Robert Claflin, DC

__ New Pt. __Updated Pt. Info

Please print clearly to help avoid billing errors

Patient Last Name First MI

Mailing Address Apt or Unit #

City State Zip

( )
Home Telephone Cell Number Work Telephone e-mail

Date of Birth Age Social Security #

Marital Status: Single Married Divorced Other Sex: Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME-Person to Bill if Other Than Patient

Mailing Address Apt or Unit #

City State Zip

Assignment and Release: I hereby authorize and direct my insurance benefits to be paid directly to Center Chiropractic and I understand will be held financially responsible for any and all non-covered services provided by Center Chiropractic.
***** Be advised our office will try and verify your insurance coverage and benefits, however, it is ultimately the patient's responsibility to understand & verify the coverage and benefits your insurance policy allows.*****

Signature: _____ Date: _____

********** *Below for Office Use Only* **********

NEW PATIENT'S INITIAL VISIT

DOS: _____ Amt Paid This Visit: $ _____ PT. CLASS: Ins. Auto WC Cash

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

NEW EXAM: 99201 99202 99203 99204

9894____	97110	97140	97012	97035	97014	97010
Manip.	Thera Ex .	Myofacial	Mech. Trx.	Ultra Sound	U-Estim	Hot/Cold Pks

MEDICARE PATIENTS ONLY: Date of Current Illness: _____

□ Check Box to BLOCK PATIENT STATEMENTS PLEASE ATTACH A COPY OF THE INS. CARD

NEW PATIENT REGISTRATION

Paul Szwez, DC

__ New Pt. __Updated Pt. Info

Please print clearly to help avoid billing errors

Patient Last Name First MI

Mailing Address Apt or Unit #

City State Zip

(_____)

Home Telephone Cell Number Work Telephone e-mail

Date of Birth Age Social Security #

Marital Status: Single Married Divorced Other Sex: Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME-Person to Bill if Other Than Patient

Mailing Address Apt or Unit #

City State Zip

Assignment and Release: I hereby authorize and direct my insurance benefits to be paid directly to Center Chiropractic and I understand will be held financially responsible for any and all non-covered services provided by Center Chiropractic.
***** Be advised our office will try and verify your insurance coverage and benefits, however, it is ultimately the patient's responsibility to understand & verify the coverage and benefits your insurance policy allows.*****

Signature: _____ Date: _____

********** *Below for Office Use Only* **********

NEW PATIENT'S INITIAL VISIT

DOS: _____ Amt Paid This Visit: $ _____ PT. CLASS: Ins. Auto WC Cash

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

NEW EXAM: 99201 99202 99203 99204

9894____	97110	97140	97012	97035	97014	97010
Manip.	Thera Ex .	Myofacial	Mech. Trx.	Ultra Sound	U-Estim	Hot/Cold Pks

MEDICARE PATIENTS ONLY: Date of Current Illness: _____

☐ Check Box to BLOCK PATIENT STATEMENTS PLEASE ATTACH A COPY OF THE INS. CARD

Center Chiropractic
29 North Main St.
West Hartford, CT 06107

Consent For Use Or Disclosure Of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

Printed Name _____ Authorized Provider Representative _____

Signature _____ Date _____

Date _____