Integrated Chiropractic Healthcare, P.A.

Dr. José R. Cadavedo & Dr. Nayda M. Nuñez

213 S. Dillard St. Suite 213, Winter Garden, FL 34787

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

PATIENT REGISTRATION

Name: ____
First Middle Last

Date of Birth: ____________________ Age: _____ Sex: Male / Female SSN: ____________________

Address: ____
Street City State ZIP

Home Phone: ____________________ Cell Phone: __________________ Cellphone Carrier: _________ Work Phone: ________________

Occupation: _________________________ Email Address: _______________________ Marital Status: S M D W

Primary Care Physician: _________________________________ Phone: ______________________________

Emergency Contact: ______________________________ Relationship: _____________________ Phone: _____________________

Health Insurance Information ☐ **No Health Insurance Benefits**

Insured's Name: __________________________________ Relationship: _____________________________

Insurance Carrier: _______________________________ Insurance Phone/Fax: _____________________________

Address: ____
Street City State ZIP

Policy #:____ Group #:____

Auto Accident Insurance Information

Insured's Name: __________________________________ Relationship: _____________________________

Insurance Carrier: _______________________________ Insurance Phone/Fax: _____________________________

Address: ____
Street City State ZIP

Policy #:____ Group #:____

Policy Effective Date: __________________ Date of Accident: ____________________ Date Reported:_____________

Adjuster Name: ______________________________ Direct Phone #: ____

Attorney Name: ______________________________ Phone/Fax: ____

Assignment of Benefits – I authorize the release of any medical information necessary to process this claim and request payment of benefits from my insurance company be made to Integrated Chiropractic Healthcare. I understand and agree that regardless of my insurance status); I am ultimately responsible for the balance on this account. I have read and completed all the information on this sheet to the best of my ability and certify that it is true and correct. I will notify you of any changes on the above information. _____ **Initials**.

Informed Consent of Treatment – I understand that spinal manipulation has health risks associated, example : fractures, sprains/strains, cerebral vascular accident, cauda equine syndrome, nerve root irritation, and spinal cord compression _____ **Initials.**

Privacy Practices – I acknowledge that I was provided a copy of the NOTICE OF PRIVACY PRACTICES and that I have read them or declined the opportunity to read them and understand the NOTICE OF PRIVACY PRACTICES. I understand that this form will be placed in my patient chart and maintained for six years. _____ **Initials.**

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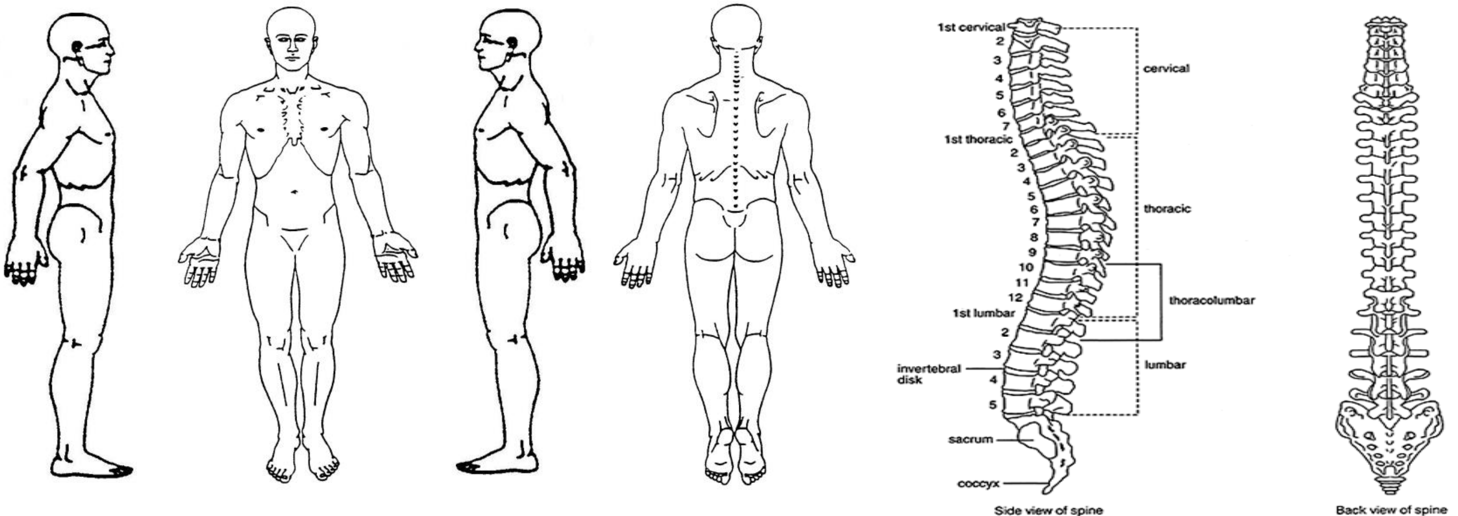
INITIAL PATIENT QUESTIONNAIRE

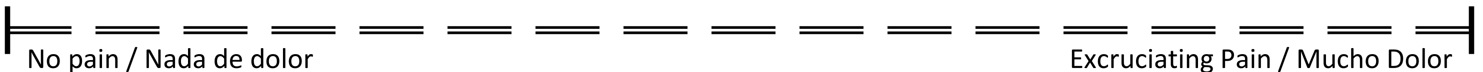
Name / Nombre:____ Date / Fecha:______________

Reason for visit? / Rason por visita? ____
On pictures, mark an X where you feel pain or discomfort / En las fotos abajo, marca con una X donde siente dolor :



When did your symptoms first appear? / Cuando comenzaron los síntomas? ____
Is the condition getting progressively worst? / La condición se está empeorando? : YES NO

Visual Analog Scale



No pain / Nada de dolor Excruciating Pain / Mucho Dolor

Indicate the type of pain / indica la clase de dolor : ____
Previous Treatments for this complaints / Tratamientos previos para esta condición:
____
____
Other complaints or problems / Otros problemas:
____
____
Current medications / Medicamentos:
____
____
Are you currently under the medical care of another doctor? / Esta usted bajo la atención medica de otro doctor? YES NO
If so, when was your last visit / De haber visitado al doctor, cuando fue su última visita:
____
List any major illnesses, with approximate dates / Liste sus condiciones médicas, con fechas aprox.: ______________________________
____

Patient Name/ Nombre de Paciente:____

List any major surgeries or operations with approximate dates / Anota tus cirugía o operaciones, con fechas:
____

List any past accidents or injuries / Anotas algún accidente o herida:
____
____

Have you ever been diagnosed with the following? / Alguna vez te han diagnosticado con lo siguiente ?

○ Diabetes ○ Heart Disease ○ High Blood Pressure ○ Cancer ○ Asthma	○ Allergy ○ Tuberculosis ○ Herpes ○ STD ○ HIV/AID	○ Depression ○ Metal Disorder ○ Liver Problems ○ Hypo/Hyper Thyroidism ○ Vascular Disease	○ Mumps ○ Measles ○ Chicken Pox ○ Arthritis ○ Suicide

Any family history of serious illnesses / Tiene una historia de enfermedad familiar: Cancer Diabetes Heart Disease Gout

If so, who / Si es certo, quien: ____

- ☐ Are you taking any nutritional supplements? / Esta tomando suplementos nutritivos? ____________________
- ☐ Do you consume? (if so, list amount) / Usted consume? (si es cierto, anota cuanto)
- ☐ Cigarettes ____________ Coffee____________ Alcohol____________

Are you currently experiencing any of the following? / Estas experimentando alguno de lo siguiente ?

HEENT	Cardio Respiratory	Gastrointestinal	Gentourinary	Neuropsych
○ Hair Loss / Scalp Pain ○ Difficulty w/ Vision ○ Double Vision ○ Diffculty Hearing ○ Ringing of Ears ○ Difficulty Breathing ○ Nasal Discharge ○ Difficulty Chewing ○ Difficulty Swallowing	○ Chest Pain ○ Left Arm Pain ○ Palpations ○ Coughing ○ Wheezing ○ Short Breath ○ Asthma ○ Allergy ○ Discharge ○ Fatigue	○ Abdomen Pain ○ Diarreha ○ Bloating ○ Constipation ○ Gerd ○ Pencil Stool ○ Liver Problem ○ Loss / Gain of Weight ○ Cramps ○ Rash Skin	○ Discharge ○ Hesitancy ○ Frequency ○ Bladder Control ○ Pain urination ○ Sexual Dysfunction	○ Dizziness ○ Confusion ○ Depression ○ Fatigue ○ Numbness ○ Tingling ○ Sweats ○ Fever ○ Memory Loss ○ Suicide ○ Abuse

- ☐ List Any Allergies/ Alergias:____
- ☐ Any pacemakers, stimulators or internal hardware? Example: Shunts, Dorsal Column Stim?____________________
- ☐ Any Additional Comments / Comentario adicional:____

Patient Signature: ______________________ **Date**: ____________

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CAR ACCIDENT QUESTIONNAIRE

Patient Name: ________________________________ Date of Accident:__________________________

Where did the accident happen? Describe the accident in your own words:

____
____
____

What was your position in your car?
□ Driver If driver, where were your hands on the steering wheel: □ Left □ Right □ Both
□ Passenger I passenger, were you sitting in: □ Front □ Right rear □ Left rear

Did your vehicle strike another car? □ Yes □ No

Angle of Impact: 1st Collision: □ Front □Back □Left □Right
(If applicable) 2nd Collision: □ Front □Back □Left □Right

Did your air bag deploy? □ Yes □ No Were you wearing your seat belt? □ Yes □No

Did you brace for impact? □ Yes □ No (If so) □ Braced with hands □ Braced with feet

Which way were you facing at the time of impact? □ Straight ahead □Left □Right

Did you strike anything in the vehicle at the time impact? □Yes □No

If Yes, specify what part of your body struck what?
□ Steering wheel □ Dashboard □ Windshield □ Roof □ Left side door □ Right side door
□ Left side window □ Right side window □ Other: ___________________________

Did the seat back bend or break? □ Yes □ No

Immediately following the accident, how did you feel? □ Dizzy/Dazed □ Disoriented □ Weak □ Unconscious
□ Nauseous □ Upset □ Nervous □ Other: ____

Did you go to the hospital? □ Yes □ No Where you admitted to the hospital? □ Yes □ No

When did you arrive there? □ At time of accident □ Next day

How did you get there? □ Ambulance □ Police car □Private transportation

What treatment was given?
□ None □Placed in cervical collar □X-rayed □Given stitches
□ Pain Medication □Given instructions regarding concussion □Bandaged
□ Given instructions regarding sprains/strains □Physical therapy
□ Instructed to call an orthopedic surgeon □Instructed to call a private physician
□ Referred to this office for treatment □Other: ______________________

Have you seen any other doctor as a result of this accident? □ Yes □ No

Doctor's Name: ____Phone Number:__________________________________

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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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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 for the aforesaid accident.

AUTHORIZATIONS FOR DISCLOSURE OF INSURANCE PAYMENT RECORD: 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 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, or at 80% if the insurance policy is limited to pay 80% of the medical claims. If any insurance company obligate to pay any insurance benefits to me, or 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 lesser than 80% of the amount billed if my coverage is limited to 80% for medical claims, I direct the aforesaid insurance company to hold in escrow the amount in dispute, and 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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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I, ____ (Patient printed name), Hereby authorize Integrated Chiropractic Healthcare, P.A. 213 South Dillard St. 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 patient's legal representative.

____________________________________ ______________________ _________________

Patient or Guardian Signature **Date of Birth** **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.

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 of Birth** **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.

I authorize ***INTEGRATED CHIROPRACTIC HEALTHCARE, P.A.*** to contact me by:

□ Email/Mail □ Text □ Cell phone □ Home phone □ Leave voice message

Patient Signature: ____________________________________ **Date:** ______________________