

FEES PAYABLE WHEN SERVICES RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE.

**General Information**

Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_\_) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Seasonal/Other Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Seasonal/other Phone (\_\_\_\_\_) \_\_\_\_\_

Sex: M F Marital Status: S M D W Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Number of Children \_\_\_\_\_ Ages of children \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Name of person responsible for account \_\_\_\_\_ Method of payment \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to Insured: Self Spouse Child Other Insured's Employer \_\_\_\_\_

Insured's Full Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**Current Health Status/History**

Briefly describe symptoms \_\_\_\_\_

Other doctors seen for this condition	Treatment rendered	When
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medications you are currently taking (prescription & non-presc.) \_\_\_\_\_

Nutritional supplements and herbs that you are taking \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ City and State \_\_\_\_\_

List other physicians seen within the last year:	For what condition(s):
_____	_____
_____	_____
_____	_____

List any surgeries you have had, with dates \_\_\_\_\_

List any allergies, including drug allergies \_\_\_\_\_





## Consent for Treatment

Name \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I, the undersigned, hereby authorize Dr. Thomas A. Rofrano and whomever he may designate as his assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.** Accounts over 30 days past due are responsible for cost of collection and an interest rate of 1.5% per month from the date the payment was initially due.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness \_\_\_\_\_

## Authorization to Release Medical Information

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete. I also know that I am entitled to receive a copy of this authorization form.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness \_\_\_\_\_

## Request for Payment of Benefits to Provider of Care

I hereby authorize the \_\_\_\_\_ Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: Thomas A. Rofrano, D.C. Natural Medicine Center 9850 Alternate A1A, Suite 509, Palm Beach Gardens, FL 33410, the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness \_\_\_\_\_

## Attorney Representation and Protection of Balance

I, the undersigned patient am directing my Attorney, \_\_\_\_\_, to pay any outstanding bills out of my settlement and, in effect, protecting any such balances. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness \_\_\_\_\_

## Consent for Treatment of Minor

I hereby authorize Dr. Thomas A. Rofrano and whomever he may designate as his assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he deems necessary to my (indicate relationship of child) \_\_\_\_\_ (child's name) \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness \_\_\_\_\_

## X-Ray / Medical Records Release

I have requested the release of records of (patient's name) \_\_\_\_\_ which are a part of the records at (facility) \_\_\_\_\_.

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: **Dr. Thomas A. Rofrano 9850 Alternate A1A, Suite 509, Palm Beach Gardens, FL 33410**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness \_\_\_\_\_