BLOCK CHIROPRACTIC AND REHABILITATION CENTER, LLC REGISTRATION

Child's Health History

Name:_____Age:_____Date:_____

Address:_____City:_____State_____Zip:_____

Mother's Name:_____ Father's Name: _____

Home Phone #: _____Cell Phone #:_____SSN:_____ Birth Date:_____

Email address: _____

Reason for visit:_____

PATIENT CONDITION

Is your child experiencing pain? If so, where? _____

When and how did the problem arise? _____

Since the symptoms appeared, have they ☐gotten better ☐gotten worse ☐remained the same?

Do the symptoms interfere with ☐sleep ☐school ☐walking ☐sitting ☐hobbies ☐other_____

Other doctors seen for this problem:_____

Please list any medications the child is taking:_____

Any surgeries?_____

PREGNANCY

Were there any complications to the pregnancy? _____

Was Mom on any medications, prescription or over the counter? _____

Did Mom or Dad smoke during pregnancy? ☐yes ☐no Who?

Was the baby ever in the breech position? ☐yes ☐no

BIRTH

Where was the baby born? ☐hospital ☐birthing center ☐home ☐other: _____

Was the delivery ☐vaginal ☐c-section? Were any devices used? ☐forceps ☐vacuum

How long was the labor? _____ How long was delivery? _____

Was oxytocin/pitocin used? ☐yes ☐no Was an epidural administered? ☐yes ☐no

INFANCY

Was the infant vaccinated? _____

Did the infant suffer any traumas such as serious falls or car accidents? ☐yes ☐no

Childhood

Does the child play any sports? ☐yes ☐no Which sport?_____

Any surgeries? _____

Emotional trauma?_____

Any other health information you feel would be helpful?_____

The statements made on this form are accurate to the best of my recollection and I request and give consent for this office to examine and care for my child.

Parent's signature: _____Date:_____

What treatments have you already received for your condition? ☐Medication ☐Surgery ☐Physical Therapy
☐ Chiropractic Care ☐None ☐Other_____

Last Date of: Spinal X-ray_____ Physical Exam_____ Chest Xray_____ Blood Test_____

Urine Test_____ MRI_____ CT Scan_____ Bone Scan_____

Primary Care Physician Name & Address_____

Are you under the care of any other health care professional? ☐Yes ☐No Who?_____

Please sign here if you would like a report to be sent to the above named doctor:

_____ Date:_____

Place a mark on the "Yes" or "No" to indicate if you had any of the following:

Aids/HIV	YES ☐	NO ☐	Fibromyalgia	YES ☐	NO ☐	Measles	YES ☐	NO ☐
Alcoholism	YES ☐	NO ☐	Gastrointestinal Issues	YES ☐	NO ☐	Migraines	YES ☐	NO ☐
Allergy Shots	YES ☐	NO ☐				Miscarriage	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	Gout	YES ☐	NO ☐	Mononucleosis	YES ☐	NO ☐
Anorexia	YES ☐	NO ☐	Heart Disease	YES ☐	NO ☐	Multiple Sclerosis	YES ☐	NO ☐
Appendicitis	YES ☐	NO ☐	Hepatitis	YES ☐	NO ☐	Rheumatoid Arthritis	YES ☐	NO ☐
Arthritis	YES ☐	NO ☐	Hernia	YES ☐	NO ☐			
Asthma	YES ☐	NO ☐	Herniated Disc	YES ☐	NO ☐	Rheumatic Fever	YES ☐	NO ☐
Bleeding Disorder	YES ☐	NO ☐	Herpes	YES ☐	NO ☐	Scarlet Fever	YES ☐	NO ☐
Breast Lump	YES ☐	NO ☐	High Cholesterol	YES ☐	NO ☐	Stroke	YES ☐	NO ☐
Bronchitis	YES ☐	NO ☐	High Blood Pressure	YES ☐	NO ☐	Suicide Attempt	YES ☐	NO ☐
Bulimia	YES ☐	NO ☐	Joint Replacement	YES ☐	NO ☐	Swine Flu	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Kidney Disease	YES ☐	NO ☐	Tension Headache	YES ☐	NO ☐
Cataracts	YES ☐	NO ☐	Liver Disease	YES ☐	NO ☐	Thyroid Problems	YES ☐	NO ☐
Chemical Dependency	YES ☐	NO ☐	Lupus	YES ☐	NO ☐	Tonsillitis	YES ☐	NO ☐
			Osteoarthritis	YES ☐	NO ☐	Tuberculosis	YES ☐	NO ☐
Chicken Pox	YES ☐	NO ☐	Osteoporosis	YES ☐	NO ☐	Tumors, Growths	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Pacemaker	YES ☐	NO ☐	Typhoid Fever	YES ☐	NO ☐
Fractures	YES ☐	NO ☐	Parkinson's	YES ☐	NO ☐	Ulcers	YES ☐	NO ☐
Glaucoma	YES ☐	NO ☐	Pinched Nerve	YES ☐	NO ☐	Vaginal Infection	YES ☐	NO ☐
Goiter	YES ☐	NO ☐	Pneumonia	YES ☐	NO ☐	Venereal Disease	YES ☐	NO ☐
Gonorrhea	YES ☐	NO ☐	Polio	YES ☐	NO ☐	Whooping Cough	YES ☐	NO ☐
Emphysema	YES ☐	NO ☐	Prostate Problem	YES ☐	NO ☐	Other_____		
Epilepsy	YES ☐	NO ☐	Prosthesis	YES ☐	NO ☐			
			Psychiatric Care	YES ☐	NO ☐			

Exercise: ☐ None ☐Moderate ☐Daily ☐Heavy Specify_____

Work Activity: ☐Sitting ☐Standing ☐Light Labor ☐Heavy Labor

Habits: ☐Smoking_____ packs a day ☐Alcohol ____drinks a week ☐Coffee/Caffeine Drinks _____Cups a day

☐ High Stress level Reason_____

Are you Pregnant? ☐ Yes ☐No If yes, due date_____

	Description	**Date**
Surgeries		
Medications		
Broken Bones		
Dislocations		
Falls		
Head Injuries		
Allergies		
Vitamins/Herbs/Minerals		

Block Chiropractic and Rehabilitation Center, LLC
3919 National Drive, Suite 110
Burtonsville, MD 20866
301-476-7575
301-476-7730 fax
www.blockchiropracticcenter.com

I _____, hereby authorize the release of any and all medical records pertaining to my current state of health to be released to my chiropractor, Dr. Debra Block of Block Chiropractic and Rehabilitation Center LLC. Please send all diagnostic results, lab work, and history information that you have on record for me.

Patient Name:_____

Patient Signature:_____ Date:_____

Date of Birth:_____Social Security #:_____

Doctors Signature:_____ Date:_____

I _____, hereby allow Dr. Debra Block of Block Chiropractic to share my healthcare information with the following individuals.

_____	_____	_____
(Contact Name)	(Relationship to patient)	(Phone Number)
_____	_____	_____
(Contact Name)	(Relationship to patient)	(Phone Number)
_____	_____	_____
(Contact Name)	Relationship to patient	(Phone Number)

Patient Signature: _____ Date: _____

Block Chiropractic and Rehabilitation Center, LLC

Dr. Debra Block
3919 National Drive, Suite 110
Burtonsville, MD 20866

Telephone (301)476-7575
Fax (301)476-7730

Patient Privacy Consent Form (HIPAA)

To our valued patients:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Department of Health and Human Services has established a 'privacy rule' to help insure that personal health care information about the patient regarding treatment, payment, and health care operations, remains private.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, and health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer.

The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and time. We want you to know that all people who work at Block Chiropractic & Rehabilitation Center, LLC strive to understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the 'privacy rule.' We also strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, law and regulations. We want to insure that we never contribute to the growing problem of improper disclosure of PHI. We strive to be compliant and adhere to federal and state health care program requirements.

We also know that we are not perfect. Because of this fact, our policy is to listen to our patients if they feel that anything in our office compromises our policy of integrity and if they have suggestions to help us better achieve the goals of PHI privacy.

Thank you for being one of our valued patients.

Print Name	Signature	Date

Block Chiropractic and Rehabilitation Center, LLC

Dr. Debra Block
3919 National Drive, Suite 110
Burtonsville, MD 20866

Telephone (301)476-7575
Fax (301)476-7730

AUTHORIZATION AND ASSIGNMENT

Section A: Authorization and Assignment

Medical Information Release Authorization

I hereby authorize release of all records pertaining to my medical history, treatment or payment information which is required in the processing of applications for payment of benefits, to Block Chiropractic & Rehabilitation Center, LLC and Dr. Debra Block.

Insurance Information Release Authorization

I hereby authorize Block Chiropractic & Rehabilitation Center and Dr. Debra Block to release to my referring doctor, any other doctor(s) I am a patient of, and insurance company any information concerning my physical condition or treatment.

Late Fees, Breach, Costs and Attorney's Fees, Venue

If a credit card payment is decline or a balance is otherwise owed and the balance is not paid within thirty (30) days of billing, interest shall begin to accrue at six percent (6%) per annum. A separate fee for a returned (bounced) check equals the amount the bank charges Block Chiropractic & Rehabilitation Center, LLC plus $25.00. **In addition, a late fee shall be added to the account up to $5.00 per month, or up to ten percent (10%) per month of the payment amount which is past due, whichever is greater.** If an account is turned over to an attorney for collection, the patient is responsible for payment of all attorney's fees actually incurred to collect the amount due hereunder, even if the attorney's fees exceed the amount to be collected, plus interest, late fees and the actual costs of collection, whether or not a lawsuit is filed. In the event that a lawsuit is filed, said action shall be brought in the courts of Montgomery County, Maryland.

Binding Obligation, Entire Agreement

All signatories to this Agreement warrant that they have full and complete authority to enter into this Agreement and to sign said Agreement on behalf of themselves or the entity on whose behalf they are signing or both. This Agreement shall constitute the entire Agreement between the parties hereto, and no variance or modification thereof shall be valid and enforceable except by another agreement, in writing, execute and approved in the same manner as this Agreement.

_____ _____

Date Patient Signature

_____ _____

Date Block Chiropractic & Rehabilitation Center, LLC

Please turn page over for Section B

AUTHORIZATION AND ASSIGNMENT

Section B: Assignment and Waiver

Assignment of Insurance Benefits or Legal Claim

In the case of an insurance or legal claim, I hereby assign and transfer to Block Chiropractic & Rehabilitation Center, LLC and Dr. Debra Block, all proceeds of any such claim and authorize the insurance company or my attorney to pay all sums due to Block Chiropractic & Rehabilitation Center, LLC and Dr. Debra Block from said proceeds before paying the balance of said proceeds to me. I further authorize direct payment of medical benefits from my insurance company or attorney to Block Chiropractic & Rehabilitation Center, LLC and Dr. Debra Block, for all services rendered. I understand that I am financially responsible for any balance not covered by my insurance or a third party claim, and I hereby assume full responsibility for all charges incurred for professional services rendered by Block Chiropractic & Rehabilitation Center, LLC and Dr. Debra Block. **If any service is denied by my insurance company, I agree to be personally financially liable for payment for said services.**

Waiver

For the purposes of assigning any insurance benefits or legal claims, I hereby waive the statute of limitations with respect to a third party cause of action.

Binding Obligation, Entire Agreement

All signatories to this Agreement warrant that they have full and complete authority to enter into this Agreement and to sign said Agreement on behalf of themselves or the entity on whose behalf they are signing or both. This Agreement shall constitute the entire Agreement between the parties hereto and no variance or modification thereof shall be valid and enforceable except by another agreement, in writing, executed and approved in the same manner as this Agreement.

_____ _____

Date Patient Signature

_____ _____

Date Block Chiropractic & Rehabilitation Center, LLC

Block Chiropractic and Rehabilitation Center, LLC
Financial Policies

The following is a summary of our payment policies and what we expect from you as our patient.

Payments:
All payment is expected at time services are rendered unless other arrangements have been made in advance. This includes but is not limited to applicable coinsurance, copayments, and deductibles for participating insurance companies. Block Chiropractic and Rehabilitation Center, LLC accepts cash, personal checks, Visa, Mastercard, and Discover. There is a $25 service charge plus the bank fee for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that certain patients do experience financial hardships. In such circumstances, you may request a financial consultation with our office manager to discuss other arrangements.

Insurance:
We bill participating insurance companies as a **courtesy** to you. You are expected to pay your deductible, copayments, and coinsurance at the time of service. We will also verify your insurance benefits as a courtesy to you. However, it is your responsibility to understand your policy's benefits.

We will also bill your secondary insurance companies as a **courtesy.** Again, it is your responsibility to communicate with your primary insurance company that you would like your bills to "forward" to your secondary insurance company.

HMOs:
If your insurance policy is an HMO and you are in need of a referral prior to your visit, it is your responsibility to obtain that referral prior to coming to your first visit in our office.

Missed appointments:
Missed appointments represent a cost to us, to you, and to other patients who could have been seen during the time set aside for you. **Cancellations are required at least 24 hours prior to the appointment.** We do reserve the right to **charge for missed or late-canceled appointments**. Our fee for a missed appointment without adequate notice is **$50.00**. Excessive abuse of scheduled appointments may result in discharge from the practice.

Delinquent Accounts:

Block Chiropractic and Rehabilitation Center, LLC reserves the right to utilize a collection agency if, after multiple attempts to collect an outstanding bill, you fail to fulfill your obligation. Patient agrees that the responsibility for said balance plus fees charged by the collection agency for the cost of collection will be the patient's responsibility.

I have read and understand the financial policies of Block Chiropractic and Rehabilitation Center, LLC.

Signature of insured or Authorized representative:_____

Date:_____

CONSENT TO TREATMENT FOR MINORS

I HEREBY AUTHORIZE DR. DEBRA BLOCK TO TREAT AND EVALUATE MY SON/DAUGHTER

_____

Name of Minor and Indicate relationship

Name of Minor _____

Date of Birth _____

Signature _____ **Date** _____

Parent/Guardian Name

Witness Signature _____