Family Chiropractic Works South Inc.

8865 Commodity Circle Suite 3, Orlando Florida 32819 (407) 354-0009 (407) 354-4882 fax

CHIROPRACTIC INFORMED CONSENT TO TREAT

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 and/or other tests 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 treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand I will be given the opportunity to discuss with the doctor of chiropractic named below and/or with other office of clinic personnel the nature and purpose of chiropractic, adjustments and 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, falls, dizziness, headaches, burns with modalities and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts, then known, and is in my best interests.

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) for which I seek treatment.

I herby give consent to have chiropractic adjustments performed in a semi-open room setting and will inform the staff if I need to discuss any confidential information in a private.

Dr. Jared Silberstein, D.C.

Patient Signature ______________________________ Date ______________________________

(Or Patient Representative)
(Indicate relationship if signing for patient)

South Park Chiropractic

8865 Commodity Circle
Suite 3 Orlando,FL
32819

ASSIGNMENT AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

Patient: ______________________________

Employer: ______________________________

Claim / Group #: ______________________________

SS#/ID#::______________________________

I hereby instruct and direct the ____________ Insurance Company to pay by check made out and mailed directly to:

South Park Chiropractic
8865 Commodity Circle
Suite 3
Orlando,FL32819

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct to make out the check to me and mail as follows:

C/O: ______________________________
____
____
____
____

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case following all guidelines privacy compliance.

Dated at ______________________________

Signature of policyholder ____________________ Witness: ____________________

Signature of Claimant if other than policyholder ______________________________

SOUTH PARK CHIROPRACTIC

PAYMENT POLICIES

1. All first visit charges are payable when services are rendered.
2. At the completion of your first visit you will be advised as to a time you may return for your second consultation when the doctor will inform you as to your examination results, and whether or not your case has been accepted. You will then be advised concerning treatment options, financial arrangements, and insurance coverage as appropriate.
3. The fee paid for X-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Copies can be made if necessary at a minimal expense.
4. Method of payment you plan to use to take care of today's charges?

    [ ] Cash [ ] Check [ ] Credit Card

REGARDING INSURANCE PAYMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand South Park Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company, and that any amount authorized to be paid directly to South Park Chiropractic will be credited to my account upon receipt. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

I also understand that my insurance company states that any information given regarding benefits is not a guarantee for payment and that benefits could be changed or denied. I also understand that my insurance company can take at least 30 days to respond to submitted claims and that it is my responsibility to inform this clinic of any changes in my policy. I agree to pay, in a current manner, any balance of said professional service charges over and above my insurance company's payments.

I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize South Park Chiropractic to obtain a credit report if deemed necessary.

Patient Name: ____

Patient Signature: ____________________________________ Date:___________

Guardian Signature: ____________________________________ Date: ___________

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined to 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 a period of six years.

____________________________ ________________

Patient Name (please print) Date

____

Parent, Guardian, or Patient's legal representative

____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR A PERIOD OF SIX YEARS.

, NOTICE OF PRIVACY PRACTICES As REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Family Chiropractic Works South Inc.

EFFECTIVE DATE OF THIS NOTICE: APRIL 14TM, 2003

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you, your treatment, and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI.
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Dr. J. Silberstein at (407) 354-0009

C. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS:

1. Treatment: The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may ask you to have laboratory tests, and we may use the results to help us reach a diagnosis. Many of the people who work for our practice may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment: Our practice may use and disclose your PHI in order to bill you for the services and items you may receive from us. For example, we may *contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine* if your insurer will pay for your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members.

3. Health Care Operations: Our practice may use and disclose your PHI to operate our business. As an example, our practice may use your PHI to evaluate the quality of care you received from us. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointments and Reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment or a follow up on treatment.

5. Non-Medical Communications: Our practice may use your PHI to contact you for non-medical reasons, such as sending you a birthday card or a holiday greeting.

6. Treatment Options: Our practice may use your PHI to inform you of potential treatment options or alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time.

7. Health-Related Benefits and Services: Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. For example, we may send you newsletters that may include information about our practice, health related issues and products and services.

8. Release of Information to Family/Friends: *Our practice may release your PHI to a family member or friend that is involved in your care,* or who assists in taking care of you. For example, a parent/guardian may ask that a babysitter take their child to the pediatrician's office for treatment. In this example, the babysitter may have access to this child's medical information.

9. Disclosures Required By Law: Our practice will use and disclose your PHI when we are required to do so by law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

1. Public Health Risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

A. Maintaining vital records, such as births and deaths;
B. Reporting child abuse or neglect;
C. Preventing or controlling disease, injury or disability;
D. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
E. Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; and
F. Reporting problems with products or devices; G. Notifying individuals if a product or device they may be using has been recalled

2. Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings: *Our practice may use and disclose your PHI in response to a court or administrative order,* if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement: We may release PHI if asked to do so by a law enforcement official:

A. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement; B. Concerning a death we believe has resulted from criminal conduct; C. Regarding criminal conduct at our offices;

D. In response to a warrant, summons, court order, subpoena or similar legal process; E. *To identify/locate a suspect, material witness, fugitive or missing person; and*

F. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased Patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

6. Organ and Tissue Donation: Our practice may release your PHI to organizations that handle organ or tissue transplantations as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research: Our practice may use and disclose your PHI for research purposes in certain circumstances (i.e. case studies). We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research; and (C) adequate written assurances that the PHI will not be disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without the use of the PHI.

8. Serious Threats to Health or Safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety, the health and safety of another individual, and/or the public. Under these circumstances, we will only make disclosures to a person/organization able to help prevent the threat.

9. Military: Our practice may disclose your PHI if you are a member of U.S./foreign military force and if required by the appropriate authorities.

10. National Security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We may disclose your PHI to federal officials in order to protect the President, other officials, or to conduct investigations.

11. Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI:

1. Confidential Communications: You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Dr. J Silberstein** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use of your PHI, you must make your request in writing to **Dr. J. Silberstein.** Your request must describe in a clear and concise fashion:

A. The information you wish restricted;

B. Whether you are requesting to limit our practice's use, disclosure or both; and

C. To whom you want the limits to apply.

3. Inspection and Copies: You have the right to obtain a copy of the PHI, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Dr. J Silberstein** in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. Your request must be made in writing and submitted to **Dr. J.Silberstein.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request, and the reason supporting your request, in writing. Also, we may deny your request if you ask us to amend information that is in our opinion.

5. Accounting of Disclosures: All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Dr. J Silberstein.**

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice: You are entitled to receive a paper copy of our notice of privacy practices.

7. Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. Please note, we are required to retain records of your care.

Attention Patients:

We apologize for an inconvenience, but we are now required to collect the following demographics information:

Race (please check all that apply):

- American Indian or Alaska Native
- Asian
- Black (or African American)
- Native Hawaiian (or Other Pacific Islander)
- White

Ethnicity:

- Hispanic (or Latino)
- Not Hispanic (or Latino)
- Prefer not to answer

Preferred Language: ______________________________

Smoking Status:

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker

Thank you so much for your cooperation!