MORREALE CHIROPRACTIC

874 Butler Street, Suite 1, Pittsburgh, PA 15223
Phone: 412-781-3150 Fax: 412-781-3156

Dr. Vincent Morreale, D.C.
Dr. Philip Didomenico, D.C.

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Morreale Chiropractic and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

Medical Insurance: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason. Your health plan may refuse payment of a claim for some of the following reasons:

1) This is a pre-existing illness that is not covered by your plan
2) You have not met your full calendar year deductible
3) The type of medical service required is not covered by your plan
4) The health plan was not in effect at the time of service
5) You have other insurance which must be filed first
6) Insurance denied authorization for treatment

The person signing on behalf of the Patient as the Responsible Party must:

- Inform Morreale Chiropractic of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Pay any required copay and/or deductible amount at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office.
- If you are not insured, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full for our services at the time they are rendered.

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, Morreale Chiropractic will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) ____

Patient Signature ______________________________________ Date ______________

Responsible Party Name (Please Print) ______________________________________

Responsible Party Signature ______________________________ Date ______________

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Receipt of Notice of Privacy Practices

Written Acknowledgement Form

This notice is effective as of ____________________________.

This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received and reviewed a copy of the Privacy Practices notice.

____ ____________________
Signature Date

____
Printed Name

If a minor or if you are being represented by another party:

____ ____________________
Personal Representative Signature Date

____
Personal Representative Printed Name

____
Description of the authority to act on behalf of the patient

Morreale Chiropractic

PATIENT REGISTRATION FORM

FILE #

LAST NAME	FIRST NAME	MI	NICKNAME	DOB

ADDRESS	CITY-STATE-ZIP	SOCIAL SECURITY #

☐ MALE ☐ FEMALE		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	SIGNIFICANT OTHER'S NAME

HOME #	WORK #	MOBILE #	EMAIL

OCCUPATION	EMPLOYER	EMPLOYER'S ADDRESS	EMPLOYER'S #

REFERRED BY	FAMILY PHYSICIAN	PHYSICIAN ADDRESS	PHYSICIAN #

SYMPTOM DETAILS

- ☐ Headache Pain
- ☐ Neck Pain
- ☐ Upper/Mid Back Pain
- ☐ Low Back Pain
- ☐ Arm/Shoulder/Elbow Pain
- ☐ Wrist/Hand Pain
- ☐ Leg/Hip/Knee Pain
- ☐ Foot/Ankle Pain
- ☐ Numbness Tingling

Use the letters listed below to indicate the type and location of your pain and sensations.

KEY
A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles

Date Symptoms Began: ______________________

☐ Sudden Onset
☐ Gradual Onset

Nature of Injury
☐ Auto
☐ Work Related
☐ Home
☐ Other:______________

Previous Treatment? ☐ Yes ☐ No

Doctor Name: ______________________

Phone #: ______________________

Explain Previous Treatment: ______________________

MEDICAL HISTORY

Arthritis	☐ Yes	☐ No	Lung Problems	☐ Yes	☐ No	Alcohol	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Advanced Directives/Living Will	☐ Yes	☐ No	Accidents/Trauma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Unusual Childhood Disease	☐ Yes	☐ No	Currently Pregnant	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Unusual Adult Disease	☐ Yes	☐ No	Vascular Condition	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Substance Abuse	☐ Yes	☐ No	Smoking	☐ Yes	☐ No

Description:

LIST MEDICATIONS, INCLUDING BIRTH CONTROL

____

____

____

ALLERGIES

____

SURGERIES/HOSPITALIZATIONS

____

Weight: ____________ Height: ____________

Please complete appropriate sections on the back of this page:

Section 1 ALL PATIENTS
Section 2 Auto Injury
Section 3 Worker's Compensation/Personal Injury

1. PAYMENT INFORMATION

☐ No Insurance/Cash ☐ Personal Insurance ☐ Auto Insurance ☐ Worker's Compensation Insurance

INSURANCE COMPANY	CLAIMS BILLING ADDRESS	
NAME OF POLICY HOLDER	POLICY HOLDER DOB	RELATIONSHIP ☐ Self ☐ Mother ☐ Father ☐ Spouse
POLICY OR CLAIM #	GROUP #	
ADJUSTER NAME	ADJUSTER PHONE NUMBER	

2. AUTO ACCIDENT DETAILS

☐ Auto v Auto ☐ Auto v Truck ☐ Motorcycle ☐ Auto v Bus ☐ Auto v Pedestrian ☐ Other: ______________

DATE	TIME	☐ AM	☐ PM	LOCATION
Body Parts Struck?		☐ YES	☐ NO	IF YES, PLEASE LIST
Emergency Care?		☐ YES	☐ NO	IF YES, PLEASE LIST
X-rays taken?		☐ YES	☐ NO	IF YES, PLEASE LIST

Loss of Consciousness? ☐ Yes ☐ No Were you bleeding? ☐ Yes ☐ No

3. WORKER'S COMPENSATION/PERSONAL INJURY DETAILS

DATE	TIME	☐ AM	☐ PM

COMPANY NAME			COMPANY ADDRESS, CITY, STATE, ZIP
Is this your place of employment?	☐ Yes	☐ No	
ADDRESS OF INJURY			
Did you report injury?	☐ Yes	☐ No	IF YES, TO WHOM
DESCRIBE ACCIDENT			
Body Parts Struck?	☐ Yes	☐ No	IF YES, PLEASE LIST
Emergency Care?	☐ Yes	☐ No	IF YES, WHERE?
X-rays taken?	☐ Yes	☐ No	IF YES, LIST REGIONS

Loss of Consciousness? ☐ Yes ☐ No Were you bleeding? ☐ Yes ☐ No

4. APPOINTMENT REMINDER

Our office provides appointment reminders to all patients at no cost. These reminders are automatically sent on the evening before your appointment through an outside service. Based on the information provided, a default message will be sent via one of the methods listed below. Please specify if you have a preference.

☐ Text Message ☐ Phone Call ☐ Home ☐ Cell Phone ☐ Please do not remind me of my appointments

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/FINANCIAL AGREEMENT

I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits. I understand that I am personally responsible for payment of all charges for my treatment. Services are payable at the time rendered.

Patient Signature: ______________________________ Date: ____________________