legally. There is a $25.00 fee for checks that are returned for insufficient funds. Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have further questions or comments, please kindly contact our Business Office Supervisor.

I hereby understand the financial policy of this practice. I guarantee payment of all charges incurred for the account of the patient named below. I further agree to pay any attorney's fees, court costs, and related collection fees incurred. I also agree that my employer may be contacted to verify employment status.

Patient name:_____ Date:_____

Guarantor Signature:_____