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 (_____) _____________________________ E-mail Address ____

Social Security # ______________________________ Occupation ____

Employer ____ Employer's Phone __________________________________

Marital Status _________________ Spouse/Partners Name ____

Referred By ____

Primary Care Physician ____

AUTHORIZATION TO BILL HEALTH INSURANCE/ASSIGNMENT OF BENEFITS

I __________________________ (print name) do hereby give full permission and authorize 22 Health Group, LLC and its locations to bill my health insurance company for services rendered by 22 Health Group, LLC. I also agree to have any checks or payment made by my health insurance company to be payable and deliverable to:

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

By signing this document I also agree to the following statements below:
I understand that I am responsible for understanding information about my health insurance policy and providing such information to 22 Health Group, LLC for correct billing. I am also responsible to notify 22 Health Group, LLC in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

I understand that 22 Health Group, LLC will be providing services and billing my health insurance for those services at various times during the course of my care at this office. I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at 22 Health Group, LLC during my care. I also understand that my insurance company and related policy plan may offer benefits for services provided at 22 Health Group, LLC, but that such benefits do not necessarily guarantee payment for those services.

I understand that the policy of 22 Health Group, LLC requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. If my account is not paid within 90 days of the date of service and no other financial arrangements have been made, I will be responsible for all legal fees, collection agency fees, and any other expenses incurred in collecting my account (normal charge -33% in addition to your outstanding balance due in our office). I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert 22 Health Group, LLC of any change in my medical status or insurance coverage.

The undersigned does agree to observe and abide by all of the statements made above.

______________________________________ ______________________________
Patient's Signature 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.

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

______________________	______________________	______________________
Patient Name	Signature of Patient	Date

HIPAA FORM

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. 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 RECORDS 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, as named above, authorize __________________________________ to release medical records to or receive from as listed:

_____Entire Record _____ MRI ____

_____X-Rays _____ Other ____

_____Release To ____

_______________________________ ______________________________________ __________________________

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

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

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

Males:

Erection quality _____
Difficulty achieving orgasm _____
Nipple sensitivity _____

Females:

Vaginal dryness _____
Difficulty achieving orgasm _____
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**________________________