YOLARIS GARCIA, DC
*– AWESOME CHIROPRACTIC CENTER - *
PATIENT INFORMATION

LAST NAME:_____FIRST_____M_____

ADDRESS_____CITY_____STATE_____ ZIP_____

SOCIAL SECURITY #_____ HOME PHONE_____CELL PHONE_____

BIRTHDATE_____ AGE_____ SEX _____ EMAIL_____

OCCUPATION_____ MARITAL STATUS: _____ SPOUSE'S NAME: _____

REFERRED BY_____

RESPONSIBLE PARTY FOR BILLING (CHECK ONE)

1-SELF 2-SPOUSE 3-HEALTH INSURANCE 4-PARENT 5-W/COMP 6-AUTO 7-OTHER

NAME OF RESPONSIBLE PARTY _____ADDRESS, IF DIFFERENT FROM

ABOVE_____ NAME OF INSURANCE CO._____

GROUP #_____ POLICY#_____ SUBSCRIBER_____

RELATIONSHIP_____ NAME OF EMPLOYER GROUP ISSUING INSURANCE_____

NAME OF FAMILY DOCTOR/INTERNIST_____ BUSINESS PHONE_____

WAS THERE ANY HOSPITAL CARE RECEIVED FOR THIS CONDITION? IF YES, HOSPITAL'S NAME, CITY &

STATE_____

I UNDERSTAND AND AGREE THAT, REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. SHOULD MY ACCOUNT BECOME DELINQUENT, I AGREE TO PAY INTEREST ON THE OUTSTANDING BALANCE OWED AT THE MAXIMUM AMOUNT PERMITTED BY LAW. IF CENTER UNDETAKES COLLECTION EFFORTS TO RECOVER ANY PAST DUE AMOUNTS, I AGREE TO PAY ALL REASONABLE COSTS INCURRED, INCLUDING ATTORNEY'S FEES.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE TO ANY INSURANCE COMPANY, ADJUSTER OR ATTORNEY INVOLVED IN THIS CASE.

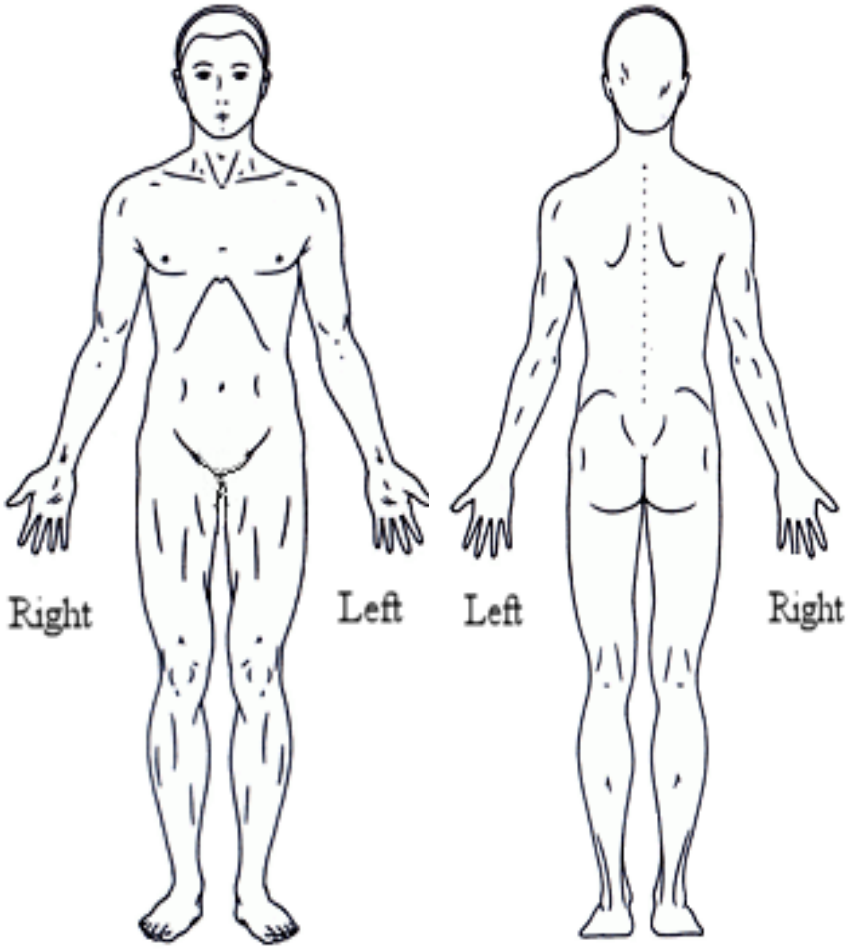
I AUTHORIZE THE DOCTOR TO INITIATE A COMPLAINT TO THE INSURANCE COMMISSIONER FOR ANY REASON ON MY BEHALF.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DOCTORS ALMALLAH, FELICIA, SUSSKIND, D'ALTERIO, EHRLICH, MOHABER, DERIENZO OR PIDDUCK FOR ANY SERVICES FURNISHED ME BY THE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT (PARENT/GUARDIAN)
SIGNATURE_____DATE_____

11730 BISCAYNE BLVD, SUITE 104, NORTH MIAMI, FLORIDA 33181
305-981-0899

YOLARIS GARCIA, D.C
11730 Biscayne Blvd. # 104 Miami, FL 33181
PH: (305) 981-0899 Fax: (305) 981-9224



Pain Chart

Patient's name _____

Signature _____

Date:_____

YOLARIS GARCIA CHIROPRACTIC CENTER, LLC / DBA AWESOME CHIROPRACTIC CENTER 11730 BISCAYNE BLVD. SUITE 104 MIAMI, FL 33181
NOTICE OF PRIVACY PRACTICES-SHORT FORM

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with brief overview of our Notice of Privacy. Our practice is complying with HIPPA's regulations.

What is HIPPA and how does the Privacy Rule affect you?
When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The privacy Rule was created to protect your rights as a patient of our practice and we are required by law to be compliant with this regulation. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information (IIHI)?
Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice?
Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of you IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted and a copy is provided in our waiting room and you can take a copy of the current notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment Reminders	Release of Information to Family/Friends
Payment	Treatment Options	Disclosure Required by Law
Health Care Operations	Health-Related Benefits and Services	

The following categories describe unique situations in which we may use or disclose your Identifiable Health Information:

Public Health Risks	Health Oversight Activities	Lawsuits and Similar Proceedings
Law Enforcement	Deceased Patients	Organ and Tissue Donation
Serious Threats to Health or Safety	Research	Military
National Security Inmates	Workers' Compensation	

What are your rights concerning your individually Identifiable Health Information (IIHI)?
What have rights regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to file a complaint
8. Right to provide an Authorization for other uses and disclosures

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.

I have read the short notice provided by South Florida Pain and Rehab of West Broward and have been informed of how to obtain more information regarding our Notice of Privacy.

_____	_____	_____
NAME	SIGNATURE	DATE

Yolaris Garcia, D. C.
11730 Biscayne Blvd. Suite 104
Miami, FL 33181
Ph: (305) 981-0899 Fax: (305) 981-9224

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic treatments and other chiropractic/medical procedures, including various forms of physical therapy and diagnostic x-ray by_____. This consent is extended to other licensed chiropractic physicians, chiropractic assistant or licensed massage therapists, who now or in the future, are employed by, working with or associated with this office.

I certify that I have the opportunity to discuss, with the doctor of chiropractic and/or other office personal, the nature and purpose of the care that is being provided. I understand that the results are not guaranteed. Further, I have been informed and I understand that, as in the practice of any of the healing arts, in the practice of chiropractic, there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that the doctor, who has explained all of these things to me, is not expected to be able to anticipate and explain all risks and complications. I will rely on the doctor to exercise appropriate judgment during the course of care, based on the facts known at this time, and in my best interest.

My signature below certifies that I have read, or have read to me the above consent. I also certify that I have had the opportunity to ask questions and options to care have been explained. By signing this consent form, I agree to the care being provided to me for the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____
Patient's name *(please print)*

_____
Witness's name

_____
Patient's signature

_____
Witness's signature

_____
Date

_____
Date

_____
if a minor or if physically or mentally impaired)

_____
Representative's relationship to patient

_____
Translated by

_____
Doctor's name

_____
Doctor's signature

YOLARIS GARCIA, D.C.
11730 Biscayne Blvd. # 104 Miami, FL 33181
PH: (305) 981-0899 FAX: (305) 981-9224

ASSIGNMENT OF INSURANCE BENEFITS

I,_____, herby assign the benefits under

policy#_____, of _____, otherwise payable to

me, but no to exceed the health care provider's reasonable charges, to
_____.

I authorize and direct that payment for covered services be made by my insurer to
_____.

Dated this _____ day of _____, 20_____.

_____	_____
PATIENT NAME	**WITNESS NAME**
_____	_____
PATIENT SIGNATURE	**WITNESS SIGNATURE**

YOLARIS GARCIA, D.C.
11730 Biscayne Blvd. Suite 104
Miami, Florida 33181
Tel: (305) 981-0899 Fax: (305) 981-9224

Past Medical History Questionnaire

Patient Name		Date of Birth	
Reason for visit		Date of injury /onset	
Have you ever received therapy for the condition mentioned above? ☐ Yes ☐ No		If so, when?	
Treatment Received:		Previous Treatment:	☐ Successful ☐ Unsuccessful

Do you now or have you ever had any of the following?

Condition:	Y	N	Condition:	Y	N	Condition:	Y	N
Arthritis	☐	☐	Diabetes	☐	☐	Thyroid Problems	☐	☐
Osteoporosis	☐	☐	Anemia	☐	☐	Headaches	☐	☐
High Blood Pressure	☐	☐	Hypersensitivity to Heat/Cold	☐	☐	Head Injury / Concussion	☐	☐
Heart Disease	☐	☐	Swelling in Ankles	☐	☐	Hernia	☐	☐
Heart Attack	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐	Kidney/Bladder Problems	☐	☐
Pacemaker	☐	☐	Seizures/Epilepsy	☐	☐	Previous Surgeries	☐	☐
Vascular Disease	☐	☐	Metal in Body or Surgical Implants	☐	☐	Hearing Loss	☐	☐
Stroke	☐	☐	Cancer/Tumor	☐	☐	Depression	☐	☐
Asthma	☐	☐	Current infection(s)	☐	☐	Anxiety	☐	☐
Shortness of Breath	☐	☐	Tuberculosis	☐	☐	Substance Abuse	☐	☐
Recent Weight Loss or Gain	☐	☐	Hepatitis	☐	☐	Other	☐	☐
Chronic Cough	☐	☐						
Fainting Spells	☐	☐						

If you answered "yes" on any of the above, please explain and give approximate date(s):

Do you have any allergies? ☐ Yes ☐ No. If yes, please list allergies:

Are you presently taking any medications? ☐ Yes ☐ No. If yes, please list and specify condition.

Medical Records will be requested from:

The information is correct to the best of my knowledge.

X	
Patient/Parent/Guardian Signature	Date

YOLARIS GARCIA CHIROPRACTIC CENTER, L.L.C.
D/B/A/ AWESOME CHIROPRACTIC CENTER
11730 Biscayne Blvd. Suite 104
Miami, FL 33181
Ph: (305) 981-0899 Fax: (305) 981-9224

PATIENT AUTHORIZTION FOR USE AND DISCLOSURE OF PROTECTION HEALTH INFORMATION IN COMPLIANCE WITH HIPPA

By signing this authorization, I authorize_____to use and/or disclose certain protected health information (PHI) about me to _____,11730 Biscayne Boulevard #202, North Miami, Florida 33181 tel: (305)981-0899 fax: (305)981-9224

This authorization permits:_____to use and/or disclose the following individually identifiable health information about me:_____

All medical records including but not limited to reports, progress notes, diagnostic studies, consult notes, radiology studies, x-rays, MRI, CAT scans, or any other writings in my medical chart and medical bills for services rendered.

REQUIRED DISCLOSURE-45 CFR 164.508C

A. This protected health information is to be used for the following purposes: a civil legal claim or proceeding.
B. This authorization may be revoked by a signed and properly dated written revocation, delivered to the healthcare provider named above, provided that his release cannot be revoked as to protected health information that had been previously released in reliance on this document.
C. The undersigned acknowledges that a refusal to sign this form will not result in a denial of healthcare by the hospital and any other healthcare provider and, that this release has not been coerced by a healthcare entity or any of its business associates.
D. The individual acknowledges that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies, and even may become public record if filed with the court of law.
E. This authorization will expire twelve (12) months after the date executed, unless earlier revoked in writing.

ALL PRIOR AUTHORIZATIONS ARE CANCELLED AS OF THIS DATE

Name:_____ DOB:_____

Signature:_____ SS:_____

Date:_____

A copy of this authorization shall be treated as an original