



APPLICATION FOR TREATMENT

Name _____ SS# _____
Date of Birth _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone / Cell Phone (best way to reach you) _____
Name of Employer _____ Occupation _____
Name of Spouse _____ Spouse's Occupation _____
In case of emergency contact _____
Major Symptoms: _____

How did this condition develop? _____
When were you first aware of this problem? _____
Have you lost any time from work? _____
Have you been treated for this condition? _____ If yes, when and where? _____

Have you ever had this problem or a similar problem before? _____
If yes, please explain _____
List all surgeries and major illnesses _____
Are you pregnant? _____ If yes, when is your due date? _____
List present medications and supplements _____

Have you ever received Chiropractic treatment? _____ Describe _____

How will you be paying for your visits? _____

If you are insured, please provide the following:

Name of Company _____ Phone Number _____
Address _____
Claim or Identification # _____ Date of Injury _____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I also understand that this office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid should be paid directly to this office and credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All charges not paid within 90 days will automatically be put through on your credit card unless prior arrangements have been made.

VISA _____ MasterCard _____ Card # _____ Exp. Date _____

Patient Signature _____ Date _____

Rubin Health Center
1500 Dr. MLK Jr. Street North
St. Petersburg, FL 33704
Phone (727) 822-1555 FAX (727) 822-1777

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices 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.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

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

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RELEASE OF PATIENT RECORDS AUTHORIZATION

Date _____

I hereby authorize _____ to release a copy of my patient records or x-rays containing protected health information to Rubin Health Center. This authorization is given in pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or patient's representatives.

Patient's or Patient's Legal Representative's Signature

Patient's Date of Birth

Patients name

Social Security #

Specific description of information to be disclosed

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St. Petersburg, FL 33704
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RUBIN HEALTH CENTER

Spinal Restoration Specialists

OFFICE AND FINANCIAL POLICY

Welcome

- Please notify our office when you have a change of address, phone number, or insurance information.
- If your insurance company does not pay your claims because we have the wrong insurance info, no info or did not get changes in your info you are responsible for the bill

Appointment And Cancellations:

- Massage appointments need a 24 hour advanced notification cancelling your appointment or you will be charge for the full appointment. Credit card must be on file to schedule.
- 12 hours advanced notification is required when cancelling an office appointment. Failure to do so may result in a \$25 fee.
- We will be unable to reschedule appointment if you have three or more broken appointments, without proper notice.

Insurance

- We will gladly file your insurance claim for you, and accept assignment of benefits. However, if the insurance company does not pay after 30 days, it will be your responsibility to pay Rubin Health Center for all services rendered on your behalf.

Attention Medicare Patients

- Medicare will not pay for any services other than the chiropractic adjustment. Your first visit, x-rays, or any other services done in this office must be paid at time of service. If you would like prices for any services feel free to ask.

Payment Arrangements:

- Payment in full is due at time of services. We accept VISA and MasterCard for your convenience.
- Should your account be turned over to our collection agency for non-payment, you are responsible for all collection/ attorney fees incurred by Rubin Health Center.

Please read this policy carefully before signing. Our staff is available to you should you have any questions or concerns regarding this policy. Your signature certifies that you understand and will comply with this policy.

Print Name

Date

Patient's Signature

Patient Billing Acknowledgement Form Non-Covered Services

Under your health plan, you are financially responsible for copayments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as vitamins or certain chiropractic supplies.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

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Services to be provided:

Chiropractic Supply _____ Therapy _____ Other _____

Time frame from _____ through _____

Schedule/details _____

Provider Signature: _____

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I _____, acknowledge that I have been told in advance by
Patient Name -- Printed or Typed

my provider that the services/products listed above are not covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature _____ Date _____