Quantum
CHIROPRACTIC | ACUPUNCTURE | SPA

1840 NW 122 Terrace
Pembroke Pines, FL 33026
Tel: (954) 443-6600
Fax: (954) 436-3500

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION:

FULL NAME: _____ DATE OF BIRTH: __ /__ /___ AGE: ___ MALE ☐ FEMALE☐

ADDRESS: _____ APT # _____ SSN _____- ____- _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: (____) _____-_____

ALTERNATE PHONE (CELL): (____) _____-_____ CELL PHONE COMPANY: _____

EMAIL ADDRESS: _____ ☐YES ☐NO Text message reminding you of your appointment

EMPLOYER'S NAME: _____OCCUPATION _____

WORK PH. (___) ____-_____ EXT _____ DATE SYMPTOMS BEGAN: ___ /___ /___

MARTIAL STATUS: SINGLE ☐ MARRIED ☐ WIDOWED ☐ HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: _____ PHONE (___) ____-_____ RELATION: _____

REASON FOR YOUR VISIT TODAY? _____

_____

_____

_____

AUTHORIZATIONS:

I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for product and services rendered.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Professionally we Serve, Personally we Care

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INFORMED CONSENT

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTOR

CHIROPRACTIC

It is important to acknowledge the difference between the healthcare specialist of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through the natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSC complexes are found chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialist. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concerns as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic gives the doctor permission and authority to care for the patient in accordance with the chiropractic test, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patients susceptible to injury. The doctor, of course, will not give a chiropractic adjustment or health care if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through the health care procedures whatever he/she is suffering from latent pathological defects, illnesses, or determine which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions exist which may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor before signing the statement policy.

I have read and understand the Informed Consent Form.

_____	_____	_____
Name (Please Print)	Signature	Date

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Massage Therapy

Informed Consent and Massage Policies

I understand that the massage I will be receiving here is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation. I understand that the massage therapist does not diagnose illness, disease, or any further physical or mental disorders. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations.

I understand that the massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have. I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent medical information.

I understand that if I experience any unusual discomfort and/or pain during my massage session it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used. I understand that I have twenty four hours before my appointment to cancel without an assessed charge. If I have to cancel my appointment and it is not within twenty four hours of my appointment time, I understand that I will be assessed a charge for $45.00.

I acknowledge that I am responsible to show up for my appointment on time and that the massage therapist is not under obligation to extend the therapy session. I also agree that I am responsible to pay for the full time I have booked with the massage therapist if I am late. I understand that the massage therapy sessions are booked for fifty minutes.

_____	_____	_____
Name (Please Print)	Signature	Date

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Acupuncture Informed Consent

Nature of Treatment: Your treatment may include Acupuncture, Moxibustion, cupping, electric stimulation, Acupressure, dermal friction (Gua Sha), application of Chinese ointments, laser acupuncture, Chinese herbs, therapeutic exercises and dietary counseling based on the fundamentals of Chinese medicine.

Purpose of Treatment: The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment are based on these theories used to promote health and treat organic or functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. We cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Acupuncture has been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:

- -Discomfort during and after the insertion of a needle
- -"Needle sickness" (dizziness, fainting, nausea)
- -Localized, minor bruising, nerve damage, numbness, tingling, infection, pain or swelling
- -Minor burns and scarring with the use of Moxibustion (Moxa)
- -Gastro-intestinal upset with the use of Chinese herbs
- -Spontaneous miscarriage, organ puncture (including lung (pneumothorax)).
- -Possible, temporary aggravation of symptoms that existed prior to treatment
- -A broken needle (rare with the use of disposable needles)

Please notify your practitioner if you have any adverse effect from treatment or if you become pregnant. Movements while the needles are being inserted, retained, or removed are prohibited.

Special Situations: Some herbs and Acupuncture points are contra-indicated during pregnancy. Please notify us if you might be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

Use of Disposable Needles: To reduce the possibility of infection from Acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your Acupuncturist has had training in Clean Needle Technique and Universal Precautions.

Consent: Acupuncture is not a replacement for diagnostic medical procedures. An Acupuncturist does not diagnose according to the standards of western medical practice, nor should a "Chinese diagnosis" be considered a replacement for standard medical evaluation or testing. I request and consent to the performance of Acupuncture and this Oriental Medicine procedure. I understand that results are not guaranteed. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask Dr. Rodriguez. I, hereby release Quantum Chiropractic from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

_____	_____	_____
Name (Please Print)	Signature	Date

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Patient Name: _____

Assignment of Insurance Benefits:

I hereby authorize payment to be made to Quantum Chiropractic of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies for the purpose of processing claims and effecting payments. I further acknowledge the assignment of benefits to not in any way relieve me of liability and that I will remain financially responsible to Quantum Chiropractic.

Furthermore, I hereby IRREVOCABLY ASSIGN to Quantum Chiropractic the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statues for any service and or charges provided by Quantum Chiropractic.

Authorization to Release Medical Records Information:

Quantum Chiropractic is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, organizations, or agencies as may be responsible for payments of services rendered by Quantum Chiropractic. This authorization is given with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Quantum Chiropractic.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

_____	_____	_____
Name (Please Print)	Signature	Date

Quantum Chiropractic, LLC
HIPPA NOTICE OF PRIVACY PRACTICES
Effective Date (June 1, 2013)

This notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully. If you have any questions about this notice, please contact: Enrique Rodriguez, DC at (954)443-6600. This notice describes the privacy practices at our office.

We are required by law to:

*Maintain the privacy of protected health information

*Give you this notice of our legal duties and privacy regarding your health information

*Follow the terms of the notice currently in effect

How we may use and disclose you health information

Described as follows are the ways we may use and disclose you health information. Except for the following purposes we will use and disclose you health information only with your permission. You may revoke such permission at any time by writing to Quantum Chiropractic.

Treatment: We may use and disclose your health information for your treatment and to provide you with treatment –related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use your health information so that others or we may bill and receive payment from you, an insurance company, or third party for treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your health care information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operations activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in your care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location condition or disclose such information to an entity assisting in disaster relief.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through as special approval process. Even without special approval, we may permit research to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of health information.

As Required by Law. We will disclose your health information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be only to someone who can prevent the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of foreign military we may release your health information to the foreign military command authority.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and recall notifications.

We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only you agree or when required to do so by law.

Health Oversight Activates. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor he health care system, government, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose you health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain and order protecting the information requested.

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4)the information is about a death that may be the result criminal conduct ; 5) the information is relevant to criminal conduct on our premises; and 6)it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Corners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or similar circumstance.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 20 to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Inspect and Copy. You have the right and copy your medical and billing records by written request to Quantum Chiropractic, LLC.

Right to Amend. You the right to request an amendment to your records by written request to Quantum Chiropractic, LLC.

Right to Accounting Of Disclosures. You have a right to an accounting of certain disclosures by written request to Quantum Chiropractic, LLC.

Right to Request Restrictions. You have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care(such as a spouse) by written request to Quantum Chiropractic, LLC.

We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to Quantum Chiropractic, LLC. We will accommodate reasonable requests.

******We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Quantum Chiropractic, LLC.

I have received a copy of the HIPPA PRIVACY & PRACTICE HANDOUT on the date listed below. I understand that I am expected to read the entire handout. Additionally, I will sign the two copies of this Acknowledgment of Receipt, retain one copy for myself, and return one copy to Quantum Chiropractic's representative listed below on the date specified. I understand that this form will be retained in my patient file.

_____ _____ _____

Signature of Patient | Printed Name of Patient | Date