CREATIVE NATURAL HEALTH dba
EMBASSY LAKES ACCIDENT & INJURY CENTER

Name: ____________________________________ **Address:** ____

City /State/Zip______________________________________ **Social Security #**:____________________________________

Birth Date: ___________ **Age:** __________ **Height:** ___________ **Weight:** ___________ **Sex:** Male Female

Home Phone: ____________________________________ **Work Phone:**____

Mobile Phone: _________________________________ **Email:** ____

Emergency Contact Name:__________________________________ **Telephone:**________________ **Relation:** _________

Primary Care Doctor: ______________________________ **Primary Care Doctor Phone:** ___________________________

Primary Care Doctor Address: ____

Occupation: _________________________________ **Employers' Name:** ____

Marital Status: Single Married Divorced Widowed. **Spouses Name:** _____________________________________

Do you have an Attorney? Yes No **Name:** ____

Emergency Contact Name:____ **Telephone:**____________________________

Date of Injury: ________________________________ **Time:** _________________________ **AM or PM**

State how the accident happened: ____

____

____

Did you report the injury? Yes No **To whom?** ____

Name and address of responsible party: ____

Phone Number and Contact Name: ____

Do you have health insurance? _________ **Insurance Company:** ____

Insured's Name: ______________________________ **Member/ID#:** ________________________ **Group #:** ___________

Insured's Birth Date: _________________________ **Insured's Employer:** _______________________________________

CREATIVE NATURAL HEALTH, PLLC dba EMBASSY LAKES ACCIDENT & INJURY CENTER
INFORMED CONSENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill. I hereby authorize physicians and staff at CREATIVE NATURAL HEALTH, PLLC to treat my condition as deemed appropriate. It is understood and agreed the amount paid the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of CREATIVE NATURAL HEALTH, PLLC responsible for any errors or omissions that I may have made in the completion of this form. Chiropractic, as well as many other types of health care, is associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment. Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns- Heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs you should report it to your doctor, or a staff member at CREATIVE NATURAL HEALTH, PLLC.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No. 2, June,1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Other Problems- There are occasionally other types of side effects associated with chiropractic care. While these are rare, they should be reported to your doctor promptly.

If you have any questions concerning this form or the above statements, please ask your doctor.

Having carefully read the above, I hereby give my informed consent to have chiropractic treatment administered.

X_______________________________ ___________________

Signature of Patient or Parent or Legal Guardian — Date

CONTACT PREFERENCES

May we call/leave a message on your home telephone number? YES NO

My home is my (circle one) **PRIMARY SECONDARY TERTIARY N/A** preference for contact.

May we call/leave a message on your work telephone number? YES NO

My work is my (circle one) **PRIMARY SECONDARY TERTIARY N/A** preference for contact.

May we call/leave a message on your mobile telephone number? YES NO

My mobile is my (circle one) **PRIMARY SECONDARY TERTIARY N/A** preference for contact

Are you interested in receiving appointment reminders/messages via text message? YES NO **Carrier Name**__________________

Are you interested in receiving appointment reminders/messages via e-mail? YES NO

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ______________________________, have read a copy of Creative Natural Health, PLLC Notice of Patient Privacy Practices.

(Patient Name)

X _______________________________ ___________________

Signature of Patient or Parent or Legal Guardian — Date

SNF

CREATIVE NATURAL HEALTH, PLLC dba EMBASSY LAKES ACCIDENT & INJURY CENTER

POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint CREATIVE NATURAL HEALTH, PLLC, and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said CREATIVE NATURAL HEALTH, PLLC which checks, drafts or money orders are made payable for services which have been made by CREATIVE NATURAL HEALTH, PLLC, at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows CREATIVE NATURAL HEALTH, PLLC, or any of its agents to sign any paper that will be necessary to enhance, expedite, and/or allow payment to said provider. This may include, but is not limited to, affidavits of non-ownership of vehicles, insurance forms, other statements and appeals as necessary (i.e. reductions or denied claims and/or procedures).

The undersigned by these presents does give and grant the said CREATIVE NATURAL HEALTH, PLLC as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to CREATIVE NATURAL HEALTH, PLLC, or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, ______________________________________ hereby authorize __________________________________
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by CREATIVE NATURAL HEALTH, PLLC, but not to exceed the charges of those services, payable to and mailed directly to:

CREATIVE NATURAL HEALTH, PLLC
2565 N HIATUS ROAD
COOPER CITY, FL 33026

Furthermore, I hereby IRREVOCABLY ASSIGN to CREATIVE NATURAL HEALTH, PLLC., the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by CREATIVE NATURAL HEALTH, PLLC.

IN WITNESS WHEROF the undersigned have hereunto set their hands, this ________ day of ______________________ 200__.

X____ ____
PATIENT'S SIGNATURE PATIENT'S NAME (PLEASE PRINT)

Creative Natural Health, PLLC dba Embassy Lakes Accident & Injury Center-Norman C. Adelkopf, DC
2565 N Hiatus Road, Cooper City, FL 33026

STANDARD MEDICAL LIEN/LETTER OF PROTECTION

I, ____ here within referred to as "patient", do hereby authorize Norman C. Adelkopf, DC./ Creative Natural Health, PLLC dba Embassy Lakes Accident & Injury Center (hereinafter "this provider") to furnish me and/or my attorney(s), with pre-paid copies of the medical records relevant to my injury or accident. I further authorize and direct my attorney to pay directly to this provider, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement, insurance proceeds of any kind or judgment as may be necessary to adequately protect and pay for my treatment. While I am injured and need care, I cannot financially afford to pay your bill at the time of services are rendered. I, therefore, grant this provider a lien on my claim against any and all proceeds of any settlement, insurance benefits or judgment which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated for/or other related services. I understand that this provider has agreed to provide me with quality medical services and to wait for payment as a courtesy to me until such time as my potential claim against either the person or the entity which caused my injuries or the insurance company providing said person with insurance resolves. **We understand insurance companies have unlimited resources, will hire defense lawyers and defense experts that will cause our payment to be delayed for months or years.**

HOWEVER, REGARDLESS OF THE OUTCOME OF THE TRIAL AND REGARDLESS OF WHAT THE JURY AWARDS, THE PATIENT SHALL REMAIN LIABLE TO THE PHYSICIAN FOR MEDICAL SERVICES RENDERED. THE PATIENT'S BILL IS NOT CONTINGENT ON TESTIMONY FROM HIS/HER HEALTHCARE PROVIDER AND THE HEALTHCARE PROVIDER SHALL ONLY BE REQUIRED TO TESTIFY IF SUBPOENAED TO DO SO.

I fully understand that I am directly and fully responsible to the above healthcare provider for all medical bills submitted by them for services rendered to me and that this agreement is made solely for their additional protection and in consideration of the services provided.

I further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case or PIP case, as to the appropriateness of services rendered and/or fees charged. Alternative third party payment, if accepted, is done as courtesy provided by this provider.

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. In the event you default on payments we may have to seek help from a collection agency. If this situation should occur you will be responsible for any and all collection fees as well as for your existing balance. A fee of $25 will be charged for returned checks. I further agree to pay this medical provider's legal fees and costs if I am sued by this provider, or its assignees, for payment of my unpaid medical expenses.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that his agreement shall be governed by the laws of the State of Florida.

Patient signature: ______________________________________ Date: ___________________________

ATTORNEY AGREEMENT AND ACCEPTANCE

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement and to withhold such sums from any settlement or judgment as may be necessary to adequately protect the above listed healthcare providers and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand.

Attorney signature: ____________________________________ Date: __________________________

State Bar Number: ______________________________