

Integrated Chiropractic Healthcare, P.A.

Dr. José R. Cadavedo & Dr. Nayda M. Nuñez

213 S. Dillard St. Suite 230, Winter Garden, FL 34787

Tel: (407) 347-5953 Fax: (407) 614-5911 Email: info@ichcare.com

PATIENT REGISTRATION

Name:	_____	_____	_____
	<i>First</i>	<i>Middle</i>	<i>Last</i>
Date of Birth:	_____	Age: _____	Sex: Male / Female SSN: _____
Address:	_____	_____	_____
	<i>Street</i>	<i>City</i>	<i>State ZIP</i>
Home Phone:	_____	Cell Phone: _____	Cellphone Carrier: _____ Work Phone: _____
Occupation:	_____	Email Address: _____	Marital Status: S M D W
Primary Care Physician:	_____	Phone: _____	
Emergency Contact:	_____	Relationship: _____	Phone: _____

<u>Health Insurance Information</u>	<input type="checkbox"/> <u>No Health Insurance Benefits</u>
Insured's Name:	_____
Relationship:	_____ Insured's Date of Birth: _____
Insurance Carrier:	_____ Insurance Phone/Fax: _____
Address:	_____
	<i>Street City State ZIP</i>
Policy #:	_____ Group #: _____
Health Savings Account: YES NO	Flexible Spending Account: YES NO

Assignment of Benefits – I authorize the release of any medical information necessary to process this claim and request payment of benefits from my insurance company be made to Integrated Chiropractic Healthcare. I understand and agree that regardless of my insurance status; I am ultimately responsible for the balance on this account. I have read and completed all the information on this sheet to the best of my ability and certify that it is true and correct. I will notify you of any changes on the above information. _____ **Initials.**

Informed Consent of Treatment – I understand that spinal manipulation has health risks associated, example : fractures, sprains/strains, cerebral vascular accident, cauda equine syndrome, nerve root irritation, and spinal cord compression _____ **Initials.**

Privacy Practices – I acknowledge that I was provided a copy of the NOTICE OF PRIVACY PRACTICES and that I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES. I understand that this form will be placed in my patient chart and maintained for six years. _____ **Initials.**

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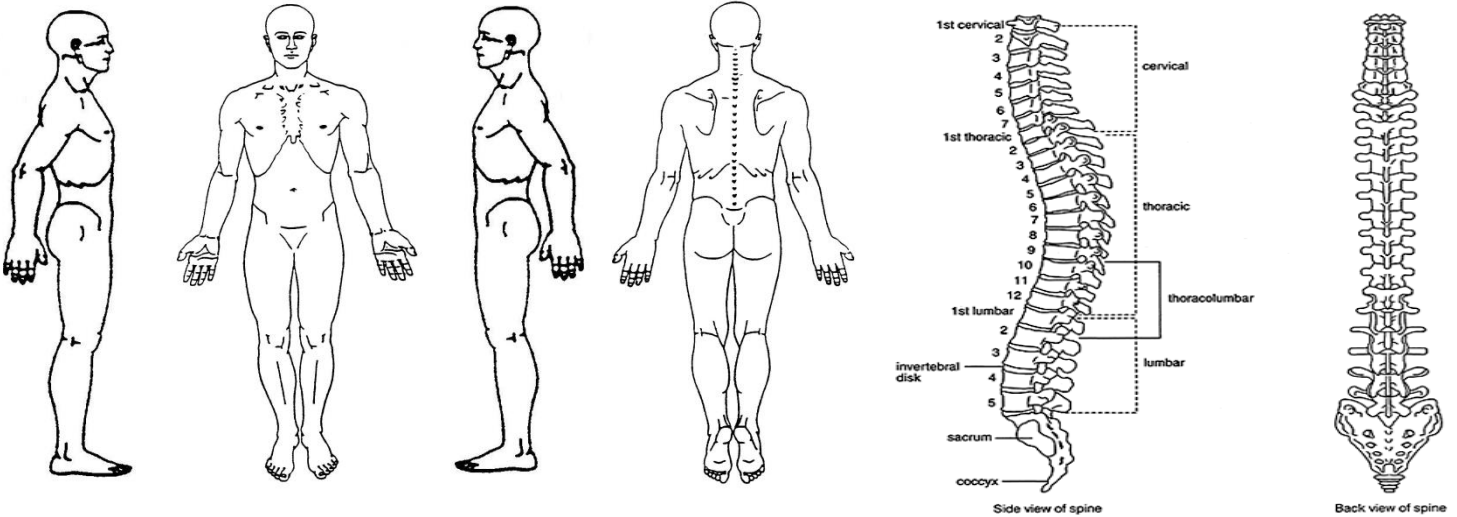
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INITIAL PATIENT QUESTIONNAIRE

Name / Nombre: _____ Date / Fecha: _____

Reason for visit? / Razon por visita? _____

On pictures, mark an X where you feel pain or discomfort / En las fotos abajo, marca con una X donde siente dolor :



When did your symptoms first appear? / Cuando comenzaron los síntomas? _____

Is the condition getting progressively worse? / La condición se está empeorando? : YES NO

Visual Analog Scale



Indicate the type of pain / indica la clase de dolor : _____

Previous Treatments for this complaints / Tratamientos previos para esta condición: _____

Other complaints or problems / Otros problemas: _____

Current medications / Medicamentos: _____

Are you currently under the medical care of another doctor? / Esta usted bajo la atención medica de otro doctor? YES NO

If so, when was your last visit / De haber visitado al doctor, cuando fue su última visita: _____

List any major illnesses, with approximate dates / Liste sus condiciones médicas, con fechas aprox.: _____

Patient Name/ Nombre de Paciente: _____

List any major surgeries or operations with approximate dates / Anota tus cirugías o operaciones, con fechas:

List any past accidents or injuries / Anotas algún accidente o herida:

Have you ever been diagnosed with the following? / Alguna vez te han diagnosticado con lo siguiente ?

<ul style="list-style-type: none"> <input type="radio"/> Diabetes <input type="radio"/> Heart Disease <input type="radio"/> High Blood Pressure <input type="radio"/> Cancer <input type="radio"/> Asthma 	<ul style="list-style-type: none"> <input type="radio"/> Allergy <input type="radio"/> Tuberculosis <input type="radio"/> Herpes <input type="radio"/> STD <input type="radio"/> HIV/AIDS 	<ul style="list-style-type: none"> <input type="radio"/> Depression <input type="radio"/> Mental Disorder <input type="radio"/> Liver Problems <input type="radio"/> Hypo/Hyper Thyroidism <input type="radio"/> Vascular Disease 	<ul style="list-style-type: none"> <input type="radio"/> Mumps <input type="radio"/> Measles <input type="radio"/> Chicken Pox <input type="radio"/> Arthritis <input type="radio"/> Suicide
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Any family history of serious illnesses / Tiene una historia de enfermedad familiar: Cancer Diabetes Heart Disease Gout

If so, who / Si es cierto, quien: _____

- Are you taking any nutritional supplements? / Esta tomando suplementos nutritivos? _____
- Do you consume? (if so, list amount) / Usted consume? (si es cierto, anota cuanto)
- Cigarettes _____ Coffee _____ Alcohol _____

Are you currently experiencing any of the following? / Estas experimentando alguno de lo siguiente ?

HEENT	Cardio Respiratory	Gastrointestinal	Genitourinary	Neuropsych
<ul style="list-style-type: none"> <input type="radio"/> Hair Loss / Scalp Pain <input type="radio"/> Difficulty w/ Vision <input type="radio"/> Double Vision <input type="radio"/> Difficulty Hearing <input type="radio"/> Ringing of Ears <input type="radio"/> Difficulty Breathing <input type="radio"/> Nasal Discharge <input type="radio"/> Difficulty Chewing <input type="radio"/> Difficulty Swallowing 	<ul style="list-style-type: none"> <input type="radio"/> Chest Pain <input type="radio"/> Left Arm Pain <input type="radio"/> Palpitations <input type="radio"/> Coughing <input type="radio"/> Wheezing <input type="radio"/> Short Breath <input type="radio"/> Asthma <input type="radio"/> Allergy <input type="radio"/> Discharge <input type="radio"/> Fatigue 	<ul style="list-style-type: none"> <input type="radio"/> Abdomen Pain <input type="radio"/> Diarrhea <input type="radio"/> Bloating <input type="radio"/> Constipation <input type="radio"/> Gerd <input type="radio"/> Pencil Stool <input type="radio"/> Liver Problem <input type="radio"/> Loss / Gain of Weight <input type="radio"/> Cramps <input type="radio"/> Rash Skin 	<ul style="list-style-type: none"> <input type="radio"/> Discharge <input type="radio"/> Hesitancy <input type="radio"/> Frequency <input type="radio"/> Bladder Control <input type="radio"/> Pain urination <input type="radio"/> Sexual Dysfunction 	<ul style="list-style-type: none"> <input type="radio"/> Dizziness <input type="radio"/> Confusion <input type="radio"/> Depression <input type="radio"/> Fatigue <input type="radio"/> Numbness <input type="radio"/> Tingling <input type="radio"/> Sweats <input type="radio"/> Fever <input type="radio"/> Memory Loss <input type="radio"/> Suicide <input type="radio"/> Abuse

- List Any Allergies/ Alergias: _____
- Any pacemakers, stimulators or internal hardware? Example: Shunts, Dorsal Column Stim? _____
- Any Additional Comments / Comentario adicional: _____

Patient Signature: _____ **Date:** _____

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Patient / Plan Member Name:	Birth Date:	SSN:
Provider's Name:	Recipient's Name: Integrated Chiropractic Healthcare, P.A.	
Provider's / Health Plan's address:		

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING: (FILL IN THE DATE OR THE EVENT, BUT NOT BOTH)

Date:	Event:
Purpose of disclosure:	

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.

Description	Dates	Description	Dates	Descriptions	Dates
<input checked="" type="checkbox"/> All PHI in medical records <input type="checkbox"/> Admissions Form <input type="checkbox"/> Dictation Reports <input type="checkbox"/> Physicians Orders <input type="checkbox"/> Intake / Outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Info <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm strips <input type="checkbox"/> Nursing Info <input type="checkbox"/> Transfer Forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor / delivery sum <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill <input type="checkbox"/> UB-92 <input type="checkbox"/> Other: <input type="checkbox"/> Other:	

I Understand that:

1. I May refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Will the recipient financial or in-kind compensation in exchange for using or disclosing this information? Yes No
 If yes, describe:

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE OF PATIENT / GUARDIAN / PLAN MEMBER REP:	DATE:
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ADDITIONAL AUTHORIZATIONS AND DIRECTIONS TO INSURER

AUTHORIZATIONS FOR DISCLOSURE OF INSURANCE DECLARATIONS PAGE: I, the patient and insured, further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide to Integrated Chiropractic Healthcare, P.A. a copy of any declarations page of any insurance policy that may provide any insurance benefits to me.

AUTHORIZATIONS FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits, on my behalf, to provide to Integrated Chiropractic Healthcare, P.A. a copy of any ledger or payment record of payments made under any insurance coverage available to me, without redacting the names of any other medical provider entity to whom insurance benefits that have been paid.

DIRECTION TO EXHAUST BENEFITS BY PAYMENT OF OTHER CLAIMS: I further authorize and direct any insurance company that might be obligated to pay any insurance benefits to me, or on my behalf, to not exhaust insurance benefits or coverage until all claims submitted by Integrated Chiropractic Healthcare, P.A. have been paid in full. If any insurance company obligate to pay any insurance benefits on my behalf, has denied payment of a claim submitted by Integrated Chiropractic Healthcare, P.A. or made a payment to Integrated Chiropractic Healthcare, P.A. at an amount lesser than the amount billed, or allowed amount of the amount billed, I then direct the aforesaid insurance company to hold in escrow the amount in dispute. If other claims would exhaust benefits I direct the aforesaid insurance company to hold in escrow the disputed amount and to not exhaust benefits or coverage by payment of the amount I have hereby requested to be held in escrow. I further authorize and direct the aforesaid insurance company to notify Integrated Chiropractic P.A. that benefits have been exhausted except for the amount held in escrow, to enable Integrated Chiropractic Healthcare, P.A. to attempt to resolve the disputed claim in a manner acceptable to Integrated Chiropractic Healthcare, P.A.

DIRECTION TO INSURER TO MAINTAIN CONFIDENTIALITY: I further direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to maintain the privacy and confidentiality of all medical records. I do not authorize any insurer to provide my medical record to anyone without first obtaining a written authorization from me to provide the medical records to any other entity.

AUTHORIZATION FOR RELEASE OF RECORDS TO PROVIDER: I hereby authorize any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to release a copy of my complete medical records in possession of such insurer to Integrated Chiropractic Healthcare, P.A. upon the request of Integrated Chiropractic Healthcare, P.A. This authorization includes the authorization to release to Integrated Chiropractic Healthcare, P.A. a copy of any medical examination or evaluation of me requested by any insurance company.

DIRECTION TO INSURER TO PROVIDE PROVIDER ADVANCE NOTICE OF IME OR EUO: I further authorize and direct any insurance company that may be obligated to pay any insurance benefits to me, or on my behalf, to provide at least 15 days advance notice to Integrated Chiropractic Healthcare, P.A. of any physical examination or examination under oath of myself that any insurance company may schedule.

Please read this document before signing, if you do not completely understand this document or have any questions about this document; please ask us to explain it to you. If there is any portion of this document that you do not wish to authorize, we will remove that portion from this document. Your signature below is your agreement that you fully understand this document and you fully agree to the terms of this document.

Patient's signature (or guardian's signature)

Date

Witness to patient or guardian's signature

Date

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I, _____ (Patient printed name), Hereby authorize Integrated Chiropractic Healthcare, P.A. 213 South Dillard Street Suite 230, Winter Garden, FL, 34787, to release copies of my medical records, x-ray reports, exam results and any other protected medical information to my insurance carrier: *(company name and address below)*

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. I understand that Florida Statute 456.057 (10) makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical records without the expressed consent of the patient or the patients' legal representative.

Patient or Guardian Signature

Date of Birth

Date Signed

CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Guardian Signature

Date of Birth

Date Signed

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purpose
- The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment, or health care operations.

I authorize **INTEGRATED CHIROPRACTIC HEALTHCARE, P.A.** to contact me by:

Email/Mail

Text

Cell phone

Home phone

Leave voice message

Patient Signature: _____

Date: _____

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Assignment of Benefits

I, _____, assign all of the rights and benefits of medical payments, or other coverage provided by any insurance policy to **Integrated Chiropractic Healthcare, P.A.**, for services and supplies provided to me.

I agree to pay any co-payment, deductible or non-covered service as applicable by my insurance company. This assignment includes, but is not limited to:

- All rights to collect benefits directly from any insurance carrier obligated to provide benefits for services and supplies I have received;
- All rights to take legal action against any insurance carrier obligated to provide benefits if for any reason the insurance carrier fails to pay any benefit due; and
- All rights to recover attorney fees, legal assistant fees, costs, and any interest on fees and cost, for any legal or other action taken by **Integrated Chiropractic Healthcare, P.A.** as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy.

I agree that **Integrated Chiropractic Healthcare, P.A.** may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have.

I have been given a copy of this assignment to retain for my records; I have read this assignment and am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

Patient Signature

Date

I undersigned, as authorized representative of **Integrated Chiropractic Healthcare, P.A.** accepts the assignment of benefits as set forth above.

[PROVIDER]

Date

REQUEST FOR PAYMENT

Patient Name: _____ **ID Number:** _____

I request that payment of authorized medical benefits be made on my behalf for any services furnished me by ***INTEGRATED CHIROPRACTIC HEALTHCARE, P.A. (Tax ID: 352340650)***, including physician services. I authorized any holder of medical information or any other information about me to be released to the insurance carrier and its agents as needed to determine these benefits or benefits for related services.

Patient Signature

Date