Infinite
HEALTH & WELLNESS GROUP

Welcome To Infinite Health & Wellness Group

Contact Information

Date: ____________

First Name: ______________________
Middle Init: ______________________
Last Name: ______________________
Address: ______________________
City: ______________________
State, Zip: ______________________
Home Phone: (____)________________
Work Phone: (____)________________
Cell Phone: (____)________________
Email: ______________________
Other

This address will not be shared, sold, or distributed to anyone, but may be used to let you know about upcoming events or specials.

Sex: ☐M ☐F
Marital: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed ☐ Minor
Birth Date: ______________ Age: ________
Soc. Sec: ______________________

Who should we thank for referring you to our office?
____

Work Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Student ☐

Method for Apt Reminders: ☐ Text ☐ Email ☐ Phone
Employer: ______________________
Children: ______________________
Occupation: ______________________
Primary Doctor: ______________________
Race: ☐ Am. Indian ☐ Asian ☐ African Am ☐ Caucasian ☐ Other
Primary Phone: ______________________
Ethnicity: ☐ Latin / Hispanic ☐ NON – Latin / Hispanic

Patient Health History - Please Read and Check ALL That Apply

Past Treatments and Tests:
☐ MRI
☐ CT Scan
☐ X-rays
☐ Blood
☐ Orthopedist
☐ Physical Therapy
☐ Neurologist
☐ Chiropractic
☐ Acupuncture
☐ Massage Therapy
☐ Surgery
☐ Plastic Surgery
☐ None
☐ Other ______________

ALL Current Medications (LIST BRAND AND MG/Day)

NAME **MG/day**
☐ ______________________
☐ ______________________
☐ ______________________
☐ ______________________
☐ ______________________
☐ ______________________
☐ None

MEDICATION ALLERGIES
☐ ______________________
☐ ______________________
☐ NONE

☐ Height ______________
☐ Weight ______________

Past or Current Conditions:
☐ Allergies ______________
☐ Headaches
☐ Migraines
☐ Sinus issues
☐ TMJ
☐ Heart Attack
☐ Heart disease __________
☐ High blood pressure
☐ Pacemaker
☐ Asthma
☐ Diff Breathing __________
☐ Alzheimer's / Dementia
☐ Bleeding Disorders
☐ Cancer: ______________
☐ Gallbladder issues ______
☐ Digestive issues ________
☐ Hepatitis
☐ HIV /AIDS
☐ Menstrual Difficulties
☐ Hormone issues
☐ Osteoporosis
☐ Growths / Tumors / Cysts
☐ Arthritis
☐ Herniated discs
☐ Neck pain
☐ Lower back pain
☐ Bladder issues
☐ Kidney issues
☐ Bowel issues
☐ Diabetes I II
☐ Gout
☐ STD's ______________
☐ Alcohol / Drug Abuse
☐ Artificial joints / Bones
☐ None of the above
☐ Other

Family History:
☐ None
☐ Heart Attack / Disease
☐ Cancer
☐ Stroke
☐ Diabetes
☐ Musculoskeletal
☐ Mental Disorders
☐ Neurological conditions
☐ Other: ______________
____
____
____
____

Allergies (please list all)
☐ ______________________
☐ ______________________
☐ No Medication Allergy
☐ No Allergies

Other Issues:
☐ Shoulder / Elbow Pain
☐ Wrist / Hand Pain / Injury
☐ Hip / Knee Pain / Injury
☐ Foot /Ankle Pains / Injury
☐ Rib Pains

For Women Only:
Are you pregnant?
☐ Yes ________ weeks
☐ No

Are you nursing?
☐ Yes
☐ No

Social History:
☐ Alcohol ______ Drinks / week
☐ Recreational Drugs ________
☐ Coffee ________ Cups / day
☐ Diet Soda / Drinks ____ / day
☐ Soda _____ / Day
☐ Processed Foods _____ /Day
☐ Fast food / Week _________
☐ Addictions: ______________
☐ Vitamins ______________
☐ Exercise ______________
☐ Other: ______________

SMOKING STATUS:
☐ Current everyday smoker
☐ Current sometimes smoker
☐ Former smoker
☐ Never smoker

Surgeries: (Please list ALL)
☐ None - Never
______________ Yr _____
______________ Yr _____

Major Accidents: (List all)
☐ None - Never
Recent Car _______ Yr _____
Car ____________ Yr _____
Slip / Fall _________ Yr _____
Sports ____________ Yr _____
Other ____________ Yr _____

Fractured Bones: (List All)
☐ None - Never
______________ Yr _____
______________ Yr _____

****What are ALL of your complaints / Injuries keeping you from doing / enjoying? ______________________**
****GOALS You are looking to achieve in our office: ______________________**

Please refrain from TALKING on your mobile device in the office. You may text / email or play games while waiting, but talking creates unnecessary stress to the other patients and staff. Thank you.

Financial - Insurance Information

Who is Responsible for this account? Self: ☐Yes (☐No Parent/Guardian): Relationship: ____________________
Insurance Company: ____________________________ Policy Number: ______________________________
Insured's name: ____________________________ **Claim Number:** ______________________________
Date of Birth: __________ SSN: ____________ **Signature:** ________________________________

Policies & Consent

Payment is due at the time of service, unless other arrangements have been made. I authorize and give consent to the Doctors & staff to perform any necessary services, during diagnosis and treatment. I have been given the opportunity to ask questions, and all risks have been explained. I understand the above written information on this form, and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes to the information I have provided.

In the event that my insurance company contacts me to, or schedules me an appointment with another doctor, I will let this office know as soon as possible, so that x-rays and notes can be prepared in a timely fashion.

Signature ____ **Date** _____/_____/_____
Adult patient Parent or Guardian Spouse

Office use only: ____

Motor Vehicle Accident Information

Last Name:	Date:
First Name:	Middle:

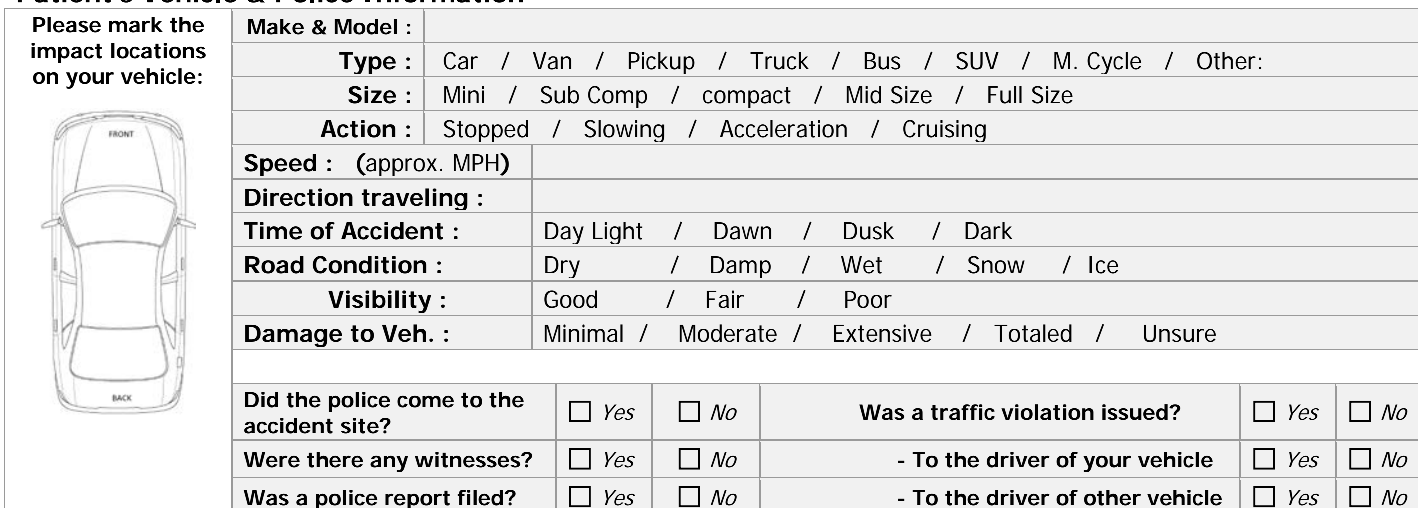
General Information

Date of Accident:		Time of Accident:
You were the: (circle one)	Driver	
	Passenger	Seat location: (circle one) Front-Right / Front-Middle / Back-Left / Back-middle / Back-right

Accident Description

Please describe the accident in your own words:
Accident location:

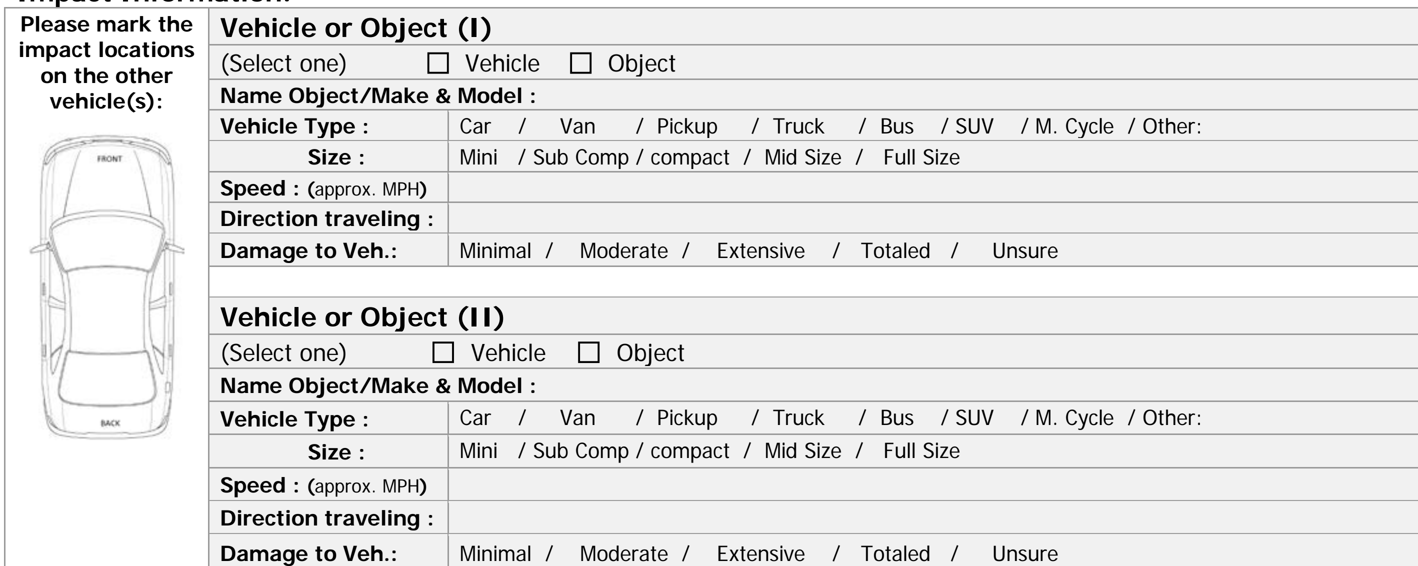
Patient's Vehicle & Police Information



Please mark the impact locations on your vehicle:						
	Make & Model :					
	Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:				
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size				
	Action :	Stopped / Slowing / Acceleration / Cruising				
	Speed : (approx. MPH)					
	Direction traveling :					
	Time of Accident :	Day Light / Dawn / Dusk / Dark				
	Road Condition :	Dry / Damp / Wet / Snow / Ice				
	Visibility :	Good / Fair / Poor				
	Damage to Veh. :	Minimal / Moderate / Extensive / Totaled / Unsure				
	Did the police come to the accident site?	☐ Yes	☐ No	Was a traffic violation issued?	☐ Yes	☐ No
	Were there any witnesses?	☐ Yes	☐ No	- To the driver of your vehicle	☐ Yes	☐ No
	Was a police report filed?	☐ Yes	☐ No	- To the driver of other vehicle	☐ Yes	☐ No

Enter impact Information for up to two Vehicles or Objects

Impact Information:



Please mark the impact locations on the other vehicle(s):		
	Vehicle or Object (I)	
	(Select one) ☐ Vehicle ☐ Object	
	Name Object/Make & Model :	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Speed : (approx. MPH)	
	Direction traveling :	
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure
	Vehicle or Object (II)	
	(Select one) ☐ Vehicle ☐ Object	
	Name Object/Make & Model :	
	Vehicle Type :	Car / Van / Pickup / Truck / Bus / SUV / M. Cycle / Other:
	Size :	Mini / Sub Comp / compact / Mid Size / Full Size
	Speed : (approx. MPH)	
	Direction traveling :	
	Damage to Veh.:	Minimal / Moderate / Extensive / Totaled / Unsure

During Impact Information:

Seat Belt?	☐ Yes	☐ No	Brakes Applied ?	☐ Yes	☐ No
Air Bag Deployed?	☐ Yes	☐ No	Seat Broken ?	☐ Yes	☐ No
Seat Back position Changed?	☐ Yes	☐ No			

Prepared for Accident : (Circle One)	Un-expected / Expected / Expected and Braced
Head Rest : (Circle one)	Low / Mid / High / None
Head Position : (Circle one)	Straight / Rotated Left / Rotated Right / Forward / Unsure / Other:
Head Motion : (Circle one)	Forward / Backwards / Right Left / Left Right / Unsure / Other:
Body Position : (Circle one)	Straight / Rotated Left / Rotated Right / Unsure / Other:
Body Ejected?	☐ Yes / ☐ No

Body Impact (Indicate any parts of your body that were **struck** during the impact)

☐ Head	☐ Left Shoulder	☐ Right Shoulder	☐ Other :
☐ Neck	☐ Left Arm	☐ Right Arm	
☐ Upper Back	☐ Left Elbow	☐ Right elbow	
☐ Chest	☐ Left Hand	☐ Right Hand	
☐ Mid back	☐ Left Leg	☐ Right Leg	
☐ Lower Back	☐ Left Knee	☐ Right knee	
☐ Abdomen	☐ Left foot	☐ Right foot	

After Accident Information:

Immediately After Accident:	☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache ☐ Disoriented ☐ Unconscious
	☐ Other:

Pain (Indicate if you experienced any pain immediately following the accident)

☐ Head	☐ Left Shoulder	☐ Right Shoulder	☐ Other :
☐ Neck	☐ Left Arm	☐ Right Arm	
☐ Upper Back	☐ Left Elbow	☐ Right elbow	
☐ Chest	☐ Left Hand	☐ Right Hand	
☐ Mid back	☐ Left Leg	☐ Right Leg	
☐ Lower Back	☐ Left Knee	☐ Right knee	
☐ Abdomen	☐ Left foot	☐ Right foot	

Numbness:	☐Left Hand ☐ Right Hand ☐ Left Leg ☐ Right Leg ☐ Left Upper Arm ☐ Right Upper Arm ☐ Left Foot ☐ Right Foot ☐ Other:

Medical Information (Did you get medical care for this accident before coming to our office)

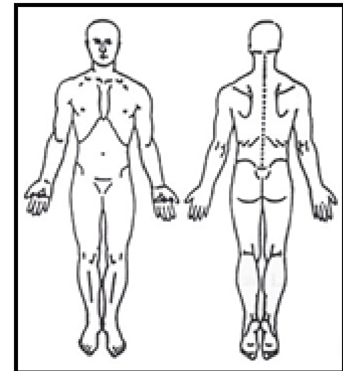
Medical Care?	☐ Yes	☐ No

Time of care	Next day / At time of Accident / Later that Day / Days Later: (Specify)
Transported	Drove Self / Ambulance / Other
Went To	Orthopedic / Chiropractor / Neurologist / Family Doc / ER / Other: (Specify)
Admitted to Hospital?	☐ Yes ☐ No Days Spent in Hospital:
Tests performed:	☐ X-ray ☐ Lab Work ☐ MRI ☐ CT Scan ☐ Other: (Specify)
Treatment:	☐ Ice Pack ☐ Hot Pack ☐ None ☐ Cervical Collar ☐ Medication ☐ Other: (Specify)

Previous Injuries

Previous Injuries / Accidents	☐ No ☐ Yes, Specify:
Residual pain from Previous Injuries/Accidents	☐ No ☐ Yes, Specify:

Current Symptoms (Please note any symptoms that started after the accident occurred) (1=Mild ⟷ 10=Severe)

Head (Entire / Front / Left / Right / Back) Severity (1-10): ________	☐ Headache ☐ Dizziness ☐ Blurred Vision ☐ Light Headedness ☐ Loss of Vision ☐ Fainting ☐ Loss of Memory ☐ Pain in ear ☐ Double Vision ☐ Other Specify:
Neck (Left / Right / Center) Severity (1-10): ________	☐ Pain in Neck ☐ Forward ☐ Backward ☐ Turn Left ☐ Popping in Neck ☐ Muscle Spasms ☐ Turn Right ☐ Bend Left ☐ bend Right ☐ Other Specify:
Shoulders (Left / Right / Both) Severity (1-10): ________	☐ Pain in Shoulder joint ☐ Tension in shoulders ☐ Muscle Spasms in Shoulder ☐ Pain across shoulder ☐ Cant raise arms above [ ] Above shoulder level [ ] Over head ☐ Other Specify:
Arms and Hands (Left / Right / Both) Severity (1-10): ________	☐ Pain in Fingers ☐ Numbness in Left Arm ☐ Hands Cold ☐ Pin & needles in hands ☐ Numbness in Right Arm ☐ Loss of Grip Strength ☐ Pin & needles in fingers ☐ Swollen joints in Fingers ☐ Other Specify:
Chest (Left / Right / Center) Severity (1-10): ________	☐ Chest pain ☐ Pain Around Ribs ☐ Shortness of Breadth ☐ Breast Pain ☐ Other Specify:
Abdomen Severity (1-10): ________	☐ Nervous Stomach ☐ Nausea ☐ Diarrhea ☐ Gas ☐ Constipation ☐ Other Specify:
Mid back (Left / Right / Center) Severity (1-10): ________	☐ Sharp Stabbing ☐ Mid pain back ☐ Pain From front to back ☐ Dull Ache ☐ Pain in Kidney Area ☐ Muscle Spasms ☐ Pain between shoulders ☐ Other Specify:
Lower Back (Left / Right / Center) Severity (1-10): ________	☐ Low Back Pain Low back pain is worse when: ☐ Standing ☐ Working ☐ Bending ☐ Stooping ☐ Sitting ☐ Lifting ☐ Coughing ☐ Lying Down ☐ Muscle Spasms ☐ Other Specify:
Hips, Legs & Feet (Left / Right / Both) Severity (1-10): ________	☐ Pain in Buttocks ☐ Pain and needles in Legs ☐ Pain down leg ☐ Pain in hip joint ☐ Feet feel Cold ☐ Swollen Feet ☐ Numbness in Toes ☐ Numbness of Leg ☐ Knee pain ☐ Leg cramps ☐ Cramps in Feet ☐ Other Specify:
General	☐ Nervousness ☐ Fatigue ☐ Irritable ☐ Depressed ☐ Generally Feel Rundown ☐ Night Urination ☐ Difficulty Urinating ☐ Irregularity ☐ Cramping ☐ Nausea Loss of Sleep : [________________________] hrs per night Loss of weight : [________________________] lbs Gain weight : [________________________] lbs Other: 

Signature: ____ Date: ________________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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

THIS FORM WILL BE PLACED IN THE PATIENT’S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

____________________________ ______________________________

____________________________ ______________________________

____________________________ ______________________________

Informed Consent to Chiropractic Adjustments and Care at Infinite Health & Wellness Group

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.
I ______________________________, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy, Physio-therapy, massage therapy, and other modalities including exercises may also be used. Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments. Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Physical / Physio Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor. Examinations have been/will be performed on me to minimize the risk of any complication from such treatments and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits, or how significant they will be. I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing (staff or covering doctor).

Alternative Treatments Available
Reasonable alternatives to these procedures will be / have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery. Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks. Rest/Exercise: It has been /will be explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues. Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery**. Non-treatment: I understand the potential risks of refusing or neglecting care, not following outlined recommendations, may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy. I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction. I have made my decision voluntarily and freely.**

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____ Signature of patient

____ Signature of witness

____ Date and time

OFFICE USE ONLY: PATIENT STATUS AT TIME OF INFORMED CONSENT PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

[ ] Of legal age
[ ] Coherent and alert
[ ] Proficient in understanding the English language
[ ] Disoriented
[ ] On prescription/OTC medication but unimpaired

[ ] Assisted in understanding by an interpreter
(Interpreter's name:_______________________________)
[ ] Resolute in denying being under the influence of alcohol and or recreational drug use at the time of consent
[ ] Unable to give legal consent
[ ] Consent given thru legal guardian

I certify that the above accurately describes the above named patient's status during the informed consent process on :

________________ ____

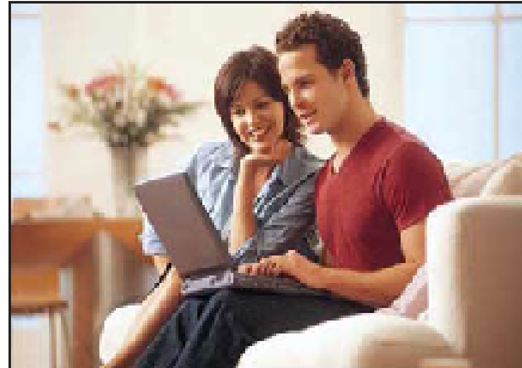
Date Signature of Doctor

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:



First name: ________________________________

Last name: ________________________________

Date of birth: ______ / ______ / ______

Email address: ____________________________

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Women's Health Issues
- ❑ Wellness Topics
- ❑ Diet and Nutrition
- ❑ Exercise and Fitness
- ❑ Stress Management

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

Insurer and Patient Please Read the Following in its Entirety Carefully!

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (hereinafter PIP), 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 an insurance company for payment of the insurance benefits. I understand the provider may file a lawsuit against my insurer for payment and if the provider's bills are paid or applied to a deductible I agree this will serve as a benefit to me and I authorize and request such litigation. This assignment of benefits includes the cost of transportation, medications, supplies, over due interest and any potential claim for common law or statutory bad faith/unfair claims handling. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five 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 reductions & without including the patient's name on the check. To the extent the PIP insurer contends there is a material misrepresentation on the application for insurance resulting in the policy of insurance is declared voided, rescinded, or canceled, I, as the named insured under said policy of insurance, hereby assign the right to receive the premiums paid for my PIP insurance to this provider and to file suit for recovery of the premiums. The insurer is directed to issue such a refund check payable to this provider only. Should the medical bills not exceed the premium refunded, then the provider is directed to mail the patient/named insured a check which represents the difference between the medical bills and the premiums paid.

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. The insured and the provider hereby contests and 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.

If the insurer schedules a defense examination or examination under oath (hereinafter "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. 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 and obtain a copy of any statements or examinations under oath given by patient.

Release of information: I hereby authorize this provider to: furnish an insurer, an 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 (declaration sheet & policy of insurance) in writing and telephonically from the insurer; request from any insurer all explanation of benefits (EOBs) for all providers and non-redacted PIP payout sheets; obtain any written and verbal statements the patient or anyone else provided to the insurer; obtain copies of the entire claim file and 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 provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits. 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.

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. The insurer is directed to pay the bills in the order they are received. However, if a bill from this provider and a claim from anyone else is received by the insurer on the same day the insurer is directed to not apply this provider's bill to the deductible. If a bill from this provider and claim from anyone else is received by the insurer on the same day then the insurer is directed to pay this provider first before the policy is exhausted. In the event the provider's medical bills are disputed or reduced by the insurer for any reason, or amount, the insurer is to: set aside the entire amount disputed or reduced; escrow the full amount at issue; and not pay the disputed amount to anyone or any entity, including myself, until the dispute is resolved by a Court. Do not exhaust the policy. The insurer is instructed to inform, in writing, the provider of any dispute.

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; and I agree the provider's prices for medical services, treatment and supplies are reasonable, usual and customary.

Caution: Please read before signing. Please ask to view a copy of our charges. 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 ______________________________ Patient's Signature ______________________________

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

Date ____________________________

Doctor Lien

To: Attorney / Insurance Carrier
____
____
____

Doctor:
Infinite Health & Wellness Group
Dr. Bruce Cherlow
6662 Parkside Drive
Parkland, FL 33067

I, _____________________________________ hereinafter Patient, hereby sign to Dr. Cherlow hereinafter doctor, all rights to payment in full from patient's claim for personal injury which occurred on or about (date) _________________, hereinafter claim, in an amount equal to full costs of services provided to patient, or patient's children, spouse or other legal charge by doctor.

Patient herein expressly agrees not to revoke, modify, or alter this agreement and the same shall remain a lien, not to be discharged until such time as doctor is fully, and satisfactorily compensated for services rendered to patient or other person pursuant to the patient / doctor contract.

Patient instructs and authorizes the attorney ____
To make full payment directly and promptly to doctor from the amount obtained by attorney in the settlement, award, or judgment of the above mentioned claim. Patient understands this notice constitutes a lien in favor of doctor on the proceeds of the patient claim.

Patient understands that patient's obligation is not contingent upon recovery, settlement, award, or judgment and patient remains fully responsible to doctor or his assigns fro the amount secured by this agreement.

Patient hereby instructs that in the event another attorney is substituted or associated in this matter, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him / her. This lien constitutes notice to any attorney responsible for the handling of this claim.

Patient herein expressly relieves attorney of any duty to compromise this lien and herein charges attorney with the irrevocable duty to pay the doctor the full sum secured herein from the settlement, award or recovery, or judgment of patient's claim.

Patient herein acknowledges that patient has been appraised of costs for diagnosis, treatment, reports, and fees, and agrees to the amounts charged as being reasonable for services to be rendered by the doctor. Patient further acknowledges that such services and treatments for injuries sustained as a result of the services and treatment for injuries sustained as a result of the patient's claim are not dependant upon patient's signature hereon and patient signs this lien after having read it, or patient's own free will and with an intent to be bound by the same.

This lien does not waive other available remedies at law or equity which doctor may have available. Patient expressly waives any statue of limitations, laches, or other defenses to cause of action should it become necessary for the doctor to commence litigation to procure compliance with this agreement or patient / doctor contract.

Patient understands that in the event attorney does not sign this agreement, patient will still be bound by the provisions set forth.

Attorney is instructed by the patient to sign this lien and return it to the doctor within five working days.

Attorney is instructed by the patient to promptly disclose to doctor any and all occurrences which may have a detrimental effect on the claim.

Attorney is instructed by the patient to serve a copy of this agreement to all counsel in the event of a substitution or association of another attorney, and notify doctor of said substitution immediately.

This agreement and the lien are freely alienable and assignable by doctor and it is patient's intent to have the provisions of this lien agreement bind patient and patient heirs as to doctor's heirs and assigns. If any legal action, arbitration or other proceedings is brought for the enforcement of this agreement or because of an alleged, breach, default, or misrepresentation in connection with any of the provisions of this agreement, the successful or prevailing party or parties shall be entitled to recover attorney's fees, legal interest, and other costs incurred in that action proceeding, in addition to any other relief to which it or they may be entitled.

Should any part of this lien be found unenforceable, the remainder shall remain in full force and effect.

Patient acknowledges having received a copy of this agreement on the date below.

Dated: ______________________________________ ____
Patient Signature

Attorney hereby agrees to observe all terms set forth in the above agreement to withhold such sums from the settlement, award, or judgment, as may be necessary to adequately and fully protect the doctor. Attorney further agrees to sign and return this agreement to doctor and a copy to patient within FIVE WORKING DAYS OF RECEIPT OF THIS LIEN AGREEMENT. Attorney agrees to pay doctor's bill in full within ten (10) days of receipt of the settlement check, draft or any other payment to plaintiff's attorney including medical benefits.

Dated: ____________________________________ ____
Attorney's Signature

Dr. Bruce Cherlow
6662 Parkside Dr.
Parkland, FL 33067

Have you consulted or hired an attorney regarding this accident/ injury.

Yes [ ] **No [ ]**

If yes, please fill out the following information.

Attorney Name:____

Address: ____

Phone Number:____

Have you informed your insurance carrier of your injuries and that you are seeking treatment?

Yes [ ] **No [ ]**

If yes, please provide a claim # ______________________________

Carrier Name:____

Adjuster Name:____

Adjuster Phone Number:______________________________

Adjuster Fax Number:_________________________________