

**Patient Consent for Use and Disclosure
of Protected Health Information**

I hereby give my consent for Rhode 2 Wellness (R2W) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

R2W reserves the right to revise its Notice of Privacy Practices. I have the right to request that R2W restrict how it uses or discloses my PHI to carry out TPO.

With this consent, R2W may call, mail or email me PHI in reference to matters that assist in carrying out TPO, such as appointment reminders, patient statements, and insurance items pertaining to my care.

All documents and x-rays created as a result of services provided at R2W will remain the property of R2W.

There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or my insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, R2W may decline to provide treatment to me.

Patient's Name

Date

Patient's Signature

Print Name of Legal Guardian, if applicable

Signature of Legal Guardian, if applicable

Doctor-Patient Relationship in Chiropractic

It is important to be an aware and informed patient. We have found that an understanding of chiropractic care is helpful. This page is to help inform you of what will be happening today and throughout your care.

Analysis: You will receive a chiropractic examination for the detection of vertebral Subluxations. A vertebral Subluxations is a misalignment of one +or more of the 24 vertebra in the spinal column that causes obstruction of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's natural ability to express its maximum health potential.

During the examination, the chiropractor will evaluate how your spine moves and what it feels like. Based upon the results of the examination, X-rays of your spine may be taken. X-rays will tell the doctor how far and in what direction the vertebra is misaligned. The X-rays will also help determine the most efficient chiropractic techniques to effectively adjust and correct the spine.

Diagnosis: Only a chiropractor can determine if your case is a chiropractic case. Your diagnosis will reflect spinal nerve interference that is caused by vertebral Subluxations. Our doctors will work with any other health care provider for your benefit. Also, you should expect other health care providers to work with your chiropractor for your benefit. This team approach to your health care will serve you the best.

Chiropractic Adjustments: By coming to the chiropractor for care, you give the chiropractor permission to adjust you. In rare cases, physical defects, deformities, or pathology may render the patient susceptible to injury. The chiropractor will not provide chiropractic adjustments if he is aware of any such conditions. If the patient is aware of any latent pathological defects, illness or deformities that would not otherwise come to the attention of the chiropractor, it is the patient's responsibility to notify the chiropractor. A chiropractor does not treat or diagnosis disease. The chiropractor provides a specialized health service for the detection and correction of vertebral Subluxations. Upon request, alternatives to chiropractic care and any risks regarding chiropractic care will be explained in detail. Risks, although rare, may include increased muscle spasm, strain, and exacerbation of disc conditions, fractures or TIA.

Results: The goal of chiropractic is to adjust vertebral Subluxations for the purpose of allowing the proper transmission of nerve energy over nerve pathways so that every part of the body may have a proper nerve supply at all times. This allows the natural healing ability of the body to work at maximum efficiency. Since there are many variables, it is difficult to predict the time schedule or results of chiropractic care. The healing process takes time. The longer the problem has been in the body, the longer the healing process will take.

Questions: We want to help you achieve your goal of health. Any time your progress is not satisfactory or you have any concerns, the chiropractor will gladly answer any questions that arise or assist you in choosing a referral doctor for another opinion. Your health is our number one priority.

Acknowledgment: I have read and understand the above.

Patient Name: _____ **Signature:** _____ **Date:** _____

Records Release / Request

I authorize and direct Rhode 2 Wellness Family Chiropractic to **Release** copies of my medical records, x-rays, exam results and any other protected health information to:

Name: _____

Address: _____

Phone: _____

Fax: _____

I authorize and direct Rhode 2 Wellness Family Chiropractic to **Request** copies of my medical records, x-rays, exam results and any other protected health information from:

Name: _____

Address: _____

Phone: _____

Fax: _____

This authorization is given pursuant to Florida Statute 456.057 and HIPPA regulations. Any third party that receives protected health information is prohibited from further disclosing any information contained in the medical records without the consent of the patient or the patient's legal guardian.

Patient Name

Social Security

Date Of Birth

Patient Signature

Date

Office of Insurance Regulation

Bureau of Property & Casualty Forms and Rates



Standard Disclosure and Acknowledgment Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services set forth below were actually rendered. This means that those services have already been provided.

2. I have the right and the duty to confirm that the services have already been provided.

3. I was not solicited by any person to seek any services from the medical provider of the services described above.

4. The medical provider has explained the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.

Insured Person (patient receiving treatment of services) or Guardian of Insured Person:

Insured Person's Name (*Print or Type Name*) Insured Person's Signature Date

The undersigned licensed medical professional affirms the statement numbered 1 above and also:

A. I have not solicited or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. I have explained the services rendered to the insured person, or his or her guardian, sufficiently for that person to sign this form with informed consent.

C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment / Services or Medical Director (Signature by his or her own hand)

Physician's Name (*Print or Type Name*) Physician's Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Standard Disclosure & Acknowledgement

ASSIGNMENT AND AUTHORIZATION OF INSURANCE BENEFITS

I, _____, the undersigned, for good and valuable consideration, including the agreement of Rhode 2 Wellness Family Chiropractic ("Assignee") to accept this assignment in lieu of demanding full payment for services on the date each service is rendered, I authorize and direct any insurance company that may be obligated to provide insurance benefits to me, or on my behalf, ("my insurance company") to accept billing and pay directly to Assignee such sums as may be due and owing Assignee for services rendered to me, both by reason of accident or illness, and by reason of any other bills that are due Assignee; and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, or any other insurance benefits obligated to reimburse me or any form of settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee.

I hereby further give lien to said Assignee against any and all insurance benefits named herein and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided.

In the event my insurance company refuses to make such payments, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against my insurance company. I further authorize and direct you, my insurance company to provide fifteen days advance notice to Assignee of any physical examination or examination under oath of myself that is scheduled by any insurance company.

I authorize and direct you, my insurance company and/or my attorney to release a copy of the payment record (PIP Payout Log) without redacting the names of payees and amounts paid and to release a copy of the declarations page of insurance policy and any pertinent information necessary for me to receive treatment and for Assignee to timely process claims. I also authorize Assignee to release any information pertinent to my care to any insurance company, adjustor, or attorney to facilitate collection under this Assignment and Authorization. I agree that a photocopy of this document may serve as the original.

I, _____, have read and fully understand the above information and agree to receive chiropractic care under these terms.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

COMPLETE IF PATIENT IS A MINOR CHILD _____ (Child's Name)

I, _____ being the parent or legal guardian of the above minor child have read and fully understand the above information and agree for my child to receive chiropractic care under these terms. **Signature:** _____ **Date:** _____

Rhode 2 Wellness Family Chiropractic

340 Franklin Street Suite B Ocoee, FL 34761 Phone (407) 614-4441 Fax (407)-598-5295

PROVIDER'S LIEN

To Attorney: _____

Address: _____

Phone # _____ Fax # _____

From: Patient _____

I authorize Rhode 2 Wellness Family Chiropractic, Inc. ("R2W") to furnish my attorney, with my examination reports, diagnosis, and prognosis notes in regard to the treatment that I am receiving from R2W.

I understand that I am directly and fully responsible to R2W for all chiropractic bills submitted by them for services rendered to me. This agreement is made for R2W's protection and in consideration of their awaiting payment.

I hereby give a Lien on my case to R2W against any and all proceeds of any settlement, judgment or verdict that may be paid to me as a result of the injuries for which I have been treated. As such, I hereby authorize and direct you, my attorney, to pay directly to R2W such sums that are due and owing R2W for chiropractic services rendered to me, both by reason of this accident and by reason of any other bills that are due R2W. I further direct you, my attorney, to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect R2W.

Date: _____ Patient's Signature: _____

This signed document acts as my express authorization for you, my attorney, to sign an agreement stating your intention to observe on my behalf the above terms.

Date: _____ Attorney's Signature: _____

A photocopy of this form shall be considered as valid as the original.

Providers Lien