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

EMBASSY LAKES Accident & Injury Center

WELCOME TO CREATIVE NATURAL HEALTH!

Name: _____ **Date:** _____

Social Security #:_____ **Birth Date:** _____ **Age:** ____ **Height:** _____ **Weight:** _____

Address: _____**City/State/Zip:** _____

Home Phone: _____ **Work Phone:**_____

Mobile Phone: _____ **Mobile Carrier:** _____ **Email:** _____

Occupation: _____ **Employers' Name:** _____

Sex: Male Female **Marital Status:** Single Married Divorced Widowed

Spouses Name: _____ **# of Children:** _____

Emergency Contact Name:_____ **Telephone:**_____

Primary Care Doctor: _____ **Primary Care Doctor Phone:** _____

Primary Care Doctor Address: _____

Insurance Company:_____ **Phone #:** _____

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

TOS/MM

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 _____ 20___.

X_____ _____
PATIENT'S SIGNATURE PATIENT'S NAME (PLEASE PRINT)