



PERFORMANCE HEALTH AUSTIN

PATIENT REGISTRATION FORM

BACKGROUND INFORMATION

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Date of Birth: _____ Patient Social Security #: _____ Sex: M F

Patient Home Phone #: (____) _____ Patient Mobile Phone #: (____) _____

E-mail: _____ Driver's License #: _____

WE SEND APPOINTMENT REMINDERS VIA E-MAIL

Employer: _____ Patient Occupation: _____

Work Phone #: (____) _____ Family Physician: _____

Marital Status: Married Single Partner's Name: _____

Emergency Contact - Name & Phone #: _____

How did you hear about us? Referral Who? _____ Internet Advertising Other _____

PAYMENT INFORMATION

Would you like us to seek reimbursement from your insurance company for their portion of your bill?

Yes No

If someone else is responsible for your bill, please complete the following information:

Guarantor's Name: _____ Address: _____

City, State, Zip: _____ Home Ph #: (____) _____

Employer: _____ Work Ph # (____) _____

Guarantor SS#: _____ Guarantor DOB: _____

Patient's Relationship to Guarantor: _____

AUTHORIZATION, FINANCIAL RESPONSIBILITY, AND CONSENT TO TREAT

I authorize Performance Health Austin or Dr. Bomben to release or obtain my medical information to any insurance company, attorney, insurance adjuster, employer or their representative as may be necessary in the treatment and payment of my care. I understand payment is due in full at the time of services, unless special payment plan arrangements have been made. I understand that there will be a **\$30.00 service charge on all returned checks**. I understand I will be responsible for **50% of the cost of the visit for failure to keep any scheduled appointment** without 24 hours prior notification. I understand that if my health insurance is not contracted with Performance Health Austin or Dr. Bomben, then I assign my health insurance benefit, my personal injury protection benefit, and my medical payment benefit to Dr. Bomben as needed to pay my bill for services rendered and **such payment should be made directly to Dr. Bomben**. I consent to all necessary examination procedures and/or treatments prescribed by my chiropractor, his/her assistants, or designees as is necessary in his/her judgment.

X _____

Patient (or Guardian) Signature

_____ **Date**

PERFORMANCE HEALTH AUSTIN
CONSENT FOR PURPOSES OF TREATMENT,
PAYMENT & HEALTH CARE OPTIONS

Patient Name: _____ **Patient DOB:** _____ **Date:** _____

I consent to the use or disclosure of my protected health information by Performance Health Austin and Dr. Ross Bomben for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Performance Health Austin. I understand that diagnosis or treatment of me by any and or all of the providers at Performance Health Austin may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice is not required to agree to the restrictions that I may request. However, if Performance Health Austin agrees to a restriction that I request, the restriction is binding on Performance Health Austin and its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that the treating provider or Performance Health Austin has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that during the course of daily healthcare operations, my "protected health information" may be indirectly disclosed to a third party who overhears a discussion regarding your information. I understand and agree that this is not a breach of my "protected health information." I understand I have a right to review Performance Health Austin's Notice of Privacy Practices prior to signing this document. Performance Health Austin's Privacy Practices have been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Performance Health Austin. The Notice of Privacy Practices is also posted in the lobby of all clinics. This Notice of Privacy Practices also describes my rights and Performance Health Austin's duties with respect to my protected health information. Performance Health Austin reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Dr. Ross Bomben
Phone: (512) 587-4263

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative