



“You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you live the quality of life you deserve.”

Date: _____ Chart#: _____

Name: _____ Sex: Male Female

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home #: (____) _____ Cell #: (____) _____ Other: (____) _____

DOB: _____ Age: _____ S.S. No. _____

E-mail: _____

Marital Status: Single Married Widowed Divorced

Referred By: Patient _____ Attorney _____

Physician _____ Mail Friend Other _____

Employer: _____ Business # (____) _____ Occupation: _____

Spouse's Name: _____ Contact #: (____) _____

Emergency Contact: _____ Phone #: (____) _____ Relationship: _____

Insurance Information

Insurance Co. Name: _____ Phone #: (____) _____

Insurance Type: Medical Auto Workers Compensation Other _____

ID/Policy #: _____ Group #: _____ Claim#: _____

Named of Insured: _____ DOB: _____ S.S. No _____

(If different from patient)

Is condition due to an accident? Yes No Date of Accident: _____ Time: _____ a.m. p.m.

If yes, please check one: Auto Work Other _____

Auto Accident Information

Were you the: Driver Front Passenger Rear Passenger

Location of Accident: _____ State _____

Year, Make & Model of the vehicle you were occupying? _____

Name of Owner: _____ Relationship to Patient: _____

Year, Make & Model of other vehicle(s) involved in accident? _____

Briefly describe accident: _____

Have you reported your accident to your auto insurance company? Yes No

Have you retained the services of an attorney? Yes No

If yes, Attorney's Name & Phone #: _____

Reason for Visit: _____

When did symptoms appear? _____ Is your condition getting progressively worse? Yes No

Does it interfere with your Work Family Life Sleep Recreation Exercise

Previous Chiropractic Care: No Yes If yes, approximate date of last visit _____

Please Check Area(s) of Pain:

- () HEAD () SHOULDER R/L () RIBS R/L () HIP R/L
- () FACE () UPPER ARM R/L () CHEST () THIGH R/L
- () JAW () ELBOW R/L () ABDOMEN () KNEE R/L
- () NECK () FOREARM R/L () MIDBACK () LOWER LEG R/L
- () WRIST R/L () LOWER BACK () CALF R/L () ANKLE R/L
- () HAND R/L () GROIN R/L () BUTTOCKS () FOOT R/L
- () FINGER R/L

Please Check Other Symptoms:

- () FATIGUE () NERVOUSNESS () TINGLING EXTREMITIES
- () ALLERGIES () NUMBNESS () CONSTIPATION
- () SLEEP LOSS () PARALYSIS () DIARRHEA
- () FEVER () DIZZINESS () SHORTNESS OF BREATH
- () HEADACHE () DEPRESSION () BLOOD PRESSURE
- () LOSS OF BALANCE () FAINTING () HEART PROBLEMS
- () LOSS OF SMELL () COLD EXTREMITIES () STROKE
- () LOSS OF TASTE () STRESS () TENSION/IRRITABILITY

Life Style:

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Computers Standing Light Labor Heavy Labor

Habits: Smoking Alcohol Coffee/Caffeine Drinks High Stress Level
Packs/Day _____ Drinks/Week _____ Cups/Day _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that I will provide the Doctor's Office with the necessary forms and/or reports to assist said Office in making collection from my insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to the insurance company and that I am responsible for any charges not paid by my insurance company and that I am ultimately responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor(s) to treat my condition, as he or she deems appropriate throughout my spine. The x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor(s) will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

As a result of my chiropractic care I would like to:

Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle |

Patient's Signature: _____

Date: _____

Guardian/Signature of Authorization: _____

Date: _____

HIPPA HAPPENINGS

Patient Authorization regarding chiropractic care being provided in an “open adjusting” environment.

It is the practice of this office to provide chiropractic care in an “open adjusting” environment. “Open adjusting” involves several patients being seen at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an “incidental disclosures” of health information. It is our view that the kinds of matters related to an “open adjusting” environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Rodolfo D. Alfonso.

Your signature indicates your authorization of this activity.

Name (printed)

Signature

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

SUNSET CHIROPRACTIC & WELLNESS

I, _____, have received a copy of Sunset Chiropractic & Wellness' Notice of Patient Privacy Practices.

Signature of Patient

Date

**FORMULARIO PARA LA CONFIRMACION POR ESCRITO DE HABER
RECIBIDO AVISO DE LAS PRACTICAS DE PRIVACIDAD.**

Yo, _____, he recibido una copia del Aviso de las Practicas de Privacidad de Sunset Chiropractic & Wellness.

Firma del Paciente

Fecha

AUTHORIZATION TO PAY

I, _____ hereby authorize
(NAME OF INSURED)
_____ to pay directly to
(NAME OF INSURANCE COMPANY)
_____ the medical and/or
(NAME OF PHYSICIAN)
chiropractic benefits, if any, otherwise payable to me for his /her services, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by my insurance.

Signed: _____ Date: _____

**AUTHORIZATION FOR X-RAYS
(FEMALES ONLY)**

In order to protect you, the patient, we need to be assured that there is no possibility of pregnancy, should the doctor choose to order x-rays.

Please check the statement below that applies to you.

_____ There IS possibility that I am pregnant.

_____ There is NO possibility that I am pregnant.

Signed: _____ Date: _____

CONSENT TO EXAMINATION AND/OR TREATMENT

I hereby consent to be examined by Dr. _____ and receive treatment prescribed for my condition according to his findings and diagnosis. I further consent to continue treatment, if necessary, with a doctor designated by Dr. _____ to cover him/her in his/her absence.

Signed: _____ Date: _____
(IF PATIENT IS A MINOR, THIS FORM MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN)

Sunset Chiropractic & Wellness
8585 Sunset Drive #102
Miami, Fl 33143
305-275-7575 Fax: 305-275-7473

Dear Patient,

Your insurance company, _____ may send you the check(s) directly for payment of services rendered. As soon as you receive this check(s), please endorse it and bring it in with the Explanation of Benefits so we can properly credit your account.

If you fail to do so, you will be responsible for all charges.

I, _____ have read the above and agree to comply.
(Print Name)

Chart #: _____ Witness: _____

Patient Signature: _____ Date: _____

Estimado Paciente,

Su compania de seguro, _____ puede ser que le envie el pago por los services prestado directamente a usted. Ensequida que usted reciba cualquier cheque, favor de firmarlo y traerlo junto con la Explicacion de Beneficios para porder acreditar su cuenta debidamente.

Si usted falla en hacer esto, ser responsable por todos los cargos adquiridos.

Yo, _____ he leído y estoy de acuerdo con lo aqui dicho.
(Nombre de Paciente)

De Expediente: _____ Testigo: _____

Firma: _____ Fecha: _____

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

Sunset Chiropractic & Wellness

I hereby give my consent for Sunset Chiropractic & Wellness to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

Sunset Chiropractic & Wellness' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Sunset Chiropractic & Wellness reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sunset Chiropractic & Wellness Privacy Officer, Dr. Rodolfo Alfonso Sunset Chiropractic & Wellness 8585 Sunset Drive #102 Miami, FL 33143.

With this consent, Sunset Chiropractic & Wellness may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Sunset Chiropractic & Wellness may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Sunset Chiropractic & Wellness may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Sunset Chiropractic & Wellness restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Sunset Chiropractic & Wellness' use and disclosure of my PHI to carry out TPO.

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, Sunset Chiropractic & Wellness may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

SUNSET CHIROPRACTIC & WELLNESS
ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND
Insurer and Patient Read the Following in its Entirety Carefully.

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile insurance, also known as Personal Injury Protection (hereinafter PIP) and Medical Payment policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's billed are paid or applied toward a deductible I agree this will serve as benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medication, supplies, overdue interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits, then the insurer is instructed to notify the provider in writing within five days of receipt of this document. Failure to inform the provider shall result in waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without reductions and without including the patient's name as a payee on the check. To the event the PIP insurer contends there is a material representation on the application for insurance resulting in the policy of insurance declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check, which represents the difference between the medical bills and the premiums paid.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health care provider and the insurer as to the amount payable under the insurance policy. The insured and provider hereby contests and objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanied language issued by the insured and deposited by the provider shall be done so under protest, at the risk of the insured, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserved the right to seek the full amount of the bills submitted.

If the insurer schedules a defense examination or examination under oath they (herein after "EOU") the insured is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EOU or IME set by the insured. The health care provider is not the agent of the insured or the patient for any purpose.

This assignment applies to past and future medical expenses and it is valid even if undated. A photocopy of this assignment is to be considered as valid as the original. I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident. The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider, and to request and obtain a copy of any statement or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical provider, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information (declaration sheet & policy statement) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtaine any written and verbal statements the patient or anyone else provided to the insurer; obtained copies of the entire claim file and all medical records, including but not limited to, documents reports, scans, notes, bill, opinion, x-rays, IMEs, and MRIs, from any other medical provider or any insurer. The provider is permitted to produce my medical records to his attorney in connection with pending lawsuit. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior expressed written permission.

Demand: Demand is hereby made for the insured to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else are received by the insurer on the same day, the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and a claim from anyone else is received by the insurer on the same day, then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform in writing the provider of any dispute.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. If you do not completely understand this document, please ask us to explain it to you. If you sign below, we will assume you understand and agree to the above.

Patient's Name: _____ **Signature:** _____ **Date:** _____

Witness : _____ **Chart No. :** _____ **DOA :** _____

LIEN FORM

Esq: _____

Patient: _____

I do hereby authorize the above doctor/clinic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him of services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give an lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may recover said fee.

Patient's Signature: _____

Witness: _____ Date: _____ File#: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold sufficient sums from any settlement, judgment or verdict to pay said doctor's bill in full.

Attorney's Signature: _____ Date: _____

A photocopy of this document shall be considered as valid as an original.

SUNSET CHIROPRACTIC & WELLNESS
8585 Sunset Drive Suite 102, Miami, FL 33143
Phone: 305-275-7474 Fax: 305-275-7473

RECORDS RELEASE AUTHORIZATION

Patient Name: _____ **Date of Birth:** _____
SS#: _____ **Chart#:** _____

To: _____
(DOCTOR OR HOSPITAL)

(ADDRESS)

I hereby authorize and request you release my complete medical records, including all diagnostic testing, in your possession, concerning my illness and/or treatment during _____ to present.

Please Mail to:**SUNSET CHIROPRACTIC & WELLNESS**
8585 SUNSET DR.
SUITE 102
MIAMI, FL 33134

Patient name: _____ Address: _____
(Print)

Signature: _____ Witness: _____
(IF RELATIVE, STATE RELATIONSHIP)

Date: _____

SUNSET CHIROPRACTIC & WELLNESS

Phone: 305-275-7474 Fax: 305-275-7473

RECORDS RELEASE AUTHORIZATION

Patient Name: _____ Date of Birth: _____
SS#: _____ Chart#: _____

From: **SUNSET CHIROPRACTIC & WELLNESS**
8585 SUNSET DR.
SUITE 102
MIAMI, FL 33134

I hereby authorize and request you release my complete medical records, including all diagnostic testing and billing, in your possession, concerning my illness and/or treatment beginning on _____. This notice shall expire on _____.

ESQ: _____
(Name)

Address: _____

Patient name: _____ Address: _____
(Print)

Signature: _____ Witness: _____
(IF RELATIVE, STATE RELATIONSHIP)

Date: _____
