AFFILIATED HEALTHCARE CENTERS

South Miami: 8000 SW 67 Avenue Miami, FL 33143
Homestead: 941 N. Krome Avenue Homestead, FL 33030
West Kendall: 15118 SW 72 Street Miami, FL 33193

Broward: 2901 W Oakland Park Blvd. A23 Ft. Lauderdale, FL 33311
Pembroke: 9091 Pembroke Road Pembroke Pines, FL 33025
Tavernier: 90290 Overseas HWY Suite 110 Tavernier, FL 33070

Date: ____/____/____

OFFICE USE ONLY:
☐ AUTO ☐ W/C ☐ IME ☐ PI _____
☐ CASH ☐ INS
CHART #: _____

PHYSICIAN: _____

PATIENT INFORMATION:

PATIENT NAME: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____ MALE ☐ FEMALE ☐

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

☐ SINGLE ☐ MARRIED ☐ WIDOWED SPOUSE'S NAME: _____

ARE YOU PREGNANT? ☐ YES ☐ NO IF YES, HOW MANY MONTHS? _____

DATE OF INJURY: ____/____/____

EMPLOYMENT:

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: _____

EMERGENCY CONTACT:

NAME: _____ PHONE #: _____ RELATIONSHIP: _____

***INSURANCE INFORMATION*: (AUTO & W/C)**

COMPANY: _____ PHONE: _____

POLICY #: _____ CLAIM: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

***INSURANCE INFORMATION*: (HEALTH)**

COMPANY: _____ PHONE: _____

POLICY #: _____ GROUP #: _____

NAME OF INSURED: _____ RELATIONSHIP: _____

COMPLAINTS

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

PATIENT SIGNATURE: _____ Date: ____/____/____

PARENT/GUARDIAN SIGNATURE: _____ Date: ____/____/____

OFFICE FOR CIVIL RIGHTS

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Get It.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.

You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file. In most cases, the file should be updated within 60 days.

Know Who Has Seen It.

By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- **Learn how your health information is used and shared by your doctor or health insurer.** Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got new health insurance, but you can ask for another copy anytime.
- **Let your providers or health insurance companies know if there is information you do not want to share.** You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider or pharmacy does not need to get paid by your insurance company.

- **Ask to be reached somewhere other than home.** You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

To learn more, visit **www.hhs.gov/ocr/privacy/**.

For more information, visit **www.hhs.gov/ocr**.

U.S. Department of Health & Human Services
Office for Civil Rights

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have read a copy of Affiliated Healthcare Centers, Inc.'s Notice of Patient Privacy Practices.

PATIENT SIGNATURE: _____ Date: **/ /**

PARENT/GUARDIAN SIGNATURE: _____ Date: / /

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INFORMED CONSENT FOR TREATMENT

Upon choosing Affiliate Healthcare Centers, Inc. as my healthcare provider, I do hereby give me permission and authorization to the doctor(s) and their assistants to care for me in accordance with diagnostic tests and analysis. This may include medical examinations, x-rays, chiropractic adjustments, physical therapy, blood work, non-invasive diagnostic testing, or whatever my treating doctor deems advisable. I have had the opportunity to ask questions and discuss the nature and purpose of the above-named procedures, including the risks and complications involved, with the doctor. I acknowledge that no guarantee has been made to me as to the results that may be obtained.

PATIENT NAME:_____ CHART #: _____

PATIENT SIGNATURE: _____ DATE: _____/____/_____

WITNESS: _____

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** a possibility that I am pregnant

_____ There is **NO** possibility that I am pregnant

PATIENT SIGNATURE: _____ DATE: _____/____/_____

WITNESS: _____