ATLANTIC COUNTY
FAMILY SPINE & REHAB CENTER
Restoring Health and Wellness through Chiropractic Care

GALLOWAY	EGG HARBOR TOWNSHIP	ATLANTIC CITY	HAMMONTON
506 S. New York Road	2500 English Creek Avenue	1125 Atlantic Avenue, Suite 106	1145 S. White Horse Pike
Galloway, NJ 08205	Egg Harbor Township, NJ 08234	Atlantic City, NJ 08401	Hammonton, NJ 08037
(609) 748-0222	(609) 677-5760	(609) 428-6499	(609) 704-3103

CONFIDENTIAL PATIENT CASE HISTORY

DEAR PATIENT: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to determine your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name: _____ Sex:____ Marital Status:____ Race:____ DOB:_____

Address:_____ City:_____

State: ____ Zip Code:_____ Home Phone:_____ Cell Phone:_____

Social Security #:_____ Email Address:_____

Occupation:_____ Company Name:_____

Family Doctor:_____ Phone:_____ Last Physical: _____

Have you had previous Chiropractic Care? ☐ Yes ☐ No Last Seen: _____

What is your main complain? _____

Other Complaints? _____

What makes it worse? _____

What makes it better? _____

Is this related to: Auto Accident ☐ Yes ☐ No; Work Injury ☐ Yes ☐ No; Slip & Fall Injury ☐ Yes ☐ No

How long have you had this condition? _____ Similar condition in the past? _____

Other Doctors treated for this condition?_____

Related testing: ☐ X-ray ☐ MRI ☐ CT Scan ☐ EMG/NCV(nerve test) ☐ Other_____

If yes, please list all test completed and where they were done: _____

MEDICAL HISTORY:

List any surgical operations and year performed: _____

_____

Have you ever had any injuries or auto accidents? ☐ Yes ☐ No If yes, when and describe? _____

_____

Do you currently or have you ever suffered from:

☐ Dizziness ☐ Backaches ☐ Heart trouble ☐ Diabetes ☐ Arthritis ☐ Headaches

☐ Asthma ☐ Neuritis ☐ Sinus Problems ☐ Nervousness ☐ Neck Pain ☐ Stroke

☐ Nausea ☐ Osteoporosis ☐ Reflux/heartburn ☐ Parkinson's ☐ Digestive Disorders

☐ Cancer ☐ Pacemaker ☐ Other _____

Are you currently on prescription medications? ☐ Yes ☐ No If yes, please list: _____

_____

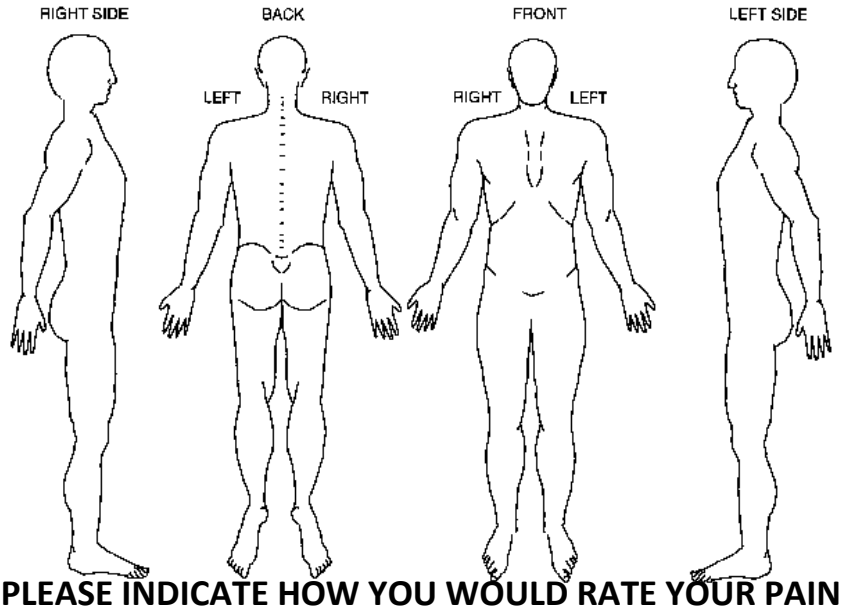
Do you have any drug allergies? ☐ Yes ☐ No If yes, please list: _____

_____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many a day and how often? _____

PAIN DRAWING: Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, ←, → arrow to indicate the pain.

A = Ache	B = Burn	R = Radiating Pain	D = Dull Pain
N = Numbness	S = Stabbing	P = Pins & Needles	O = Other



PLEASE INDICATE HOW YOU WOULD RATE YOUR PAIN

(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

HISTORY OF PRESENT CONDITION

I was involved in a:

☐ Automobile Accident; ☐ Work Injury; ☐ Slip & Fall Injury; ☐ Other _____

Date of Injury: _____/_____/_____

If an automobile accident related injury, check all that apply:

☐ I was the driver ☐ I was a passenger sitting in the ☐ front seat ☐ back seat

Were you wearing a seatbelt? ☐ Yes ☐ No

Describe how the accident occurred: _____

_____

What were your symptoms immediately following the accident?: _____

_____

Did you go to the hospital? ☐ Yes ☐ No Name of Hospital _____

If yes, by ambulance? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

If you did not go to the hospital, where and when did you first seek treatment? _____

_____

PAST TRAUMA/HISTORY PRIOR TO THIS ACCIDENT

Have you ever had an injury or similar symptoms? ☐ Yes ☐ No

Type of previous injury or similar symptoms:

☐ Automobile Accident; ☐ Work Injury; ☐ Slip & Fall Injury; ☐ Other _____

List dates of injuries: _____

Previous Surgery? ☐ Yes ☐ No List All _____

Prior x-rays, MRI's, EMG's (nerve testing)? ☐ Yes ☐ No List all _____

MOTOR VEHICLE INSURANCE

Do you have auto insurance or reside with someone who has auto insurance? ☐ Yes ☐ No

Auto Insurance Name: _____ Phone #: _____

Policy # _____ Adjuster Name: _____

Policy Holder: _____ Relationship: _____

Did you report the accident to insurance company? ☐ Yes ☐ No Claim # _____

Attorney Name: _____ Phone # _____

Did you fill out a PIP applications at your attorney's office? ☐ Yes ☐ No

_____ _____

Signature Date

HEALTH INSURANCE AND FINANCIAL RESPONSIBILITY:

If you have supplied a copy of your card, please write **"see card"** in the name space. If no insurance, write **"none."**

Primary Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? ☐ Yes ☐ No If yes, did you bring it with you today? ☐ Yes ☐ No

Secondary Insurance Name: _____ Phone #: _____

ID # _____ Group # _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Is a referral required? ☐ Yes ☐ No If yes, did you bring it with you today? ☐ Yes ☐ No

All services rendered are charge directly to you, the patient. You then are ultimately responsible for all payments regardless of whether or not this office accepts insurance assignment

1. PATIENTS WITHOUT INSURANCE – All payments are expected at the time services are rendered, unless prior financial arrangements have been established. Patient balances may not exceed $150.00 at any time.
2. PATIENTS WITH INSURANCE – Deductible and all copayments are expected at the time services are rendered. Patient balance may not exceed $150.00 at any time.

It is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions concerning your health care or our policy, please let us know. We welcome your referrals and look forward to an excellent doctor-patient relationship what works for our mutual benefit.

I understand if I default in paying my portion due, I will be responsible for any and all collection fees, legal cost and attorney fees.

I DO NOT HAVE ANY ADDITIONAL INSURANCE COVERAGE OTHER THAT WHAT I HAVE PROVIDED ABOVE. IT IS MY RESPONSIBILITY TO PROVIDE THIS OFFICE WITH ANY CHANGES OR UPDATES WHEN IT COMES TO MY MEDICAL COVERAGE. IF I DO NOT PROVIDE THE PROPER INFORMATION REGARDING MY COVERAGE, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANYTHING NOT COVERED BY MY INSURANCE COMPANY.

I understand and agree that the health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection for the insurance company and that any amount authorized to pay directly to this chiropractic office will be credited to my account on receipt. However, 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 HAVE READ AND UNDERSTAND THE ABOVE POLICY AND FULLY ACCEPT ALL OF ITS TERMS.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

ATLANTIC COUNTY FAMILY SPINE AND REHABILITATION CENTER

Restoring Health and Wellness through Chiropractic Care

We believe a clear definition of our office policy will allow both patient and the doctor to concentrate on the big issues – REGAINING AND MAINTAINING YOUR HEALTH.

APPOINTMENTS

1. We honor all appointments at the scheduled time.
2. Multiple appointments will be given for your convenience in order to incorporate these appointments into your daily routine.
3. It is the frequency of visits that count and not the days, therefore, if you are unable to keep a scheduled appointment, please CALL IMMEDIATELY to reschedule your visit. It is your obligations to make up a missed appointment within the same week of any cancellation.

HEALTH CLASS

IN ORDER FOR US TO BETTER CARE FOR YOUR SPINAL HEALTH NEEDS, WE FEEL IT IS NECESSARY TO EDUCATE OUR PATIENTS SO THEY WILL HAVE A BETTER UNDERSTANDING OF HOW THE SPINE FUNCTIONS AND WHAT WE TOGETHER CAN DO TO ASSURE YOU A HEALTHIER FUTURE.

WITH THIS IN MIND, AS A PART OF YOUR TREATMENT PLAN YOU WILL BE REQUIRED TO ATTEND A SPECIAL CONSULTATION ON A WEDNESDAY AFTERNOON OR EVENING, WHICHEVER IS CONVENIENT FOR YOU.

THIS CONSULTATION (ONLY ONE) WILL EASILY FIT INTO ONE OF YOUR REGULAR OFFICE VISITS.

PLEASE CHOOSE BELOW WHICH TIME WILL BEST FIT INTO YOUR SCHEDULE.

☐ AFTERNOON CLASS 1 PM ☐ EVENING CLASS 7 PM

TERMS OF ACCEPTANCE

The purpose of chiropractic is to restore and maintain the flow of the nerve energy along the spinal cord and its nerve roots. Any misalignment of the spinal bones can interfere with the flow of this nerve energy. Interference to the nerve energy flow may disrupt the proper activity of various organs, muscles, or body parts.

The only goal of chiropractic is to correct spinal misalignments called vertebral subluxations. This restores the flow of nerve energy so that the parts of the body may have a normal nerve supply.

With proper nerve supply, health can improve. In some people symptoms may clear quickly. In others, the process is slower. Unfortunately, in some people there is only partial healing or none at all.

Regardless of what disease or condition is called, the chiropractor does not offer to heal or treat it. Nor does the chiropractor offer advice regarding the treatment of disease. The only goal is to allow the body to do its job. The only method is the correction of these subluxations. The chiropractor promises no cure from and offers no treatment of disease.

I have read the above, understand it fully, and undertake chiropractic care on this basis.

_____ _____

Signature Date

AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

I hereby authorize:

Atlantic County Family Spine & Rehab
506 South New York Road
Galloway, NJ 08205

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to: Atlantic County Family Spine and Rehab
Street Address: 506 South New York Road City: Galloway State: New Jersey Zip Code: 08205

Please indicate the information or types of information to be disclosed, including dates if necessary:

_____

_____

Specify dates (or date ranges) if applicable: _____

_____

This request is for the purpose of: _____

I understand that I have the right to revoke this authorization at any time. I understand that my revocation should be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date: _____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that the information in my health record may include information pertaining to treatment of drug and alcohol abuse, mental health, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis information of genetics.

_____ _____

Signature of Patient or Authorized Representative Date:

ATLANTIC COUNTY FAMILY SPINE AND REHABILITATION CENTER, LLC

506 South New York Road, Galloway, NJ 08205 (609) 748-0222 Fax: (609) 748-0270

HIPAA Notice of Privacy Practices

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

The Health Insurance Portability and Accountability Act of 1996(HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse Protected Health Information (PHI).

This Notice of Privacy Practices described how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (HCO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use or disclose, as needed, your protected health information to support the business activities of this practice. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of an upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health Issues required by law: Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity, Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when requited by the

Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of HIPAA.

OTHER PERMITED AND REQUIRED USES AND DISCLOSURES will be made only with your consent, authorization or opportunity to object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you will have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this Notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

_____ _____

Signed Dated

FOR OFFICE USE ONLY

☐ Patient Refused to Sign

☐ Patient Unable to Sign for the following reason _____

ATLANTIC COUNTY
FAMILY SPINE & REHAB CENTER
Restoring Health and Wellness through Chiropractic Care
506 S. New York Road, Galloway, NJ 08205 Phone: (609) 748-0222

ASSIGNMENT OF BENEFITS
&
LIMITED POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments to directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due to you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

_____ _____

Date Patient's Signature

_____

Patient Name

ATLANTIC COUNTY
FAMILY SPINE & REHAB CENTER
Restoring Health and Wellness through Chiropractic Care
506 S. New York Road, Galloway, NJ 08205 Phone: (609) 748-0222

I _____, residing at _____ hereby enter into a guarantee of payment with Atlantic County Family Spine and Rehab, hereafter known as "the provider". I understand that I am directly and full responsible to "the provider" for all medical bills for services rendered to me. I understand that I am directly and fully responsible to "the provider" for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier. This document further serves to acknowledge my responsibility to repay **all** remaining balances subsequent to all applicable insurance payments. I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collection effort that is undertaken.

The provider agrees to seek compensation from the appropriate insurance carrier(s) prior to invoking the terms of this lien based on the accuracy of the information the patient has provided. The patient shall provide all necessary insurance information, including any private health insurance, police reports, and any additional documentation or information deemed necessary by the provider for the submission of the aforementioned insurance claims applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of benefits.

I hereby direct and authorize direct payment to "the provider", such sums as may be due and owing for medical services rendered to me. I further direct my attorney, _____, to honor the foresaid lien and to withhold such sums from any settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me toward any outstanding balances with regard to my accident of _____.

I hereby further instruct that in the event another attorney is substituted in my case that the new attorney honor this lien as inherent to the settlement, judgment, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on demand, to provide the status of such litigation to the "the provider" or his attorney. Furthermore, I direct my attorney to contact "the provider" prior to disbursement of any funds to ascertain any outstanding balances due and owing to Atlantic County Family Spine and Rehabilitation Center.

_____ _____

Patient's Signature Date