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

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 HEALTHCARE

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

Notice of Privacy Practices

Your Rights & Our Responsibilities

Effective: January 1st, 2024

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