MEC • CA
INTEGRATED MEDICAL

CONSENT FOR CHIROPRACTIC AND PHYSICAL THERAPY TREATMENT

1. I hereby authorize Dr. Sapienza, Dr. Curreri, Dr. Hamdan, Dr. Poretsky, Dr. Ploshnick, and such assistants as may be selected by my physician to evaluate or treat the following condition or conditions which appear to be indicated by my symptoms and physician findings: low back pain, neck pain, radicular pain, reduced range of motion, headaches, extremity pain, and/or post-operative rehabilitation.

2. The procedure(s) necessary to evaluate or treat my condition along with possible alternative treatments has/have been explained to me by Dr. Sapienza, Dr. Hamdan, Dr. Poretsky, Dr. Ploshnick, Mr. Schena and/or Ms. Mendez and I understand the nature of the procedure to be: chiropractic care, IDD Therapy, physical therapy, massage therapy, and/or class IV laser treatment.

3. The assessment of the likelihood that the procedure will accomplish the desired objectives has been explained to me.

4. It has been explained to me that during the course of the procedure, unexpected conditions may be found that might require a different procedure(s) than the one originally planned. I, therefore, authorize and request the above-named physician and assistants to perform such procedures as are necessary to best treat the condition found at the time of my procedure.

5. I have been made aware of the significant risks, benefits, and alternatives associated with the proposed procedure(s). The major risks include, but are not limited to: general muscle soreness, treatment area discomfort, headache, fatigue, nausea/dizziness, and/or inflammation. I am aware that some uncommon risks are unpredictable and unforeseeable including vertebral artery desiccation. I am also aware that no guarantees have been made regarding the results of the procedure.

6. I have been made aware of the relevant risks, benefits, and side effects related to alternatives, including not receiving the proposed care, treatment, or services.

7. If my physician or a member of the practice's staff is exposed to one of my body fluids during this procedure, I consent to the testing of my blood for the Human Immunodeficiency Virus (HIV) and Hepatitis B and C. The test results will be shared with the above-named physician, appropriate health care workers, and the involved employee.

8. Based on the above discussion, I fully consent to treatment.

By signing this Consent for In-Office Procedure, you acknowledge that you have read and understand the foregoing.

CLINIC DIRECTOR

Name: Michael Sapienza, DC
Date:_____

PATIENT

_____

Name:_____
Date:_____

If the patient is unable to sign or is a minor, then complete the following:
Patient is a minor (_____ years of age) or unable to sign because:_____

WITNESS

_____

Name:_____
Date:_____

RESPONSIBLE PARTY

_____

Name:_____
Date:_____
Relationship to Patient: _____

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ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM

FINANCIAL RESPONSIBILITY

I have requested professional services from Mecca Integrated Medical Center, LLC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to the Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payments to the Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA AUTHORIZATION

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; (2) the right and ability to act on my behalf to pursue such claim, right , or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031 (b) (3) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective as the original.

Policy Holder Name: _____ Signature: _____ Date: _____

Patient: _____ Signature: _____ Date: _____

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CONSENT FOR DISCLOSURE OF PATIENT INFORMATION

The Privacy Rule that is contained in HIPAA establishes a federal requirement that health care providers obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO). This must be obtained before information may be used or disclosed for TPO purposes, except in emergency situations.

The following information must be included in a patient record release form used by the Practice to be in compliance with HIPAA requirements.

I understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. I have the right to review the provider's "notice of privacy practices" before I sign this consent. The provider reserves the right to change the terms of the notice of privacy practices. Changes in the privacy practices will be made available to me. I may request additional restrictions on access to this information for treatment, payment or health care operations purposes. I understand that the provider may not be able to comply with this request. I request the following special restriction(s):

_____

_____

_____

I understand that from time to time my physician and his/her staff may inform me of new treatments, or other services that may be appropriate for my condition and from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.). I consent to the use of my identifiable patient information to notify me of such new treatments, or other services that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health with the understanding that the provider will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

I understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my patient record.

I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

Patient: _____ Signature: _____ Date: _____

MECCA
INTEGRATED MEDICAL

Please take a moment to familiarize yourself with Mecca Integrated Medical Center's updated 2014 policies and procedures.

- Studies completed by North American Medical, the makers of the Accuspina, demonstrate patients reach maximum medical improvement at 25 visits. After 25 visits per year, patients will no longer be candidates for decompression sessions on the Accuspina. However, there are many benefits to continuing physical therapy and chiropractic care, so prior to completing your 25th visit Dr. Sapienza will review your wellness protocol and treatment.

- Certain Horizon 'Out of Network' plans will send insurance checks to our patients for treatment rendered at this office. These checks are the property of Mecca Integrated Medical Center and/or its treating providers. Checks accompanied by the Explanation of Benefits are expected to be signed over and delivered to our office within a 24 hour period. Failure to do so may result in the patient being sent to collections.

- Patients are required to fulfill their co-payment prior to receiving treatment at each visit. We will no longer treat patients with outstanding balances of $50 or more until their payment has been remitted.

- Cancellations are only permitted during real emergency situations. We reserve the right to apply a $25 fee for patients that cancel within 24 hours of their appointment time, or are a "no show" to an appointment.

These policies have been created in an effort to better serve our patients. The staff at Mecca Integrated Medical Center is dedicated to providing quality medical care to all our patients.

Sign: _____ **Date: _____**