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

INTEGRATED CHIROPRACTIC
BECAUSE WE CARE
EST. 2008

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

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: _____