CREATIVE NATURAL HEALTH
...When You're Sick & Tired of Being Sick & Tired...

EMBASSY LAKES Accident & Injury Center

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:** _____

Who owns the vehicle involved in the accident?_____ **Relationship:**_____

Insurance Company: _____ **Date of Accident:**_____

Claim #:_____ **Policy #** _____

Year/Make/Model: _____ **Tag#:** _____ **VIN:** _____

Do you own a vehicle that was not involved in the accident? _____ **Year/Make/Model:** _____

Are you the owner of a policy or named on a policy? _____ **Name of Insurance/Policy#:** _____

Do you own a vehicle that is NOT insured or is inoperable? _____

Do you reside in a household where anyone owns a vehicle? _____ **Who?** _____

Year/Make/Model: _____ **Tag#:** _____ **VIN:** _____

Did the accident happen while you: Were a passenger on a bus or as a pedestrian? _____

Did the accident happen while you were riding a bicycle or motorcycle? _____

Was a ticket issued? Yes No **To Whom?** _____ **Did an ambulance come to the scene?** Yes No

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.

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

AUTO

CREATIVE NATURAL HEALTH, PLLC dba
EMBASSY LAKES ACCIDENT & INJURY CENTER
2565 N Hiatus Road
Cooper City, FL 33026

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND

Insurer and Patient Please Read the Following In its Entirety

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign all the rights and benefits of my automobile insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against and insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e./., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts and for any other services unrelated to the automobile accident.

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE & DEMAND (CONT)

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements or examinations under oath the patient provided to any insurer.

Release of Information: I hereby authorize this provider to: furnish and insurer, and insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from the insurer all EOBs for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer, obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs and MRIs from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days.

Certification: I certify that: I have read and agree to the above, I have not been solicited or promised anything in exchange for receiving health care, I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document, please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name _____

(Please Print)

Patient's Signature X_____

(If patient is a minor, signature of parent/guardian)

Date_____

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: _____