Giust Chiropractic Center

Confidential Patient Information

Chart # _____

Date _____

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ Zip Code _____

Age _____ Birth Date _____ SSN # _____ Handed: R L Both

Marital Status: M S W D How many children? _____ Smoking Status: Every Day Some Days Former Never

Cell _____ Email _____ Alcohol Use : Regularly Socially Occasionally Never

Race: White Black American Indian Asian Other _____

Occupation: _____ Employer: _____

Emergency Contact: Name _____ Phone _____ Relationship: _____

Do You Have Insurance: Yes No Name of Policy Holder _____ Birth Date _____

Relationship to Patient _____ SSN of Policy Holder _____

Is Your Visit Due to an accident? Yes No Workers Comp: Adjuster _____ Phone _____

Current MD or Specialist _____ List Medical Allergies _____

What or whom referred you to us? _____

Current Medications:

Medication Name	Dosage (mg)	Times per day:

Payment is expected at time of visit, unless arrangements with financial planner have been made!

I understand that I am responsible for payment. Furthermore, I understand that Giust Chiropractic Center, P.A. will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to Giust Chiropractic Center, P.A. will be credited to my account. However, I clearly understand that all services rendered to me are charged directly to me and I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ Date _____

Signature Authorizing Care/Relationship _____ Date _____

Doctor's Remarks _____

_____

_____

_____

Giust Chiropractic Center

Patient Health Information Consent Form

Please initial each line to indicate that you have read and understand each section.

Release of Health Information to Giust Chiropractic Center

_____ I hereby authorize Dr. Mark S. Giust, Chiropractor, and any of his staff members to release any information acquired in the course of my examination of treatment.

Chiropractic Insurance

_____ 1. As a convenience to our patient with chiropractic insurance, our office submits the charges to your insurance carrier at no cost to you.

_____ 2. Please understand that insurance is a contract between you and your insurance company.

_____ 3. No insurance company covers all chiropractic costs. Some companies pay fixed allowances for adjustments and therapies and others pay a percentage of the charges.

_____ 4. It Is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

_____ 5. If you have a question regarding your insurance coverage you will be responsible for contacting your insurance carrier.

_____ 6. If your insurance has not paid within 60 days, you are responsible for your balance in full.

Patient Health Information Consent Form

The individuals or parties that could have access to Patient Health Information for Giust Chiropractic Center include but may no be limited to the staff of Giust Chiropractic Center and the following persons. (List individuals who may have access to your health records.)

1. _____ 2. _____

3. _____ 4. _____

Necessary health care providers or vendors who may need to be consulted if related to the patient's conditions. (List any providers that may have access to your records.)

1. _____ 2. _____

3. _____ 4. _____

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information

(Notice available at front desk)

I acknowledge that I have read received/reviewed Giust Chiropractic Center's Notice of Privacy practices for Protected Health Information.

Date: _____ Name of Patient (Print): _____

Signature of Patient/Personal Representative _____