PERSONAL INJURY PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____

Sex M☐ F☐ Sex at Birth M☐ F☐

Home Address _____ City _____ State ____ Zip _____

Home Phone (___)_____ Business Phone (___)_____

Cell Phone (___)_____ Email Address _____

Social Security # _____ Occupation _____

Employer _____ Employers Phone # _____

Marital Status _____ Spouse/Partners Name _____

Your Auto Insurance Company _____ Policy # _____

Claim # _____ Adjusters Contact # _____

Primary Care Physician _____ Attorney Name _____

Referred By _____

AUTHORIZATION TO RELEASE AUTO INSURANCE INFORMATION AND/OR PIP BENEFIT PAYOUT INFORMATION

I hereby grant my authorization for 22 Health Group, LLC. to request and obtain my PIP insurance policy benefits for the accident previously noted. I also hereby authorize and direct my insurer to send to 22 Health Group, LLC. an accounting ledger showing all PIP benefit payouts for the previously noted accident.

Patient Signature _____ Date Signed_____

ASSIGNMENT OF PIP BENEFITS

I hereby assign my PIP automobile insurance policy benefits relating to the above captioned accident to 22 Health Group, LLC. for professional services rendered and covered under my PIP and/or medical payments policy. All payments for such services shall be forwarded directly to 22 Health Group, LLC.. All payments will be overdue if not paid within the allowed 30-day period after the insurer is furnished with properly completed claim form and medical records. Overdue payments will bear 10% interest per annum. In the event an insurer fails to pay 22 Health Group, LLC. the full amount of the treatment allowed by current fee schedules, I authorize and direct the insurer to set aside/escrow an amount equal to the full amount of any such reduction until 22 Health Group, LLC. has exercised its rights under this assignment and the dispute is resolved. This assignment will remain in effect until 48-hours after 22 Health Group, LLC. receives written notice that it is being revoked. It is specifically agreed that any such revocation of this assignment will not apply to any treatment or associated expenses incurred on or before the date of notice of revocation is received by 22 Health Group, LLC.. The undersigned agrees to pay any applicable deductible and/or copayments not covered under the available PIP and/or medical payments policy. Furthermore, the undersigned agrees to pay all outstanding balances in excess of the available insurance coverage limits.

Patient Signature _____ Date Signed _____

LETTER OF PROTECTION

22 Health Group, LLC has agreed to provide services for the above named patient. 'Services' is defined to include supplies. In exchange for not requiring full payment at the time of service, the patient has agreed to execute this letter of protection and we have agreed to accept this letter of protection. The patient hereby agrees to pay the billing for our services from any recovery obtained by the patient due to the above noted accident. This letter of protection is intended to be a legally enforceable agreement requiring the attorney(s) and/or law firm representing the patient to pay the billing for our services from any recovery obtained for the patient. Accordingly, this letter of protection included both the signature of the patient and the authorized signatory of the patient's attorney(s), agreeing to pay the billing for our services from any recovery obtained for the patient. At the time of any recovery on behalf of the patient for the above noted accident, the attorney(s) agree to request in writing the balance due from our office and we agree to respond in writing stating the balance owed for services related to the above noted accident.

The attorneys for the patient agree that any outstanding bill for services owed to us by the patient due to the above noted accident shall be paid directly to us form the amount recovered and collected, if such amount is adequate to cover the bill. The "amount recovered" for the patient shall be defined as the gross sum received, less payment of our attorney's fees and client costs, and also less statutory liens that take priority over this letter of protection. If the patient objects to the amount of the bill, the attorney(s) agree to hold in their trust account an amount sufficient to pay the entire bill or that portion of the amount recovered that is available to pay the bill, whichever is less. The only exception would be upon an Order of a Court of competent jurisdiction directing the payment of such funds. If, after a reasonable period, there appears to be no agreement between us and the patient, the attorney(s) will notify both the patient and us that the entire amount held to pay the bill will be deposited with the Clerk of the Court in the County in which the funds are being held in trust and shall be made the subject of an interpleader action. It is intended the patient's signature on this agreement is an irrevocable letter of protection directing payment of our bill by any subsequent attorney of the patient for the above-noted accident. If the patient obtains a recovery and has no attorney at the time of such recovery, it is intended this agreement by the patient is a direction to any party paying such recovery to honor this letter of protection. This letter of protection does not eliminate or compromise the obligation of the patient to pay the billing for our services if there is a no recovery obtained by the patient.

I have reviewed, understand, and agree to the terms of this letter of protection:

Patient _____ Date _____

Doctor _____ Date _____

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ☐ or have had read to me ☐ the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

22 HEALTH GROUP, LLC 1052 West SR 436 Suite 1070 Altamonte Springs, FL 32714

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____	_____	_____
Patient Name	Signature of Patient	Date

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to 22 Health Group, LLC.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. The Notice of Privacy Practices for the Chiropractor is also posted in the waiting room at 22 Health Altamonte. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____	_____	_____
Printed Name	Signature of Patient	Date

MEDICAL RELEASE

Authorization to Release Information

Patient Name _____ DOB _____ Phone_____

Address _____ City _____ State _____Zip _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken already. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and State law which prohibits disclosures without specific written authorization of the undersigned or as otherwise permitted by such regulations.

I authorize _____ to release medical records to or receive from as listed:

☐ Entire Record ☐ MRI _____

☐ X-Rays ☐ Other _____

☐ Release to

_____

☐ Insurance Company (ies) _____

☐ Other _____

_____ _____ _____

Printed Name Signature of Patient Date

Hormone Health Assessment

Please fill out this form so we may assess your hormone optimization. If you are uncomfortable answering some questions, please indicate at the bottom of the form and our patient liaison will call you to discuss your symptoms and concerns. Hormone optimization can affect the outcome of your care and provide you with additional options to ensure proper healing from your injuries.

	Yes	No
Do you use products that contain nicotine?	☐	☐
Do you consume alcohol?	☐	☐
Do you exercise regularly?	☐	☐
Are you happy with your current weight?	☐	☐

How many bowel movements per day? _____

How many hours of uninterrupted sleep per night? _____

Rate the following symptoms with a number between 0 – 10 (0 = Low) and (10 = High)

Morning Energy _____	Stress _____	Pain _____
Afternoon energy _____	Anxiety _____	Memory _____
Loss of muscle mass _____		

Rate the following symptoms with a number between 0 – 10 (0 = None) and (10 = Severe)

Hair loss _____	Dry skin _____	Mood instability _____
Difficulty falling asleep _____	Hot or cold intolerance _____	Loss of motivation _____
Difficulty staying asleep _____	Difficulty with urination _____	Acid reflux _____
Night sweats _____	Urinary leakage _____	Hot flashes _____

Males:	**Females:**
Erection quality _____	Vaginal dryness _____
Difficulty achieving orgasm _____	Difficulty achieving orgasm _____
Nipple sensitivity _____	PMS symptoms _____
	Heavy periods _____

If qualified by this assessment, our patient care liaison will reach out to you for a private discussion of your assessment and treatment options. How would you prefer to be contacted?

(Print)Name_____ **Phone** _____ **Email**_____

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