HORNBERGER WELLNESS & CHIROPRACTIC
4001 Swift Rd, 1st floor
SARASOTA, FL 34231

PATIENT INFORMATION: **Today's Date:** _____

Patient's First Name _____, **Middle Initial:** _____, **Last Name:** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Cell Phone: _____ **Hm Phone:** _____ **Wk Phone:** _____

Birth date ___/___/____

☐ **Male,** ☐ Female, SS#_____ **Marital Status:** ☐ M, ☐ S, ☐ W, ☐ D Student: ☐

Who referred you? Name: _____, Spouse: _____, Spouse Phone: _____

Language: _____, **Race**: (optional): _____, **Ethnicity** (optional): _____

Email: Home: _____, Work: _____

Can we call or contact you? Cell: ☐YES ☐ NO, **Home:** ☐ YES ☐ NO, **Work:** ☐ YES ☐ NO

Insurance Information

Insurance Carrier: _____ Policy Holder (name on card): _____

Policy Number: _____

Please provide our office with your insurance card and Photo ID

TO BE FILLED OUT BY OFFICE BILLING DEPARTMENT:

Type: ☐ ChiroHeath USA, ☐ Private, ☐ Self Pay, ☐ Auto, ☐ Worker Compensation, ☐ Slip & Fall

Primary Insurance Company_____

Policy No. _____, ChiroHealsthUSA,_____

Name of Person Responsible for Payment_____

Insurance Address_____

Name of Person Spoken to: _____

Chiropractic Coverage: Yes_____No____Deductible: _____Deductible Met: _____

Coverage: _____

Adj 1-2 regions (98940) : _____, Adj 3-4 regions: _____, MM1-2 regions (98940): _____
MM# 3-4 regions (98941): _____, X-rays: C:_____T:_____L_____, Massage: (97124): _____
EMS (97014): _____, IT (97012: _____, Exercise (97140) _____
US (97035): _____, MH (97010): _____, ICE (97010): _____

Limitations: _____

Additional Information: _____

Assigned Provider: ☐ Michael Hornberger, DC ☐ Joseph Hornberger, DC 8/23/2916

HORNBERGER WELLNESS & CHIROPRACTIC

Patient name: _____ Date: _____

(List the Doctor(s) You Have Seen Previously for This Injury in Order of Occurrence)

NONE: ☐

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, or any other)

NONE: ☐

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_____

NOTES:

(Dr. Initials): _____

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 Major Medical 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 Medical Payments Coverage of the policy 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.** an updated copy of the 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 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 Wellness & Chiropractic

Informed Consent

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear. The nature of the chiropractic adjustment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "Click," much as you have experience when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures which may be performed on you:

- Spinal manipulative therapy
- Range of motion testing
- Palpation
- Muscle strength testing
- Orthopedic testing
- Ultrasound
- Basic neurologic testing
- Radiographic studies
- Hot/cold treatment
- Blood pressure performed
- Vital signs
- Urine analysis
- Electrical muscle stimulation
- Acupuncture
- Trigger point injections
- Inferred heat
- Nutrition/supplementation analysis and recommendations
- Therapeutic exercise assessment and recommendations
- Aerobic exercise evaluation and prescription
- Herbal remedies, vitamin supplementation, and dietary recommendations
- Self-administered topical analgesics
- Any other offered by our office.

The material risks inherent in the chiropractic adjustment:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separation, and burns. Some types of manipulations of the neck been associated with injuries to the arteries on the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care: however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibly to inform the doctor.

The probability of those risks occurring.:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated or stopping treatment prematurely:

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Stopping treatment prematurely and not following the doctor's recommendation will most likely prevent optimal recovery and increase the probability that the condition will degrade with time as indicated above.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE:

I have read, or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Joseph or Dr. Michael Hornberger, D.C., or other licensed practitioners practicing within Hornberger Wellness & Chiropractic and have had my question answered to my satisfaction and give consent to being examined and treated at Hornberger Wellness & Chiropractic.

Patient's Name: _____ Doctor's Name: Joseph or Michael Hornberger, DC.

Signature: _____ Doctors Signature: _____

Signature of Parent or Guardian (if a minor): _____

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 _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices regarding Hornberger Wellness & Chiropractic 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.

By checking the lines below, I authorize being contacted for practice reminders by:
Mail: ☐
Email: Home: ☐; Work: ☐
Telephone numbers: Cell: ☐; Home: ☐; Work: ☐
By voice mail: ☐
By text message: ☐
By Facebook address: ☐; Facebook address: _____.

By checking this checking the lines below I authorize being contacted for birthday greetings or promotions about the practice by:
Mail ☐
Email: ☐; at email address _____
Telephone numbers: Cell: ☐; Home: ☐; Work: ☐
By voice mail: ☐
By text message: ☐
By Facebook address: ☐; Facebook address: _____

By checking this box, I authorize the doctors or staff to personally discuss with me products that may benefit my health or condition: ☐

_____ _____
Patient Name (please print) Date

_____
Print Name of Parent, Guardian or Patient's legal representative

_____
Signature of Patient, Parent, Guardian or Patient's legal representative

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

List below the names and relationship of people to whom you authorize the Practice to release Personal Health Information:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

AUTHORIZATION TO RELEASE RECORDS FROM ANOTHER FACILITY TO

HORNBERGER WELLNESS & CHIROPRACTIC

I hereby authorize and request you to release all health records including x-rays to Hornberger Wellness & Chiropractic from the following facilities:

Name and address of facility/s:

_____

_____

Mail or Fax records to:

Hornberger Wellness & Chiropractic

4001 Swift Rd, 1st floor, Sarasota, Florida 34231

Office Phone Number: 941.924.4400

Office Fax Number: 941.924.4404

PATIENT FULL NAME ON RECORD:

Print Clearly: _____

Patient date of birth: _____/_____/_____

Authorized Signature: _____

Date Signed: _____/_____/_____

HORNBERGER WELLNESS & CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
(45 CFR 164.520)

PLEASE REVIEW THIS NOTICE CAREFULLY.

This notice describes how medical information about you may be used and disclosed and you can get access to that information as required by 45 CFR 164.520.

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from the Practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. The privacy of PHI in patient files will be protected when the files are taken to and from the Practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the Practice authorized to remove the files from the Practice's office. It may be necessary to take patient files to a facility where a patient is confined or to a patient's home where the patient is to be examined or treated. This Notice may be amended or revised at which time you will be provided the revised or amended Notice to review.

NO CONSENT REQUIRED

The Practice may use and/or disclose your PHI for the purposes of:

- (a) Treatment - In order to provide you with the health care you require, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your health condition and needs. For example, a physician treating you for a condition or disease may need to know the results of your latest physician examination by this office.

- (b) Payment - In order to get paid for services provided to you, the Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide the Medicare program with information about health care services that you received from the Practice so that the Practice can be properly reimbursed. The Practice may also need to tell your insurance plan about treatment you are going to receive so that it can determine whether or not it will cover the treatment expense.

- (c) Health Care Operations - In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

1. The Practice may use and/or disclose your PHI, without a written Consent from you, in the following additional instances:

(a) Any information is deleted that would identify you.

(b) To a company or person who is not employed by the practice to provide a service such as billing insurance and/or electronic records. These persons/companies are called "Business Associates." Only that information necessary to perform the service will be submitted to the business associate if the Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.

(c) To a person that you designate as a personal representative who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations -

- (i) for the purpose of obtaining or rendering emergency treatment to you provided that the Practice attempts to obtain your Consent as soon as possible; or

- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Communication Barriers - If, due to substantial communication barriers or inability to communicate, the Practice has been unable to obtain your Consent and the Practice determines, in the exercise of its professional judgment, that your Consent to receive treatment is clearly inferred from the circumstances.

(f) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease and that does not identify you and, even without your name, cannot be used to identify you.ii

(g) Abuse, Neglect or Domestic Violence - To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm.

(h) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, criminal investigations, disciplinary actions, or general oversight activities relating to the community's health care system.

(i) Judicial and Administrative Proceeding - For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

(j) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena. Or, the Practice may disclose your PHI if the Practice believes that your death was the result of criminal conduct.

(k) Coroner or Medical Examiner - The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(l) Organ, Eye or Tissue Donation - If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(m) Research - If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI and that does not identify you and, even without your name, cannot be used to identify you.

(n) Avert a Threat to Health or Safety - The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

(o) Workers' Compensation - If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) Disclosure of immunizations to schools required for admission upon your informal agreement.iii

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits

and services that may be of interest to you. Appointment reminders are used by the Practice. The Practice will use those methods which you designate at the end of this Notice, such as: a) a postcard mailed to you at the address provided by you; b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone; or sending you an email or text message.

DIRECTORY/SIGN-IN LOG

The Practice maintains a directory of and sign-in log for individuals seeking care and treatment in the office. Directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the Practice's office suite. This information may be seen by, and is accessible to, others who are seeking care or services in the Practice's offices.

FAMILY/FRIENDS

The Practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for your care unless you direct the Practice to the contrary. The Practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, of your location, general condition or death. However, in both cases, the following conditions will apply:

- (a) If you are present at or prior to the use or disclosure of your PHI, the Practice may use or disclose your PHI if you agree, or if the Practice can reasonably infer from the circumstances, based on the exercise of its professional judgment that you do not object to the use or disclosure.

- (b) If you are not present, the Practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests and, if so, disclose only the PHI that is directly relevant to the person's involvement with your care.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization.iv

YOUR RIGHTS

1. You have the right to:

(a) Revoke any Authorization and/or Consent, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.

(b) Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.

Restrictions from your health plan (insurance company): You have the right to request that we restrict disclosure of your medical information to your health plan for covered services, provided the disclosure is not required by other laws. Services must be paid in full by you, out of pocket.

(c) Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.

(d) Inspect and obtain a copy your PHI as provided by 45 CFR 164.524. To inspect and copy your PHI, you are requested to submit a written request to the Practice's Privacy Officer. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request

(e) Amend your PHI as provided by 45 CFR 164.528. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you will have the right to submit a written statement of disagreement.

(f) Receive an accounting of disclosures of your PHI as provided by 45 CFR 164.528. The request should indicate in what form you want the list (such as a paper or electronic copy)

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(g) Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.

(h) Receive notice of any breach of confidentiality of your PHI by the Practice.

(i) Prohibit report of any test, examination or treatment to your health plan or anyone else for which you pay in cash or by credit card.

(j) Complain to the Practice or to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201, 202 619-0257, email: ocrmail@hhs.gov or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capitol, Tallahassee, FL 32399-1050, 850 414-3300 if you believe your privacy rights have been violated. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.

(k) Request copies of your PHI in electronic format.

To obtain more information on, or have your questions about your rights answered; you may contact the Practice's Privacy Officer, Mabel Cruz, at Homberger Wellness & Chiropractic, or via email at OfficeChiro9@gmail.com.

PRACTICE'S REQUIREMENTS

1. The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

- (b) Is required by State law to maintain a higher level of confidentiality with respect to certain portions of your medical information that is provided for under federal law. In particular, the Practice is required to comply with the following State statutes:

  Section 381.004 relating to HIV testing, Chapter 384 relating to sexually transmitted diseases, Section 456.057 relating to patient records ownership, control and disclosure and Section 501.171 relating to protecting your personal information, Social Security and driver license numbers, credit or debit card information, financial accounts information, email address, and medical information.

- (c) Is required to abide by the terms of this Privacy Notice.

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- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

- (e) Will distribute any revised Privacy Notice to you prior to implementation.

- (f) Will not retaliate against you for filing a complaint.

QUESTIONS AND COMPLAINTS

You may obtain additional information about our privacy practices or express concerns or complaints to the person identified below whom is the Privacy Officer and Contact person appointed for this practice. The Privacy Officer is Mabel Cruz.

You may file a complaint with the Privacy Officer if you believe that your privacy rights have been violated relating to release of your protected health information. You may, also, submit a complaint to the Department of Health and Human Services the address of which will be provided to you by the Privacy Officer. We will not retaliate against you in any way if you file a complaint.

EFFECTIVE DATE

Effective date: 1/1/2016.