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

INTEGRATED CHIROPRACTIC
BECAUSE WE CARE
EST. 2008

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

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

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

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**

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

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
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

Health Insurance
Advance Beneficiary Notice (ABN)

Date: _____ Patient: _____ Insurance: _____

- You are receiving this notice because your insurance company may not pay for all of the services that you receive during your visit to our office.

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask questions

Supplies and Services	Reason Insurance May not Pay	Estimate Cost
☐ Initial Exam ☐ Spinal Manipulation ☐ Theraupetic Exercises (Stretrching) ☐ EMS(Electrical Muscle Stimulation)	☐ COPAY ☐ DEDUCTIBLE	

☐ YES I want to receive these services. If my commercial insurance carrier denies payment, I am completely responsible for payment in full. I understand that I can appeal this decision for nonpayment by my insurance carrier.

☐ NO I have decided not to receive these services.

☐ OTHER Should I decide to request these services in the future, I understand I will be charged and am responsible for payment in full.

By signing this notice you agree to take full financial responsibility for the cost of the supplies and services listed above should your insurance company deny covered for listed items.

Guarantor Signature:	Date:

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 / 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: