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 INTAKE

PATIENT'S NAME

DOB

DATE OF APPOINTMENT

INSURANCE NAME

POLICY/CLAIM NUMBER

DATE OF ACCIDENT

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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 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. In addition, I understand that the use of Therapeutic Laser on the human body may be considered investigational or experimental by insurance companies or the Department of Health; I understand this concept and agree to this Laser treatment if it may help my condition and the doctor agrees to use it on me. I understand that the literature reveals that the proper use of Therapeutic Laser is safe, except for the direct shining into the retina, over cancer, over certain infections or over certain glands.

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) f)or which I seek treatment.

_____ _____
Patient or Guardian Signature **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.
- The right to request billing statements within a period of treatment. I understand that Integrated Chiropractic billing department have five to ten business days to provide me with a copy of such documents.

I authorize *INTEGRATED CHIROPRACTIC HEALTHCARE, P.A.* to contact me by:
☐ Email/Mail ☐ Text ☐ Cell phone ☐ Home phone ☐ Leave voice message

Patient Signature: _____ Date: _____

INTEGRATED CHIROPRACTIC
BECAUSE WE CARE
EST. 2008

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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 least15 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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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**

INTEGRATED CHIROPRACTIC
BECAUSE WE CARE
EST. 2008

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State Law Required New Patient Standard Disclosure and Acknowledgement Form
OFFICE OF INSURANCE REGULATION Bureau of Property & Casualty Forms and Rates

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

6. The service or treatment set forth below were actually rendered. This means that those services have already been provided.
   INTIAL EXAM:

   ____ 99201 ____ 99202 ____ 99203 ____ G0283 EMS ____ 97035 Ultrasound ____ 97012 Traction

   ____ E1399 Cryoderm (Topical Analg.) ____ A9273 Gel Packs Other_____

7. I have the right and the duty to confirm that the services have already been provided.
8. I was not solicited by any person to seek any services from the medical provider of the services described above. This means That no person has initiated contact with me/of persuaded me to use the doctor or licensed professional, clinic, or medical institution that provided the services.
9. The medical provider has explained the services to me for which payment is being claimed.
10. 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)* Signature Date

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

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

Licensed Medial Professionals Rendering Treatment/Services or medical Director, if Applicable *(Signature by his/her own hand):*

Dr. Jose R. Cadavedo, DC _____ _____
Name *(Print)* 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 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 electrically furnished. Failure to furnish this form may result in non-payment of the claim.

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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
[✓] All PHI in medical records [ ] Admissions Form [ ] Dictation Reports [ ] Physicians Orders [ ] Intake / Outtake [ ] Clinical Test [ ] Medication Sheets		[ ] Operative Info [ ] Cath Lab [ ] Special test/therapy [ ] Rhythm strips [ ] Nursing Info [ ] Transfer Forms [ ] ER Information		[ ] Labor / delivery sum [ ] OB nursing assess [ ] Postpartum flow sheet [ ] Itemized bill [ ] UB-92 [ ] Other: [ ] 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
4. revocation. Further details may be found in the Notice of Privacy Practices.
5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal
6. privacy regulations and may be re-disclosed.
7. 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.
8. 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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PIP LOG REQUEST FORM

Date: _____

Insurance Company Name: _____
Attention (adjuster): _____

Our Patient: _____
Claim No.: _____
Date of Accident _____

To Whom It May Concern:

I, _____ (Patient Name), authorize Integrated Chiropractic Healthcare (Provider's Name) to request and obtain a copy of any PIP LOG, statements or examinations under oath given by me.

Please provide an **UPDATED PIP LOG** to my provider Integrated Chiropractic Healthcare.

The Payment Log may be faxed to 407-614-5911 or emailed at reports@ichcare.com

_____ _____
Patient Name Date

_____
Patient Signature

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NOTICE OF INITIATION OF TREATEMENT

(Name of insured patient) _____

(Name of PIP insurer) _____

(Claim number) _____

Pursuant to Florida Statue 627.736(5) (c) 1., you are hereby notified that treatment on

Your insured , _____ (name of patient), was initiated on

_____ (date of first diagnosis or treatment), for injuries

sustained in an automobile crash in _____(date of accident)

_____
Chiropractic Physician (Name Print)

_____
Chiropractic Physician (Signature)

_____
Date

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Letter of Protection

To: _____ Date: _____
_____
_____
_____
_____

Name of the Patient: _____
Date of Birth: _____
Date of Injury: _____
Social Security No. : _____

Claim Number / Policy Number: _____

I request and instruct my attorney to issue a letter of protection on my behalf. I understand that services have been rendered to me by INTEGRATED CHIROPRACTIC HEALTHCARE, PA and understand that by signing this letter of protection, I agree to pay out any outstanding balances due to Integrated Chiropractic Healthcare, PA at the end of settlement. If recovery is not made, then I am aware that I am financially responsible for any unpaid balances due to Integrated Chiropractic Healthcare, PA.

_____ _____
Patient Signature Date

_____
Patient Name Printed

INTEGRATED CHIROPRACTIC HEALTHCARE

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

Notice of Privacy Practices

Your Rights & Our Responsibilities

Effective: January 1st, 2020

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical health condition and related health care services. **Please review it carefully.**

Your Rights

This section explains your rights and how we are required to acknowledge them.

Request a copy of your paper or electronic medical record

- Upon request, we will supply you with a *Request to Inspect or Copy Patient Information* form. The form contains the name of our privacy official and his/her contact information.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee for cost of labor, postage, and supplies associated with your request (in compliance with state and federal laws re- garding medical records request). We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs- based benefit program.

Receive a paper copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Request correction of your medical record

- Upon request, we will supply you with the *Request to Amend Patient Record* form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; our response will be in writing within 60 days

Request confidential or alternative communication

- Request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e mail.
- Request alternative communications; you must make your request in writing to our privacy office, a *Request for Alternative Communications* form will be provided upon request.

Ask us to limit the information we share

- List individuals who are involved in your care and as a result PHI can be disclosed; a *PHI Use and Disclosure Authorization* form will be provided, upon request.
- Restrict payer access. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. You must make your request in writing to our privacy office; a *Request to Restrict Disclosure to Health Plan* form will be provided upon request.

Receive a list of those with whom we've shared your information

- You have the right to request an accounting of disclosures of your health information made by us. We are not required to list certain disclosures, including: disclosures made for treatment, payment, and health care operations purposes (TPO).
- You must submit your request in writing, a *Request for Accounting of Disclosure of PHI* form will be provided upon request. The first accounting of disclosures (*Response to Request for Disclosure* form) you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures.

Right to Receive Notice of a Breach

- We are required to notify you by fi class mail or by email (if you have indicated a preference to receive information by e mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

File a complaint if you believe your privacy rights have been violated

- If you believe your privacy rights have been violated, you may file a complaint with our privacy officer; we will supply you with a *Complaint Form* upon request (form contains the name of our privacy official and his/her contact information).

- All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**
- We will not retaliate against you for filing a complaint.

Your Choices

This section addresses your choices regarding health information we may share.

You have the choice to tell us to:

- Share information with your family and friends about your condition.
- Disclose your health information when disaster relief organizations seek your health information to coordinate your care. Note: If you are unable to communicate your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest.

We will never share your information in these cases without permission:

- Marketing purposes. We are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may use and disclose health information to tell you about health related benefits or services that may be of interest to you.
- Sale of your information. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization

Our Uses and Disclosures

This section lists ways in which we may use your information and disclose it.

Healthcare Treatment

- Plan your care and treatment, including preauthorization and precertification.
- Communicate with other providers such as referring physicians.
- Billing and coordination of payment for services with health plan administrator.
- Quality and outcome assessments for improvement of care we render.
- Contracted third party business associates for services, such as answering services, transcriptionists, record keeping, consultants, and legal counsel.
- Communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Public Health and Safety Issues

- Product recalls
- Reporting suspected abuse, neglect or domestic violence in compliance with state and federal laws.

Compliance with the law

- Department of Health and Human Services investigations for complying with federal privacy laws.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions such as a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law.
- If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

Our Responsibilities

- If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information.
- We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.
- To provide you with notice, such as this *Notice of Privacy Practices* and abide by the terms of our most current *Notice of Privacy Practices*;
- Notify you if we are unable to agree to a requested restriction.

Changes to the Terms of this Notice

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain. Should our information practices change; a revised *Notice of Privacy Practices* will be available upon request. We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices*. If you have limited proficiency in English, you may request a *Notice of Privacy Practices* in Spanish.

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Integratred Chiropractic Healthcare .

I understand that the Notice describes the uses and disclosures of my protected health information by Integratred Chiropractic Healthcare and informs me of my rights with respect to my protected health information.

_____

Patient's Signature or that of Legal Representative