



DeFabio Spine and Sports Rehab, LLC

Chiropractic Nutrition Chronic Pain

308 Springfield Avenue Berkeley Heights, NJ 07922 • (P) 908-771-0220 • (F) 908-771-0114

CONFIDENTIAL PATIENT INFORMATION

Patient Information

Patient Name _____ Today's Date _____
 Date of Birth _____
 Street Address _____
 City _____ State NJ _____ Zip _____
 Home Phone () - _____ Work Phone () - _____ Cell Phone () - _____
 E-mail _____ Preferred Language _____
 Marital Status: ☐ S ☐ M ☐ W ☐ D Ethnicity _____ Hispanic/Latino _____ Non-Hispanic/Latino
 Race _____ Gender M _____ F _____ Left-Handed _____ Right-Handed
 Smoking status _____ Never _____ Former _____ Current _____ How much? _____ Social Security# _____ - _____ - _____
 Referred By _____ Primary MD _____
 Employer/School _____ Occupation _____
 Employer/School Address _____
 Emergency Contact _____ Emergency Contact Phone Number () - _____

Reason For Today's Visit

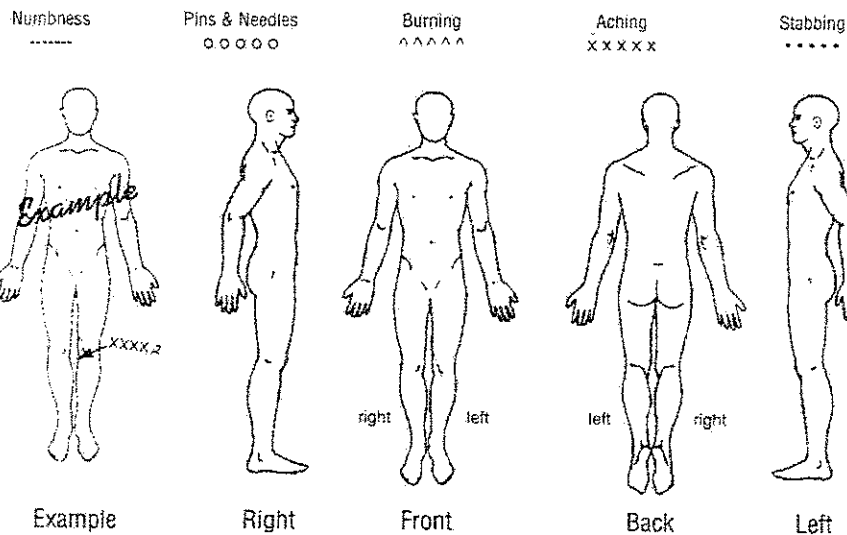
List present complaints and injuries _____

How long have you had this condition? _____ Does it bother you occasionally/frequently/constantly?

Who else have you seen for this condition? _____

What did they recommend? _____

Pain Scale



Patient Signature for Consent to evaluate and treat today: _____

DeFabio Spine and Sports Rehab, LLC

Insurance Information and Assignment Authorization

Patient's Name _____ Date _____

Patient's Social Security # ____/____/____ Insurance Company _____

Insurance Policy # _____ Group # _____

Assignment Authorization and Agreement

I agree to provide DSSR with relevant **information and referral forms** necessary for treatment or payment prior to seeing the Doctors and

I hereby assign DSSR to receive payments from insurance companies or negligent parties.

Payments are payable to:
DeFabio Spine & Sports Rehab, LLC
308 Springfield Avenue
Berkeley Heights, NJ 07922

I authorize DSSR to release any relevant information to any insurance company, adjustor or attorney who will assist in the processing and payment of my claim.

I fully understand and agree insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.

A photocopy of this form shall be as valid as the original.

Patient's Signature

Date

Patient's Notice of Privacy Practices

I, _____, acknowledge I was offered a copy of DeFabio Spine & Sports Rehab's Notice of Privacy Practices, with complete understanding and I had all my questions answered to my satisfaction.

I may receive assessment and treatment in a private room or an open therapy suite and every attempt will be made to speak in a discreet conversational level.

I may be contacted in the following manner:

☐ E-mail address _____ via defabiochiropractic@gmail.com, a non-encrypted server

☐ Best telephone number to contact me _____

☐ OK to leave a detailed message ☐ Leave a message with a call back number only

☐ I authorize _____ access to release my health records

Relationship to patient: _____

Patient's Signature

Date



DeFabio Spine and Sports Rehab, LLC

Christopher J. DeFabio, DC, Webster Certified

Donald C. DeFabio, DC, DACRB, DACBSP, DABCO

Board Certified in Chiropractic Orthopedics, Physical Rehabilitation and Sport Injury

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New Jersey Disclosure

New Jersey laws and the New Jersey Department of Health require healthcare providers to inform patients of the healthcare plans in which they participate and the facilities with which they are affiliated. In compliance with these requirements, you as the undersigned patient is hereby notified in writing, that:

A. Health Plans with which Our Practice participates:

Medicare / Blue Cross Blue Shield

B. Facility with which Our Practice affiliates:

DeFabio Spine and Sports Rehab, LLC

308 Springfield Avenue, Suite 1

Berkeley Heights, New Jersey 07922

C. Licensed Healthcare Providers:

Christopher J. DeFabio, DC

Donald C. DeFabio, DC

I understand the healthcare providers with whom I am seeking healthcare services are:

☐ **“In network”** and they do participate with my insurance carrier.

☐ **“Out of Network”** and they do not participate with my insurance carrier and I am responsible for the amount or of my healthcare services and charges, regardless of my insurance carrier’s provisions.

I acknowledge receipt of this disclosure from my healthcare providers, acknowledge and understand its content. I certify I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand this disclosure.

Name: _____

Signature: _____

Date: ____/____/____

Photograph, Video & Written Testimonial Consent and Release Form

Purpose of the Release: The purpose of this release is to give your permission to DeFabio Spine & Sports Rehab, LLC (hereinafter referred to as **the practice**) to use your information (photographic/video/testimonial) for the practice's own advertising, publicity, educational and promotional purposes.

You agree as follows:

1. Your Photography/ Video/ Written Testimonial: This includes all items and/or information you provide to and/or let the practice record for example, quotes attributable to you, your voice, video footage, photos, etc.).
2. You understand and agree that **the practice** has the unrestricted right to:
 - (a) Reproduce, copy, modify, create derivatives of, or use the photograph/video/testimonial and
 - (b) Use your name in connection with photographs/video/testimonials as **the practice** may choose, and
 - (c) Display, distribute, send or broadcast the photograph/video/testimonial by any means or method.

You give **the practice** your permission to use your photograph/video/ testimonial for the purpose of creating, publishing and distributing promotional, educational, advertising and publicity materials. **The practice** shall be the copyright owner of all published materials and all extensions and renewals of such copyright. You agree that no promotional idea or document containing the use of the published material needs to be submitted to you for approval.

3. The terms of this permission shall begin on the date you have signed below.
4. You agree to waive all rights and release **the practice** form, and shall not sue **the practice** or take any legal action against **the practice** for, any claim or cause of action, whether now known or unknown, including without limitations, for defamation, invasion of right to privacy, publicity, or personality, commercial misappropriation of name or likeness or any similar matter, or based upon or relating to the use and exploitation of the photograph/video/testimonial.

Authorization to use and disclose health information for marketing purposes

I authorize **the practice** to use and disclose my health information for marketing as follows.

1. Description of health information that may be used and/or disclosed: I authorize **the practice** to use and disclose my protected health information; specifically, information about the condition for which **the practice** treated me and the outcomes of that treatment, and all information described above.
2. Authorized recipients of my health information for **the practices** own advertising, publicity, educational, and promotional purposes, and the outcomes of that treatment, and all information to any recipients of **the practices** advertising, publicity, educational, promotional material.
3. I understand that I have the right to revoke this authorization prior to the expiration date shown below. I may revoke this authorization by writing to **the practice's** privacy officer at the following address.

_____ (Compliance Officer), _____ (Email) _____ (Tel.)

4. I understand that the information disclosed under this authorization may potentially be re-disclosed by the recipients. The federal privacy rules may do not protect my health information from re-disclosure by recipients under this authorization.
5. I understand that I may decline to sign this authorization. **The practice** may not refuse to treat me if I do not sign this authorization.
6. This authorization shall expire 10 years from the date shown below.

I have read this release, understand it, and am signing it voluntarily. I understand that any consideration received is full and fair for purposes described above for the use of the photograph/video/testimonial. By my signature, I represent that I am at least eighteen years of age and am competent to execute this authorization and agree to permit the disclosures permitted by this authorization.

Patient Printed Name

___ Accept

Patient Signature

___ Decline

Date