

Steven Zaeske, DC

18309 Distinctive Drive
Orland Park, IL 60467

Insurance Information

Please list the name, birth date and social security # of the **insurance policy holder** (if other than yourself):

Name:

Birth Date:

Social Security #:

Authorization to Accept Insurance Assignment

I authorize payment of medical benefits directly to Steve Zaeske, D.C.

I authorize the release of any medical information necessary in the processing of my insurance claims.

I am responsible for any charges my insurance carrier does not pay within 90 days.

Signature: _____ Date: _____

Authorization to Obtain Medical Records

It may be necessary for our office to obtain your medical records from another physician. Please sign below indicating your authorization for our office to perform this task.

Signature: _____ Date: _____

Notice of Privacy Practices Regarding Medical Information (HIPAA)

This notice is effective as of April 14, 2003. By signing below, I acknowledge that I have read and understand Steve Zaeske DC's Notice of Privacy Practices regarding my health information. I understand this notice describes how medical information about me may be used and how I can get access to this information.

Signature: _____ Date: _____

Registration Information

Last Name: _____ First Name: _____ Middle Initial: _____ Marital Status: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Please list the **phone #** where you can best be reached: Home Cell Work Email Address: May we contact you via Email? Yes No

Birth Date: _____ Age: _____ Social Security #: _____ How were you referred to our office? _____