PERSONAL INJURY PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____

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 _____

Your Auto Insurance Company _____ Policy # _____

Effective Date _____ Name on Policy (if other than self) _____

Claim # _____ **Primary Care Physician** _____

Attorney Name _____

22 Health Group, LLC.
1052 West State Road 436 Suite 1070 Altamonte Springs, FL 32714
Ph (407) 951-8921 Fax (407) 951-8926

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 _____

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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

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

_____Entire Record _____ MRI _____

_____X-Rays _____ Other _____

_____ Release to **22 Health Altamonte, Series**
1052 West State Road 436 Suite 1070
Altamonte Springs, Fl. 32714
Fax- 407-951-8926

_____Insurance Company (ies) _____

_____Other _____

_____ _____ _____

Printed Name Signature of Patient Date

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PATIENT RESPONSIBILITY AGREEMENT

Patient Information:

Name _____ Age _____ Date of Birth _____

Home Address: _____

_____

_____

_____

Home Phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____

E-mail Address _____

Social Security #_____ Occupation_____

Employer_____ Employer's Phone(____) _____

Marital Status _____ Spouse/Partners Name _____

Primary Care Physician _____

_____

Accident/Claim Information

Date of Loss _____ Type of Loss _____

At Fault Party(ies) _____

At Fault Party Insurer _____

Policy No. _____

Attorney Name _____

Law Firm _____

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Agreement

22Health Group, LLC ("22 Health") and its locations, have agreed to provide services for the patient named above (the "Patient"). Patient understands that he/she is obligated to pay for the health care items and services provided by 22 Health. Patient also understands and agrees that payment is ordinarily due at the time such items and services are rendered. However, in lieu of requiring immediate payment at the time of service, Patient has agreed to execute this Patient Responsibility Agreement and 22 Health has agreed to accept this Patient Responsibility Agreement. Patient understands that this is a legally binding obligation to pay 22 Health for all health care items and services it provided to Patient regardless of the outcome of Patient's claim/lawsuit.

Patient expressly agrees and states that he/she was not referred to 22 Health for treatment under this Patient Responsibility Agreement by his/her attorney, or any other individual.

Patient agrees and states he/she discussed all payment options available to 22 Health patients, including, but not limited to, billing Patient's auto insurance, paying Patient's deductible/copayment/coinsurance, entering into a promissory note, and self-pay at the time of service. After consideration of all payment options, Patient elected to enter into this Patient Responsibility Agreement.

As consideration for 22 Health's agreement to defer payment Patient hereby agrees to pay all fees for 22 Health's services from any recovery obtained by him/her arising out of or related to the claim, accident, injury, or lawsuit identified above. The rates for 22 Health's services shall be as set forth on a separate rate sheet provided to me, or, in the event none is provided, as described in Section 768.0427, Fla. Stat.

This Patient Responsibility Agreement is intended to be a legally enforceable agreement requiring Patient's attorney(s) and/or the law firm representing Patient to council on behalf of this agreement and pay the bills for 22 Health's services from any recovery obtained for or on behalf of Patient, whether through verdict or settlement. By signing this Patient Responsibility Agreement, Patient and his/her attorney(s) and/or law firm representative expressly agree to pay the costs of the healthcare items and services provided by 22 Health directly to 22 Health directly from any recovery obtained for or on behalf of Patient.

At the time of any recovery for or on behalf of Patient for the claim, accident, injury, or lawsuit identified above, Patient shall cause his/her attorney(s) to make a written request for the balance due from 22 Health's office shall provide a written summary of the charges which shall be, to the extent reasonably possible, itemized to include the date(s), service(s), CPT/HCPCS code(s), and any other information required by Chapter 768, Fla. Stat., and shall include the total balance owed for all such services related to the claim, accident, injury, or lawsuit.

By signing below, Patient expressly authorizes his/her attorney(s) and/or law firm(s) agrees to pay 22 Health's outstanding charges directly from the amount recovered and collected, prior to any disbursement to Patient. The "amount recovered" for Patient shall be defined as the gross sum received, less payment of his/her attorney's fees and costs, and also less any statutory liens with priority over the one created by this Patient Responsibility Agreement.

If Patient objects to the amount of the bill, or any charges therein, the patient attorney(s) shall pay 22 Health that portion which is s not in dispute and agree to hold in his/her/their trust account an amount sufficient to pay the disputed amount until such time as 22 Health and Patient amicably resolve the matter. If, after a reasonable period, 22 Health and Patient cannot reach an agreement, Patient's attorney(s) shall deposit the disputed amount with the Clerk of the Court in Orange County, Florida, and 22 Health and Patient shall be required to litigate the matter. The prevailing party in such litigation shall be entitled to his/her/its attorney's fees and costs incurred in the dispute.

It is intended the patient's signature on this agreement grants an irrevocable Patient Responsibility Agreement directing payment of 22 Health's bill for health care items and services by any current or subsequent attorney representing Patient in the claim, accident, injury, or lawsuit identified below. If Patient obtains a recovery and has no attorney at the time of such recovery, it is intended this agreement by Patient is a direction to any party paying such recovery to honor this Patient Responsibility Agreement. This Patient Responsibility Agreement does not eliminate or compromise the obligation of the patient to pay the billing for our services if there is no recovery obtained by the patient.

I have reviewed, understand, and agree to the terms of this Patient Responsibility Agreement:

Signature for Patient	Date
Print	Relationship to Patient
22 Health	Date
Print	Title

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