



1. PIP - PATIENT INFORMATION
(Personal Injury Protection)

PATIENT'S NAME _____ D.O.B. _____
Address: _____ Social Security # _____
_____ M F S M D W
Telephone # _____ Date of Injury: _____

INSURANCE COMPANY: _____ Telephone # _____
Claim Adjuster: _____ Claim # _____
Policy # _____ Deductible: \$ _____ Met? Y N % of coverage _____
Insured's Name _____ D.O.B. _____
Insured's Address: _____
Relationship to Insured (If other than self) _____ Social Security #: _____

2nd INSURANCE COMPANY: _____ Telephone # _____
Claim Adjuster: _____ Claim # _____
Policy # _____ Deductible: \$ _____ Met? Y N % of coverage _____
Insured's Name _____ D.O.B. _____
Insured's Address: _____
Relationship to Insured (If other than self) _____ Social Security #: _____

ATTORNEY: _____ Phone # _____
Address: _____ Patient's Account # _____
Diagnosis Code #'s _____, _____, _____, _____, _____, _____



2. PIP - APPLICATION FOR NO FAULT BENEFITS
(Personal Injury Protection)

Name of Insurance Co _____ Date _____
Our Policy Holder: _____ Date of Accident: _____

To enable us to determine if you are entitled under the Florida Personal Injury Protection Law, please complete this form and return it promptly. Any person knowingly and with intent to injure, defraud or deceive any insurance company MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION, is guilty of a felony of the third degree.

Last Name _____ First Name _____ Phone# (home) _____
Phone# (Business): _____ Date of Birth: _____ SS#: _____
Address: _____ City: _____ St.: _____ Zip: _____
How long how you lived in Florida? _____ Time & Date of Accident: _____
Place of accident (address, city, and state): _____
Brief description of accident and vehicles involved: _____

Describe motor vehicle you own: _____
Describe motor owned by any member of your family: _____
In this accident, were you injured?
[] YES If your answer is YES, complete the rest of this form
[] NO If NO injuries, sign here and return form to front desk _____

Describe your injury: _____
Were you going to work? [] YES [] NO Were you treated by a doctor? [] YES [] NO
Doctor's name/address: _____
In the hospital, were you an? [] Outpatient [] Inpatient Amount of medical bills: _____
Hospital's name and address: _____
Will you have more medical expenses? [] YES [] NO Average weekly salary: _____
Did you lose any salary as result of your injuries? [] YES [] NO If YES, amount _____
Date disability from work began _____ (if lost wages) | Date you returned to work _____

Have you received, or are eligible for payments under any workmen's compensation or unemployment law?
[] YES [] NO If YES, amount \$ _____ [] per week, [] per month | Any other expenses? [] YES [] NO

List names and addresses of your present employer (s) and give your occupation and dates of employment for each:
Employer and address _____ Your occupation _____ From _____ To _____

Signature _____ Date: _____



3. PIP – AUTHORIZATION FOR MEDICAL INFORMATION & AUTHORIZATION FOR WAGE AND SALARY INFORMATION (Personal Injury Protection)

Authorization for medical information

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 **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 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 as binding as an original signature page.

The undersigned does hereby ratify and confirm 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.

Release of information: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

Authorization for wage and salary information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Florida "no fault" auto insurance law (chapter 71-252 f.s.).

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of third degree.

Name _____ SS: _____

Signature _____ Date: _____



4. PIP – CONSENT FOR TREATMENT / POWER OF ATTORNEY (Personal Injury Protection)

CONSENT FOR TREATMENT

I hereby give consent for treatment, consultation, or testing as necessary and I allow the provider **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, to release any information as required.

POWER OF ATTORNEY

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY 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 **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 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 all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, which checks, drafts or money orders are made payable for services which have been made by **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 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 **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 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 affidavits of non-ownership of vehicles, insurance forms and other statements. The undersigned by these presents does give and grant the said **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 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 **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 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 as binding as an original signature page.

The undersigned does hereby ratify and confirm 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.

Release of information: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurer; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, X-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors without the patient's and the provider's prior express written permission.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
To: (Name of insured) (Name of Insurance Carrier)

Payable to and mailed directly to: **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**, 6555 Powerline Road, Suite 103, Fort Lauderdale, FL 33309 The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to **NEW LIFE CHIROPRACTIC CLUB** any 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 **NEW LIFE NATURALLY HEALING TECHNOLOGIES, LLC**,

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, 200_____

Name _____ SS: _____

D/A: _____ Signature _____

Witness Name: _____ Witness's Signature _____



5. PIP – UNDERSTANDING BILLING PROCESS (Personal Injury Protection)

Welcome to New Life Naturally, Healing Technologies, from all your friends at the billing department. This letter will help to clarify the billing and collection process. Feel free at any moment to contact us with any questions or regards you might have.

How it works:

Your primary automobile insurance will be billed throughout the course of your treatment. They will pay a portion of the charges directly to us.

The remaining balance will then be billed to the secondary insurance, which is the insurance of the member who was at fault in the accident.

If you were at fault we will workout a payment arrangement with you. If you were not at fault we will contact the secondary insurance. However, because we are the third party, they will only negotiate with you, not with us. If we are still owed money, the adjuster (the person in charge of the claim) will offer a settlement for the case. Please do not accept any offer for settlement until you have spoken with us.

The insurance company will then send you a check in the mail. This check is to cover medical expenses, not for your personal use. You may either, bring the endorsed check given to you by the insurance carrier, or write us a personal check for the settled amount immediately. Mail the check to our office, or bring it in on your next visit. **Under no circumstance is it legal for you to spend money still owed in your case.**

Please sign the bottom portion of this form to insure that you have read and understood the content of this letter. Thank you for your cooperation, and once again, welcome to the New Life family.

Secondary Insurance Agreement

I _____, agree that I have read and understood the billing and collections process. I understand that my responsibility is to cooperate with the staff at New Life Chiropractic Naturally Healing Technologies, LLC. If New Life Naturally, Healing Technologies is owed money, I will not make a settlement with any insurance carrier without their prior consent. Once I receive the payment by the insurance carrier, I will pay New Life Naturally, Healing Technologies the amount due to them immediately. By signing this agreement I accept full responsibility for this matter. I understand that failure to honor this agreement will give New Life Naturally, Healing Technologies the right to pursue this matter legally in an attempt to collect a debt.

Print Name

Signature

Date

DATE:

PERSONAL HISTORY QUESTIONNAIRE

Personal Information Name Age: DOB Male Female
Home Phone: Work Phone: Cell Phone:
Street: City: State: Zip:
E-mail: Occupation:
How did you hear about our office? (Name please)
Health insurance: Yes No Name of Insurance Company:

Past Chiropractic Care Have you had chiropractic care in the past? (Yes No)
Why did you go?
How long did you receive care?
When was your last visit?
Why did you stop going?

General Health Information Table with columns: Check correct box!, Good, Fair, Poor, Getting Better, Getting Worse. Rows include physical health, emotional/mental health, diet, exercise habits, rest and sleep habits, and attitude.

Spouse and Children Please tell us about your family. (Spouse and children)
Marital Status: Married Single Separated Widowed # of children: Are you pregnant and/or nursing? (Yes No) Months pregnant: Months nursing:
Name Age(s) Lives Home? Any health problems?
Spouse
Children

Family History Name of your medical doctor(s) and specialty if any i.e. cardiologist, neurologist.

Check if you or an immediate family member has had any of the following illnesses? Table with columns: Self, No, Relative for various conditions like Alcohol overuse, Allergies, Anemia, etc.

Have you recently been hospitalized/had surgery? (Yes No) Do you still have all your body parts? (Yes No) Name procedures/surgeries and approximate dates? Do you have any health complaints that are especially important to you today?

Have you had any of the following: spinal tap spinal injections physiotherapy neck collar spinal brace traction heel lift x-ray treatments corrective shoes or bars on shoes extensive diagnostic x-rays acupuncture chemotherapy transfusion immobilized or body part in a cast

Review of Systems	
--------------------------	--

Please check **YES** to the following questions **ONLY** if the problem is of significant concern in the recent past or unless the question specifically states '**EVER**'.

<p>1. GENERAL:</p> <p>Do you usually feel persistently tired or worn out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you recently been drinking more water or fluids? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has there been any unusual weight gain or loss recently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. CARDIOVASCULAR:</p> <p>Do you have pain, tightness or pressure in your chest? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any swelling of your feet or ankles? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does your heart ever beat fast or irregularly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have cramps in the calf muscles when you walk? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your fingers/toes ever get cold, numb or get very white or bluish? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. CENTRAL NERVOUS SYSTEM:</p> <p>Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you often have spells of dizziness, faintness or lightheadedness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you recently fainted, blacked out, lost consciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have trouble remembering recent events? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you ever have convulsions or fits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. EYES: Have you had:</p> <p>Any pain in your eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blurry vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Halo around lights? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>5. ENT: Do you have:</p> <p>Any trouble hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ringing in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Earaches or ear discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Post nasal drip? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent nosebleeds? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Persistent hoarseness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bleeding gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. GASTROINTESTINAL:</p> <p>Have you recently had any change in your eating habits? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you recently noted any trouble in swallowing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have a lot of indigestion or heartburn? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever vomited blood? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you bothered with constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have frequent loose stools or diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. SKIN: Do you have:</p> <p>Any change in the color of your skin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any rashes or itching? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any growths or lumps on your skin? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any sores or wounds that do not heal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any change in the color or size of warts or moles? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. GENITOURINARY: Do you have:</p> <p>Burning or pain when you urinate? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>To pass water frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>To get up at night? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Trouble with losing urine when you cough or sneeze? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. RESPIRATORY: Do you have:</p> <p>Frequent chest colds or pneumonia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A constant or bothersome cough? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Coughing or blood? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing or whistling in your chest? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	---

Physical Trauma and Accidents	Tell me about all accidents, injuries, falls, traumas:
--------------------------------------	--

Include motor vehicle accidents: (Even if you were a passenger, even if you think you were not hurt.) Please list approximate dates and estimate the severity of the accident (mild, moderate, severe), include all modes of transportation: Was your birth: drug induced forceps or suction C section breech prolonged natural other

.....

.....

.....

.....

.....

.....

.....

.....

Chemical Stress	Mark type of medications/drugs you use(d): (Rx) Prescription (OTC) Over-the-counter (R) Recreational
------------------------	--

Drug Name	Type and reason For Use	Drug Name	Type and reason For Use

Are you vaccinated? (Yes No) Are your children vaccinated? (Yes No)

Have you ever worked with any chemicals, fumes, dust, powders, smoke for prolonged periods? (Yes No)

Please indicate how often you use the following items: **(D) Daily (W) Weekly (B) Bi-weekly (M) Monthly (O) Occasionally (N) Never**

Alcohol		Diet Food		Raw Vegetables		Poultry	
Coffee/caffeine		Refined sugar		Fruits		Fish	
Tobacco		Refined Flour		Whole Grains		Seafood	
Artificial sweeteners		Eggs		Dairy (milk products)		Weight control diets	
Junk food		Canned Vegetables		Fried foods		Fasting	
Soda		Cooked Vegetables		Beef		Organic foods	

Emotional Stress	Please indicate any sources of past or present mental/emotional stress. Comment!
-------------------------	--

<input type="checkbox"/> Work/School	<input type="checkbox"/> Sports/competition	<input type="checkbox"/> Change in lifestyle	
<input type="checkbox"/> Personal Relationship	<input type="checkbox"/> Financial	<input type="checkbox"/> Abuse	
<input type="checkbox"/> Family	<input type="checkbox"/> Loss of loved one	<input type="checkbox"/> Stress of being sick	



NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME: _____

DATE: _____

For any YES answer, please notify the Doctor (circle one):

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of hand grip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do our legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do you suffer from headaches, dizziness or memory loss?
Comment: _____ | NO | YES |
| 12. Do you have difficulty maintaining your balance?
Comment: _____ | NO | YES |
| 13. Do you suffer from vertigo or blurred vision?
Comment: _____ | NO | YES |
| 14. Do you suffer from a reduced hearing capacity?
Comment: _____ | NO | YES |
| 15. Do you suffer from ringing in your ears?
Comment: _____ | NO | YES |
| 16. Do you have bladder or bowel control problems on a regular basis?
Comment: _____ | NO | YES |



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on _____ and will remain in effect until it is amended or replaced by us. It is our right to change our privacy policy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Karen Vulgamore. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members access to your health information according to their primary job functions.

Disclosure: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organization or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care in case of an emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law, (Court or administrative orders, subpoena, discovery requests or other lawful process.) We will use and disclose your information when requested by national security, intelligence or other State and Federal officials and/or if you are inmate or otherwise under the custody of the law enforcement.

Abuse or Neglect: We may disclose your health care information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your healthy or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with product, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail message, postcards or letters.

Requests: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit and appropriate request for, please contact our Privacy Officer for a copy of the form. You may also request access by sending us a letter to address at the end of the Notice. Once approved, an appointment can be made to review your records. Copies, if requested will be \$1.00 per page and the staff time charged will be \$10.00 per hour including the time required to locate a copy your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergencies. Please submit your requests in writing.

QUESTIONS OR COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complain form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Practice: New Life Chiropractic Club/Dr. Jeffrey Hazim
Privacy Officer: Karen Vulgamore
Phone: 954-776-1880 Fax: 954-776-1808
Address: 6555 Powerline Road, Fort Lauderdale, FL 33309

This form does not constitute legal advice and covers only federal not state law.

6555 Powerline Road, Suite 103, Fort Lauderdale, FL 33309
(954) 776-1880 Fax: (954) 776-1808 www.NLCclub.com Silvia@NLCclub.com



DISCLOSURE & CONSENT for CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have the right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor named below and or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnoses, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to fractures, disc injuries, strokes, dislocations, sprains, and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient

Print name

Signature of Patient

Date signed

To be completed by the patient's Representative, If necessary, e.g. if the patient is a minor or physically or legally incapacitated.

Print name of patient

Print name of patient's representative

Signature of patient's representative

as: _____

Relationship or authority to patients

Date signed

To be completed by doctor or staff

Witness to patient signature

Date

Translated by

Date



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature