DR. GERALD J. KRUBA
CHIROPRACTOR
5761 Spring Road, Shermans Dale, PA 17090

PLEASE PRINT

Date _____

Name _____ E Mail: _____
Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip Code _____
Age _____ Birthday _____ Sex M F Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
Occupation _____ Employer _____ Work Phone _____
Name of Spouse _____ Spouse Date of Birth _____
In case of emergency, notify _____ Phone _____

Names of Children (Minors only)	Age	Health

Referred by: _____
Past chiropractic care received: (when & where) _____
Have you been seen for any health condition by a doctor other than a chiropractor in the last year? ☐ Yes ☐ No
If Yes, explain: _____

This Area For Doctor's Use

Patient's major complaints and the dates they first noticed them: _____
_____
Is present condition the result of an accident or injury? ☐ Yes ☐ No
If you have no specific problem but are here for health maintenance, check (✓) here: ☐
List all surgeries, falls, accidents and injuries you have had and give date: _____
_____
_____
_____

Drugs (include prescription and non-prescription drugs, such as birth control, aspirin, heart medicine, laxatives, cold tablets, etc.)

Type	Dosage	Purpose

Are you pregnant? ☐ Yes ☐ No Due date: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment: _____
Will you be filing insurance through our office? ☐ Yes ☐ No
Company _____ Subscriber's Name _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. If I file insurance, Dr. Gerald J. Kruba, Chiropractor is authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by Dr. Gerald J. Kruba, and I hereby release Dr. Gerald J. Kruba of any consequence thereof.

Patient's Social Security Number X _____

Patient's Signature X _____ Date X _____

Parent or Guardian's
Signature authorizing care _____ Date _____

TERMS OF ACCEPTANCE

When a person seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that they both be seeking and working for the same goals.

Chiropractic has only one goal. It is, therefore, important that the patient understands the goal and the means that will be used to attain it. In this way, there will be no confusion, misunderstanding or disappointment.

Patients usually want to get rid of whatever ailments or conditions are bothering them. This, however, is not the goal of the chiropractor.

The purpose of chiropractic is to restore and maintain the integrity of the relationship between the spinal cord and its nerve roots. These vital nerve pathways are housed in and protected by the bones of the spine. Tiny misalignments of the vertebrae or bones of the spine, which interfere with the function of these nerve pathways, are called subluxations. Subluxations come from many causes and prevent various organs, glands and tissues from functioning properly.

By means of a chiropractic adjustment, subluxations are corrected (reduced). Thus, the normal nerve function restores itself. The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times.

This allows the innate healing ability of the body to work at maximum efficiency.

With a proper nerve supply, health improves. In some, symptoms clear up quickly. In others, the process is slower, and in some, it is only partial or not all all. Regardless of what the disease is called, the chiropractor does not offer to heal or even treat it. Nor does he offer advice regarding the treatment of disease. His only goal is to allow the body to do its job. His only means is the correction of vertabral subluxation. He promises no cure from and offers no treatment of disease.

As a safety factor, it is important that full information concerning any injury, surgery, sickness or drug-usage be reported to the chiropractor and made a permanent part of the patient's records. It is the responsibility of the patient to update these records in the event of any future injury, surgery, sickness or drug-usage.

I, X_____have read the above, understand it fully, and undertake chiropractic care on this basis.

Date X_____

(Patients who have had accidents, complete this section.)

Date of accident _____ Hour _____ Location _____

How did accident occur? ☐ Auto collision ☐ On-the-job injury ☐ Other _____

Please describe the accident: _____

_____

_____

_____

_____

List the extent of the injuries as you know them: _____

_____

_____

Did you report the injury to your employer? _____ Did your employer recommend care at our office? _____

Did you require hospitalization after the accident? _____ How long? _____

Have you lost any days of work? _____ Dates _____

Were you totally disabled? _____ Partially disabled? _____

Have you been contacted by an insurance adjustor or company representative regarding this claim? _____

KRUBA CHIROPRACTIC CENTER

Dr. Gerald J. Kruba
5761 Spring Rd.
Shermans Dale, PA 17090
(717) 582-7900

SIGNATURE ON FILE

I authorize the doctor named above to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

_____ Initial

I authorize release of any information related to any claims to all my Insurance Companies or other relevant parties.

_____ Initial

I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

_____ Initial

I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.

_____ Initial

I authorize payment of health benefits otherwise payable to me, directly to my doctor.

_____ Initial

I permit of copy of this authorization to be used in place of the original.

_____ Initial

This Signature on file is valid for one year from the date indicated below.

_____ _____

Signature of Beneficiary, Guardian, Date

Personal Beneficiary

_____ _____

Print name of Beneficiary, Guardian Relationship to Beneficiary
Personal Beneficiary

Kruba Chiropractic Center

5761 Spring Road Shermans Dale, Pa.17090

Telephone: 717-582-7900 Fax: 717-582-3027

PATIENT PRIVACY NOTICE FORM

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.

Kruba Chiropractic Center is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION:

TREATMENT: We will use your health care information for treatment.

PAYMENT: We may disclose your health information to your insurance provider for the purpose of payment or health care options.

WORKER'S COMPENSATION: We may disclose your health care information as necessary to comply with State Workers compensation laws.

EMERGENCIES: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency of your death.

PUBLIC HEALTH: As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

JUDICIAL AND ADMINSTRATIVE PROCEEDINGS: We may disclose your health information in the course of any administrative or judicial proceedings.

LAW ENFORCEMENT: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

DECEASED PERSONS: We may disclose your health information to coroners or medical examiners.

RESEARCH: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

CHANGE OF OWNERSHIP: In the event that Kruba Chiropractic Center is sold or merged with another organization your health information /record will become property of the new owner.

YOUR HEALTH INFORMATION RIGHTS: You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however that Kruba Chiropractic Center is not required to agree with the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Kruba Chiropractic Center amend your protected health information. Please be advised however that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied you will be provided with an explanation of our denial reasons and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Kruba Chiropractic Center.

You have a right to a paper copy of this notice at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES: We reserve the right to amend this notice at any time in the future and will make the new provisions effective for all information that it maintains. Until such an amendment is made we are required by law to comply with this notice.

Kruba Chiropractic Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practice with respect to your health information. If you have any questions about any part of this notice please contact our office at 717-582-7900.

COMPLAINTS: Complaints about your privacy rights or how Kruba Chiropractic Center has handled your health information should be directed to our office by calling 717-582-7900. You may be able to make an appointment for a personal conference in person or by telephone with three working days. If you are not satisfied with the manner in which this office handled your complaint you may submit a formal complaint to: DHHS OFFICE OF CIVIL RIGHTS 200 INDEPENDENCE AVENUE SOUTH WEST ROOM 509F HHH BUILDING WASHINGTON, D.C. 20201

This notice is effective as of today's date listed below:

I have read and understand my rights contained in this notice. By way of my signature I have provided this office my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in this notice.

LAST NAME: _____ FIRST NAME: _____ DATE: _____

I authorize this provider to disclose information related to my care and treatment to the following individuals:

_____ _____

I authorized this provider to discuss information related to my bill with the following named individuals:

_____ _____

DO WE HAVE PERMISSION TO CONTACT YOU BY THE FOLLOWING MANNER?

LEAVE A MESSAGE ON YOUR TELEPHONE ANSWERING MACHINE?	YES	OR	NO
LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?	YES	OR	NO
LEAVE A MESSAGE ON YOUR CELL PHONE VIA VOICE MAIL?	YES	OR	NO
CONTACT YOU OR INFORM YOU VIA YOUR E-MAIL?	YES	OR	NO

Scheduling and Payment Agreement

YOUR AGREEMENT TO KRUBA CHIROPRACTIC CENTER:

- I agree to keep my appointment time or give Kruba Chiropractic Center a courtesy call to cancel my appointment at least **four hours** prior to my scheduled appointment, by leaving a message on the answering machine or with the receptionist.
- When I make an appointment, I am ultimately responsible to arrive on time at Kruba Chiropractic Center on the day and time of my appointment.
- Not showing for a scheduled appointment will result in me as the patient being billed **a fee of $40.00** for that appointment time that I have missed **with or without a curtesy reminder call received**. *Please note that your insurance company does not pay for your missed appointments. You will be responsible to pay this fee.*

(Legitimate emergencies and bad weather do not apply to missed appointments.)

When you arrive for your visit:

- Check in with the receptionist.
- Pay your co-pay or office visit fee. I**f you do not have your payment, we have the right to reschedule your appointment for a later date.**
    - If we have to bill you for any outstanding balance, including portions that the
    - insurance companies do not pay, payment is due within 30 days of the statement date. If payment is not made in that timeframe, there will be an additional charge of $8.00 each month the payment is not made.

KRUBA CHIROPRACTIC CENTER'S AGREEMENT TO YOU:

- Kruba Chiropractic Center will make it as convenient as possible to schedule you and to help you remember your appointments by providing you with **curtesy** reminder calls one or two days prior to your scheduled visit. We value and respect your busy schedules. Likewise, we would appreciate you as the patient to value and respect our schedule by keeping your scheduled appointments or providing us with at least four hours notice prior to the cancellation. We want to provide efficient scheduling so that you do not have a long wait in the waiting room. We thank you for your cooperation.

By signing this form I agree to all of the above statements and will do my best to keep my scheduled appointments and pay any outstanding balances.

Signature _____ Date _____