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 _____

Primary Care Physician _____ Attorney Name _____

Referred by _____

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

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

_____ _____ _____

Patient Name | Signature of Patient | Date

HIPPA 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 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

PATIENT RESPONSIBILITY AGREEMENT

Patient Information:

Name _____ age _____ date of birth _____

Address: _____

_____

_____

_____

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

Cell Phone (___) _____

Mailing address _____

Social #_____ Occupation _____

the employer _____ Employer's phone (____) _____

Marital Status _____ Name of Spouse/pareja_____

Primary Care Physician _____

_____

Accident/Claims Information

Date of Loss _____ Type of Loss _____

At-fault party(s)_____

Part culpable_____

Insurer Policy No. _____

Attorney's Name _____

Law Firm _____

Agreement

22Health Group, LLC ("22 Health") and its locations, have agreed to provide services for the patient named above (the "Patient"). The patient understands that they are obligated to pay for health care items and services provided by 22 Health. The patient also understands and agrees that payment is normally due at the time such items and services are rendered. However, instead of demanding 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 provided to Patient, regardless of the outcome of Patient's claim/demand.

Patient expressly agrees and represents that either his attorney or anyone else referred him or her to 22 Health for treatment under this Patient Responsibility Agreement.

Patient agrees and represents that he or she discussed all payment options available to 22 Health patients, including, but not limited to, billing for the patient's auto insurance, payment of the patient's deductible/copayment/coinsurance, underwriting a promissory note, and self-payment at the time of service. After considering all payment options, Patient elected to enter into this Patient Responsibility Agreement.

In consideration for 22 Health's agreement to defer payment, Patient agrees to pay all fees for 22 Health's services of any recovery obtained by him/her arising out of or related to the claim, accident, injury, or lawsuit identified above. Fees for 22 Health's services will be as set forth in a separate fee 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 that requires Patient's attorneys and/or the law firm representing Patient to join together on behalf of this agreement and pay bills for 22 Health's services of any recovery obtained for or on behalf of Patient, either through a verdict or a 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 health care 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 the Patient for the claim, accident, injury, or lawsuit identified above, the Patient will have his/her attorney(s) make a written request for the balance due from the 22 Health office to provide a written summary of the charges that will be, to the extent reasonably possible, detailed to include the date(s), service(s), CPT/HCPCS code(s), and any other information required by Chapter 768, Fla. Stat., and will include the total balance due for all services related to the claim, accident, injury, or lawsuit.

By signing below, Patient expressly authorizes his/her attorney(s) and/or law firm(s) to pay 22 Health's outstanding charges directly from the amount recovered and collected, prior to any disbursement to Patient. The "amount recovered" for the Patient shall be defined as the gross sum received, menos el pago de los honorarios y costos de su abogado, y también menos cualquier gravamen legal con prioridad sobre el creado por este Acuerdo de Responsabilidad del Paciente.

If Patient objects to the amount of the bill, or any charges thereon, the patient's attorney(s) shall pay 22 Health the undisputed portion and agree to hold in its trust account an amount sufficient to pay the disputed amount until such time as 22 Health and Patient resolve the matter amicably. If, after a reasonable period of time, 22 Health and Patient is unable to reach an agreement, the Patient's attorney(s) will deposit the disputed amount with the Clerk of Court in Orange County, Florida, and 22 Health and Patient shall litigate the matter. The prevailing party in such litigation will be entitled to its attorney's fees and costs incurred in the dispute.

It is intended that the patient's signature on this agreement will grant an irrevocable Patient Responsibility Agreement mandating payment of 22 Health's bill for health care items and services by any current or subsequent attorney representing the Patient in the claim, accident, injury, or lawsuit identified below. If Patient obtains recovery and does not have an attorney at the time of such recovery, this Patient agreement is intended to be an instruction for any party paying such recovery to comply with this Patient Responsibility Agreement. This Patient Responsibility Agreement does not remove or compromise the patient's obligation to pay the billing for our services if the patient does not obtain a recovery.

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

_____	_____
Patient Signature	Date
_____	_____
Patient Name	Patient Relationship
_____	_____
22 Health Group LLC.	Date
_____	_____
Name	Title