



## PATIENT REGISTRATION FORM

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ E-mail Address \_\_\_\_\_

GENDER: M F

Marital Status: ☐ Single ☐ Married ☐ Sep ☐ Divorced ☐ Widowed

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_

### If Insurance policy under Another Name (Spouse, Parent, etc.) Please Complete

Insured Name \_\_\_\_\_ DOB \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**How did you hear about our office?** ☐ Website ☐ School Flyer ☐ Signage outside school ☐ Newspaper

☐ Walk-by ☐ Friend/Relative: \_\_\_\_\_ Other: \_\_\_\_\_

### MEDICARE AUTHORIZATION

I request that payment of authorized benefits be made either to me or on my behalf to the Doctor of Murphy Chiropractic, for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits for related services.

By signing this form, I the patient, indicate that I have read the above information provided to the best of my knowledge, accurate and true information. (If patient in under Eighteen, a parent or guardian must sign all forms).

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Treatment Permission:** I give permission to the health care providers of Murphy Chiropractic to administer treatment and perform such general procedures as deemed necessary in the diagnosis and treatment of my condition. Furthermore, risks regarding treatment will be explained to me before such treatment is performed and information regarding treatment will be provided to me upon request.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



150 Registry Blvd, Suite 103 St. Augustine FL 32092  
Phone: (904)940-9813

## **Informed Consent**

### **Chiropractic, Physical Medicine, and Rehabilitation Treatment**

Doctors of chiropractic, medical doctors, and physiotherapists who use manual therapy techniques such as spinal adjustment/manipulation are required to advise patients that there are or may be some risks associated with such treatment. In particular, you should note:

1. While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal adjustments;
2. There have been rare cases of reported injury to a vertebral artery following cervical spinal adjustments. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may on occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustment is extremely remote;
3. There have been reported cases of disc injuries following cervical/lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be highly effective treatment for spinal pain, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustments) as well as the contents of this informed consent. I also understand that there is no guarantee of results.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor including spinal adjustment.

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Patient's Signature

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Date



## **24 HOUR APPOINTMENT CANCELLATION POLICY**

I understand cancellations are sometimes unavoidable and I will work with you to be as flexible as possible. However, last minute cancellations or no shows are costly and eliminate the possibility to open that time up for other clients/patients.

Therefore, a 24 hour cancellation/reschedule policy has been put in place. Murphy Chiropractic Health Center reserves the right to charge a \$25.00 "no show" fee for non-cancelled or missed appointments. A missed appointment charge occurs when the patient fails to notify this office of cancellation prior to scheduled visit.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Murphy Chiropractic Health Center, as described above.

Thank you for your understanding and cooperation.

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Print

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Signature

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Date





## OFFICE POLICES

**Insurance Coverage:** This office CANNOT guarantee what percentage of care will be covered by your insurance. All care given in this office will be based upon medical necessity. All charges are usual and customary for like services.

**Assignment of Right to Payment/Lien Against Benefits:** I hereby authorize Murphy Chiropractic Health Center, to file my claim(s). I assign to them my attorney right to receive any and all payment and or recoveries from any insurance company, attorney or third party for professional services rendered by Murphy Chiropractic Health Center. I convey a lien against any funds, authorize and direct any third party to withhold sums from any benefits, judgments, verdict settlements, or recoveries and to adequately protect and to make payment for these services directly to Murphy Chiropractic Health Center, pursuant to this assignment and lien.

**Assignment of Cause of Action:** In the event, that any insurance company or other third party, that may be obligated to make payment to me or to Murphy Chiropractic Health Center, for the charges made for service, refuses to make payment upon demand, I hereby assign, transfer and convey to Murphy Chiropractic Health Center, to prosecute said action either in my name or their name to collect fees due for care rendered at Murphy Chiropractic Health Center, and legal expenses, and to resolve said claim as they see fit.

**Consent to Release Records:** I give my permission to Murphy Chiropractic Health Center to release any relevant records to any insurance company or third party payers that request this information in conjunction with amounts owed for services rendered.

**Treatment Permission:** I give permission to the health care providers of Murphy Chiropractic Health Center, to administer treatment and perform such general procedures as deemed necessary in the diagnosis and treatment of my condition. Furthermore, risks regarding treatment will be explained to me before such treatment is performed, and information regarding treatment will be provided to me upon request.

**Regarding Medicare patient Assignment:** We bill all Medicare patients according to the Medicare fee schedule. Medicare will pay 80% of those charges after an annual deductible. The deductible and 20% will be due from you or your secondary insurance company. If your secondary insurance company does not fully pay the annual deductible or the 20%, this balance will be due from you.

**Non-Covered Supply Items:** EMS, adhesive pads, supplements, ice packs, pillows and other medical durable equipment recommended by the doctor are non-covered by Medicare and most insurance companies. These items are to be paid for at the time of service and are non-refundable.

**OVER & SIGN**

**Newsletter and Appointment Reminders:** The health care providers of Murphy Chiropractic Health Center, may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other information that may be of interest to you. If this contact is made by phone we may leave a message for you to call us. You hereby authorize us to contact you with these reminders and information. Your personal information will only be used for our professional services and will be kept strictly confidential. You have the right to revoke this authorization at any time, but it must be done in writing. This authorization will expire in seven years after the date on which you last received services from us.

**Payment Responsibilities:** I understand that I am personally responsible for all charges, whether or not paid by any third party. I agree that all charges are payable, collectible and can be prosecuted in St. John's County. I understand that if I DO NOT make payment on my account after it is forty five (45) days past due, that account may be turned over for collections. The undersigned agrees to pay for any attorney's fees and court costs incurred in any action brought to collect sums due, said attorney's fees and costs to be included in, and made a part of any judgment entered in the collection of sums due. All portions of any bill sent to me by Murphy Chiropractic Health Center, shall be assumed valid unless disputed within thirty (30) days of receiving the bill for any portion not paid by insurance.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

PLEASE MAKE YOUR CHOICE:

- ☐ Payment by cash
- ☐ Payment by check
- ☐ Payment by credit card

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THIS OFFICE OF ANY ADDRESS OR INSURANCE CHANGES.**

**Missed Appointments:** Murphy Chiropractic Health Center reserves the right to charge a \$25.00 "no show" fee for non-cancelled or missed appointments. A missed appointment charge occurs when the patient fails to notify this office of cancellation prior to scheduled visit.

I HAVE READ AND AGREE TO THE ABOVE STATEMENTS. I UNDERSTAND THAT I CAN BE GIVEN A COPY OF THE MURPHY CHIROPRACTIC HEALTH CENTER PRIVACY NOTICE AT MY REQUEST.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **Notice of Privacy Practices**

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.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulations. The Privacy Officer also will take your complaints and can give you information about how to file a complaint. Our privacy Officer for the practice is Mark Murphy, D.C. **You can contact the Privacy Officer at (904)940-9813.**

### **Use and disclosure of your protected health information that we may make to carry out treatment, payment and healthcare operations.**

We may use information in your records to provide treatment to you. We may disclose information from your record to help you get health care services from another provider, a hospital, etc. For example, if you want an opinion about your condition from a specialist, we may disclose information to that specialist to obtain that consultation. We may use or disclose information from your record to obtain payment for services that you receive. For example, we may submit a diagnosis with a health insurance claim in order to demonstrate to the insurer that the service should be covered.

We may use or disclose information from your record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating care with providers. For example, we may use information in your record to train staff about your condition and treatment.

### **Your Rights**

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment or health care operations. However, we do not have to agree to these restrictions. You have the right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us. You have the right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment.

Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices. (Including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

**OVER & SIGN**

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization

was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

**Use of disclosure of your protected health information that we are required to make without your permission.**

In certain circumstances, we are required by law to make disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Human Services, if requested to prove that we are complying with regulations that safeguard your health information.

We may use or disclose information from your record if we believe it is necessary to prevent or lessen a serious and eminent threat to safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

**Use or disclosure of your protected health information that we are allowed to make without your permission.**

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest and may have to meet certain guidelines and limitations.

We may assist in health oversight activities, such as investigations of possible health care fraud. We may disclose information from your record as authorized by worker's compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process even if this is not ordered by a court.

Your provider or office staff may contact you to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment.

We may contact you with information about treatment alternatives or health-related benefits or services that may be of interest to you.

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Signature

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Date



**Assignment of Benefits and Direction to Pay Benefits Owed**

I, the undersigned insured or beneficiary of an insurance policy, irrevocably assign to Murphy Chiropractic Health Center, LLC. (hereafter "Provider") whatever rights I have under any policy of insurance and under Florida law, including, without limitation, any and all claims for attorney's fees, costs, interest and/or damages pursuant to Florida Statute 624.155. This Assignment of Benefits (AOB) includes an assignment of any potential claim for the common law or statutory bad faith. If the Insurer disputed the validity of this AOB, then the insurer is instructed to notify the provider in writing within 10 days of receipt of this document. Failure to do so shall result in the Provider relying on this AOB for direct payment and could constitute a waiver by the insurer to contest the validity of this document. I do hereby confirm that this AOB is irrevocable and instruct any insurance company or other collateral source for which I am entitled to benefits to pay for monies owed as a result of medical services rendered by **Provider** to promptly make payment in the name of and directly to or its chosen billing service.

Pursuant to this AOB, **Provider** is authorized to file suit on my behalf against any insurance company that reduces or denies benefits for medical services rendered to me and to collect any damages awarded or settlement monies for services rendered plus interest, costs, reasonable attorney's fees and a contingency fee multiplier. I understand that in any such lawsuit, my name or other identifying information will need to be included in and/or portions of my medical file attached to pleadings and/or formal discovery. I waive any confidentiality of my records and/or information but only to the extent necessary to prosecute a claim for unpaid or owed medical expenses against the insurance company or any other responsible party.

I acknowledge that **Provider** objects to any reductions or partial payments by the Insurer. Any partial or reduced payment, regardless of the accompanying language, issued by the Insurer and deposited by **Provider** shall be done under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. **Provider** reserves that right to seek the full amount of the bill submitted from the insurance company(ies) or me. Accordingly, the insurer is hereby instructed to set aside (escrow) any and all reduced or denied benefit payments for medical services rendered by this provider and not pay the disputed amount to anyone until the dispute is resolved.

I further instruct my insurance company to cooperate with the above-captioned **Provider** in resolving all medical billing disputes. Cooperation includes, but is not limited to, providing any and all declaration pages, PIP logs, payout ledgers, explanations of benefits, copies of checks, and any and all other documents or information to **Provider** or its attorneys, employees or other representatives acting on behalf of **Provider**. If the insurer schedules a defense examination, examination under oath (EUO) or Independent Medical Examination (IME) of the patient, the insurer is hereby instructed to send a copy of said notification to this provider and the provider's attorneys. The provider and/or the provider's attorneys are not authorized to appear at any patient EUO or IME set by the insurer. **THIS ASSIGNMENT OF BENEFITS DOES NOT ASSIGN ANY RIGHTS OR OBLIGATIONS UNDER THE POLICY OF INSURANCE TO SUBMIT TO AN EUO OR RECORDED STATEMENT.** I further direct and authorize you to speak to an attorney, employee or any other representative of Provider or anyone acting on their behalf over the phone and provide them with any and all information you may have or documentation not previously listed above that they may request.

I, as the patient, agree to remain personally liable for the amounts billed by **Provider** regardless of the amount paid by the insurance company, unless ordered by a court of law. I fully understand that said health care services were provided to me in consideration for an unconditional promise to pay and for me providing these instructions to my insurance company. I, as the patient, further agree to be liable for reasonable attorney's fees and costs incurred in collecting any delinquent accounts or unpaid balances. By executing this document, I am placing my insurance company(ies) on notice that the claims for medical treatment rendered by **Provider** are related to my accident (or my covered conditions) and should be paid directly to **Provider** pursuant to this assignment of benefits and Florida Law. Any delay in paying benefits owed under the insurance policy could adversely affect me.

BY EXECUTING THIS DOCUMENT, I AM PLACING MY INSURANCE COMPANY ON NOTICE THAT THIS IS A DIRECT ASSIGNMENT OF BENEFITS PURSUANT TO FLORIDA LAW. AS THE INSURED OR BENEFICIARY OF SAID INSURANCE POLICY, I AM IRREVOCABLY ASSIGNING WHATEVER RIGHTS I HAVE UNDER MY POLICY OF INSURANCE (LESS THE DUTY TO ATTEND AN EUO) AND UNDER FLORIDA LAW TO THIS HEALTH CARE PROVIDER. A photocopy of this assignment shall be considered as effective and valid as the original.

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Patient's Name & DOB

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Signature of Policy holder or Claimant/Date

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Name of Policy Holder or Claimant

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Acceptance of **Provider**/Date