INTEGRATIVE HEALTHCARE SOLUTIONS
1313 BEACH BLVD STE C, JACKSONVILLE BEACH, FL 32250

PHONE: (904) 372-0623
FAX: (904) 372-0672

Please Print all Answers

New Patient Information

Name _____ Age _____ Sex _____ Date _____

Street Address _____ City / State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Employer _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name _____

PCP Name _____ Spouse's Employer _____

PCP Phone _____ Spouse's Birthdate _____

PCP Address _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Phone _____ Relationship _____

Name of Relative or Friend Not Living with You Phone

REFERRAL INFORMATION

Who recommended you to our office? ☐ My Doctor ☐ Family/Friend ☐ Attorney ☐ Internet _____

Name _____ ☐ Other _____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____ Relationship to insured _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

PIP Adjuster _____ Adjuster Phone # _____

Accident Claim # _____ Policy # _____

Attorney Name _____ Phone # _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____ Claim # _____

Contact Person _____ Phone Number _____

PROVIDE RECEPTIONIST WITH DRIVER'S LICENSE & INSURANCE CARD TO BE COPIED FOR PERMANENT MEDICAL FILE

Welcome to our multi-specialty group practice, offering chiropractic, physical therapy, rehabilitation, and massage therapy. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are prohibited from using cell phones while in our office due to federal privacy rules and/or unauthorized photography of our patients and are strongly encouraged to leave valuables at home or with an accompanying family member or friend because this Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items. Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties which we deem on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice which is detailed on the next page of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff. Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this facility and that you grant the physicians, therapists and/or all staff of this facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of any money you may owe this facility and/or for issues that concern this facility operations and responsibilities. We encourage questions and/or concerns to avoid misunderstandings, so please direct any questions or concerns to a member of our staff. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment, please notify us at least 24 hours in advance. We are available to immediately see new patients the same day. As a courtesy to you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or contact you please let us know in writing for your file.

-- please proceed to next page of this document--

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

We understand that medical information about you and your health is personal. This facility is required by law to abide by the terms of HIPAA, the Health Care Privacy Notice, The Security Rule, as well as other applicable federal and state laws governing privacy practices in health care so the doctors, therapists & staff at this office are committed to protecting your medical information but the federal government, under HIPAA, the Privacy Notice, the Security Rule and our own office administration requires us to make sure you are aware and be sure you understand, agree to adhere with and have read or have had read to you all of the following policies & procedures. In addition this office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results because your satisfaction is a vital interest to us. Our facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our facility and/or make available to patients updated notices. Photocopy of this Notice is available to you upon request. The term facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI includes but is not limited to your medical records and personal information such as your name, social security number, address, birth date, phone number and includes demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice or records from another facility that have been forwarded to our office and are now a part of your medical record. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this facility. Our facility may use and disclose your PHI with or without your written authorization to anyone at anytime for any reason including but not limited to health care delivery purposes, your care, treatment(s), collecting money due this facility, to support any operation of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. All requests must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee or a processing fee for their time which will be in compliance with state law. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our facility from taking any retaliatory actions against anyone who files a complaint. I understand that this facility, its doctors and staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, massage, and physical therapy there are some risks including but not limited to soreness, dizziness, fractures or joint injury, disc injuries, strokes, dislocations, sprains-strains, reactions and/or other incidents which may be short or long term or side effects which cannot be pre-determined. I do not expect the doctor, therapist or provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor and/or provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore, I give my full consent to the doctor, therapist, provider or staff member to render treatment on me or the minor for whom I am legally responsible by a health care provider of this facility. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed, hereinafter referred to as the "facility" against any and all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of an accident, injury, illness or health condition for which I have been treated by the facility. I further irrevocably agree to pay all money and/or charges owed this facility in full within 60 days of the date of occurrence, service or treatment, even if an insurance claim submitted on my behalf is delayed or denied for any reason and/or a case manager or attorney representing me for any accident, injury or illness has not settled my case. I, the assignee further authorizes and instructs any and all insurance company(ies), attorney and any & all third party payers to pay directly to the facility in full all sums of money due to them for any and all services rendered to me or to the minor by whom I am fully responsible for by reason of accident, injury, illness or health condition and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health, accident, workers compensation and/or including all insurance or third party benefits. Also by my signature and as the assignee I irrevocably agree that this facility and staff may process medical reports, deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance by me, and authorize this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this facility and assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the facility will attempt to obtain a verification of your applicable insurance benefits and will report them to you or assume they are accurate as they are quoted to us but some third party payers, case managers and/or attorneys misquote benefits, coverage and liability so our facility and staff are not responsible for what a third party payer, representative, case manager and/or attorney may tell us. Any and all contractual, written, verbal or other obligations or arrangements between you and an attorney, case manager, insurance company, liable or third party payer are between you and said person or company and do not delay your obligation to pay.

1. Our facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are fully responsible for all charges for all service(s) and/or product(s) which may be denied or not covered for any reason by an insurance carrier, case manager, attorney and/or when a third party and/or insurance carrier does not reimburse this facility enough to meet our cost of service.
4. All account balances must be paid in full within 60 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay this facility the said balance in full within the 60-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all interest and costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $50.00 charge.
6. Patients are eligible for a maximum $250 personal credit limit when approved by our insurance manager and we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and understand and agree to be irrevocably responsible for all terms and conditions. I also acknowledge that I have received a photocopy upon my request of this document and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

X

Signature (if minor, parent must sign)

Date

INTEGRATIVE HEALTHCARE SOLUTIONS
1313 BEACH BLVD STE C, JACKSONVILLE BEACH, FL 32250
PHONE: (904) 372-0623
FAX: (904) 372-0672

PATIENT & FAMILY HISTORY

Preferred language (spoken & written) [ ] English [ ] Spanish [ ] _____
Race [ ] American Indian or Alaska Native [ ] Asian [ ] Caucasian [ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander [ ] Other _____
What is your occupation? _____ ☐ Full Time ☐ Part Time
What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐ Retired
☐ Temp Disability ☐ Perm Disability Last Day of Work _____
Do you use tobacco? ☐ No ☐ Yes Packs/Day: _____
Do you consume alcohol? ☐ No ☐ Yes Drinks/Wk: _____
Do you consume caffeine? ☐ No ☐ Yes Cups/Day: _____
Severe accidents or trauma & dates _____
List ALLERGIES to drugs *chemicals *latex *iodine *etc _____

MEDICATIONS - list below all medications you are taking

_____ _____ _____
_____ _____ _____

DIAGNOSIS - list below all diagnosis or health conditions you have

_____
_____

PAST MEDICAL HISTORY - list all doctors you have seen, hospitalizations &/or tests you have had & diagnosis you were told

_____
_____

PAST SURGICAL HISTORY - list all surgeries &/or procedures you had & your age when you had them

_____
_____

FAMILY HISTORY

Father	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Mother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Brother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Sister	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Other	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Other	□ Living	Age: _____	□ Deceased – Cause of Death	_____

√ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

□ AIDS/HIV	□ Cataracts	□ Hernia	□ Osteoporosis	□ Stroke
□ Alcoholism	□ Chemical Dependency	□ Herniated Disc	□ Pacemaker	□ Suicide Attempt
□ Allergy Shots	□ Chicken Pox	□ Herpes	□ Parkinson's Disease	□ Thyroid Problems
□ Anemia	□ Diabetes	□ High Blood Pressure	□ Pinched Nerve	□ Tonsillitis
□ Anorexia	□ Emphysema	□ High Cholesterol	□ Pneumonia	□ Tuberculosis
□ Appendicitis	□ Epilepsy	□ Kidney Disease	□ Polio	□ Tumors, Growths
□ Arthritis	□ Fractures	□ Liver Disease	□ Prostate Problem	□ Typhoid Fever
□ Asthma	□ Glaucoma	□ Measles	□ Prosthesis	□ Ulcers
□ Bleeding Disorders	□ Goiter	□ Migraine Headaches	□ Psychiatric Care	□ Vaginal Infections
□ Breast Lump	□ Gonorrhea	□ Miscarriage	□ Rheumatoid Arthritis	□ Whooping Cough
□ Bronchitis	□ Gout	□ Mononucleosis	□ Rheumatic Fever	□ Other _____
□ Bulimia	□ Heart Disease	□ Multiple Sclerosis	□ Scarlet Fever	_____
□ Cancer	□ Hepatitis	□ Mumps	□ Sexually Transmitted Disease	

_____
Print Name of Patient

X _____ _____
Signature (if minor, parent must sign) Date

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HEALTH & SYMPTOM SURVEY

What is your chief problem or symptom? _____

What caused the problem or symptom to occur? _____

When did the problem or symptom begin? _____

What aggravates your symptoms? _____

What decreases your symptoms? _____

Have you seen another doctor for this problem? □ No, If yes, who _____

What tests/procedures have been performed? □ X-Ray □ MRI □ Surgery □ Hospitalization □ _____

Have you had this problem or symptoms in the past? □ No, If yes, explain _____

Have you tried any other treatments for this? □ No, If yes, explain _____

Is the problem or symptoms getting worse? □ No, If yes, explain _____

PAIN EVALUATION & DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Pain	: : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / /
Ache	X X X X X

Describe your pain (check all that apply):

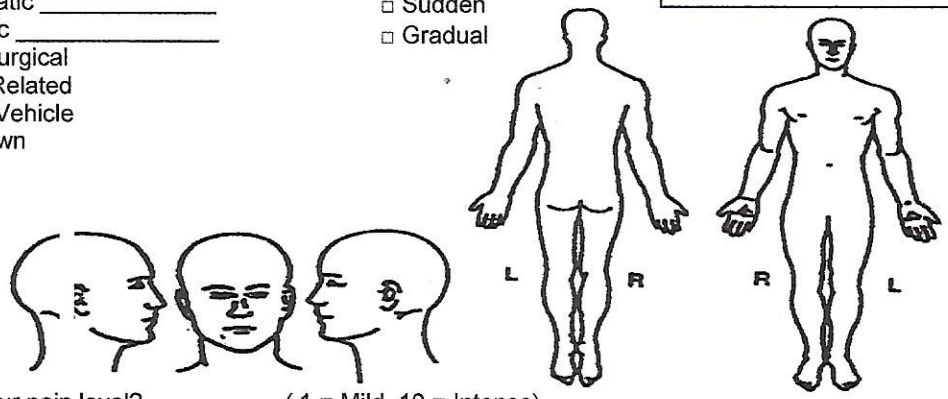
- □ Constant
- □ Intermittent
- □ Recurring
- □ Stabbing
- □ Dull Ache
- □ Sharp
- □ Deep Ache
- □ Throbbing
- □ Tingling
- □ While Resting
- □ Daily
- □ During Exercise
- □ Nightly
- □ _____

Cause of Pain:

- □ Traumatic _____
- □ Chronic _____
- □ Post Surgical
- □ Work Related
- □ Motor Vehicle
- □ Unknown

Onset of Pain:

- □ Sudden
- □ Gradual



On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives you relief? _____

_____
Print Name of Patient

X _____
Signature (if minor, parent must sign)

_____
Date

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IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE

□ **Automobile Accident**
Date _____ Time _____ [am] [pm] Location _____
Did your accident happen in the State of Florida? □ Yes □ No if no, what state? _____
Year/Make/Model of your vehicle: _____
Year/Make/Model of the other vehicle(s) involved: _____
Approximately how fast was your vehicle moving? _____ MPH The other driver? _____ MPH

Describe how accident occurred and what happened to your body motion at the time of the accident.
_____
_____
_____

Upon impact did you hit any objects inside of the car? Please list what object hit each body part.
Ex. Headrest, steering wheel, door frame, etc.

Head _____
Face _____
Shoulder _____
Neck _____
Chest _____
Hip _____
Foot _____
Knee _____

Position of your head and body at the time of impact? □ Straight □ Rotated right □ Rotated left □ Other _____
Was your head and body thrown? □ Backward then forward □ Forward then backward □ Right to left □ Left to right
□ Other _____

How did you feel 24 hours before the accident?

□ FINE — NO PAIN	□ _____	
Were you	□ Driver □ Passenger □ Rear seat	
Headrest position	□ High □ Middle □ Low	
Others in car	□ No	□ Yes
Were they hurt	□ No	□ Yes
Wearing seat belt	□ No	□ Yes
Wearing eye glasses	□ No	□ Yes
Where were you hit	□ Behind	□ Front/Side
Damage to vehicle	□ Minimal	□ Moderate
Was car totaled	□ No	□ Yes
Did seat back break	□ No	□ Yes
Did glass break	□ No	□ Yes
Did air bag deploy	□ No	□ Yes
Police report made	□ No	□ Yes
Did you go to E.R.	□ No	□ Yes
Had accident before	□ No	□ Yes
Missed any work	□ No	□ Yes

If you went to the hospital, which hospital did you go to? _____
At the hospital, were you □ Examined □ X-rayed □ Prescription □ Released □ Other testing _____
Have you treated with any other Doctor for this injury? □ No □ Yes
If yes, Date _____ Doctor/Clinic Name _____
Procedures/Testing/Referrals _____

_____
Print Name of Patient

X _____ _____
Signature (if minor, parent must sign) Date

Rev. 2016

Dr. Edgar T. Vesce, CCSP
Chiropractic Physician

INTEGRATIVE HEALTHCARE SOLUTIONS

1313 Beach Blvd Ste C
Jacksonville Beach, FL 32250
Phone: (904) 372-0623
Fax: (904) 372-0675

Patient: _____ **DOB:** _____

I hereby request and authorize: Edgar Vesce, CCSP, of Integrative Healthcare Solutions to:

_____ disclose information to: _____ receive information from:

Provider - _____
Address - _____
City/State/Zip - _____

Information to be disclosed include(s) copies of:

____ Entire Record
____ Progress Notes
____ Physical Exam Forms
____ Daily Chart Notes
____ X-Ray Reports
____ MRI Report
____ Other; Specify: _____
____ All of the above

Purpose of Disclosure:

_____ To allow for appropriate treatment modalities, adjusting techniques, exercise regimen and spinal rehab protocols.

_____ Other (specify) _____

This authorization will be effective for 6 months after the date signed, unless cancelled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Signature of Patient or Responsible Party: _____
Date: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

ASSIGNMENT OF BENEFITS

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Integrative Healthcare Solutions and/or its affiliated entities for any charges not covered by health care benefits. It is my responsibility to notify Integrative Healthcare Solutions of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Integrative Healthcare Solutions and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits: I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Integrative Healthcare Solutions for all covered medical services and supplies provided to me during all courses of treatment and care provided by Integrative Healthcare Solutions and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will have continual effect for so long as I am being treated or cared for by Integrative Healthcare Solutions, and will constitute a continuing authorization, maintained on file with Integrative Healthcare Solutions, which will authorize and allow for direct payment to Integrative Healthcare Solutions of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by Integrative Healthcare Solutions.

Authorization to Release Information: I authorize the release of any medical or any other information to Physicians Services medical billing company, my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Integrative Healthcare Solutions. A copy of this authorization will be sent to Physicians Services, my insurance carrier(s), or other medical entity, if requested. The original authorization will be kept on file by Integrative Healthcare Solutions.

Name of Patient (Printed)	Date of Birth	Social Security Number
Signature of Patient	Date	Witness Signature