



**Patient Questionnaire - Work-Accident**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Date of Exam: \_\_\_/\_\_\_/\_\_\_ Provider: \_\_\_\_\_ New Patient  Yes  No

**Basic Information about the Accident:**

Date Accident Occurred or Started: \_\_\_/\_\_\_/\_\_\_ Time of Day when Accident Occurred or Started: \_\_:\_\_\_ AM / PM

Describe how the Accident took place: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the condition or symptoms caused by the Accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Work-Accident Specific Information**

Check all that apply:

- Did the accident occur on the premises of the facility where you normally work (i.e., your local work address)?
- Did the accident occur during your normal working hours?
- Did you report the accident to your Employer?
- Is your Employer covered by Workers' Compensation Insurance under state law?
- Has your Employer prepared an initial written report?



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- Does the Employer's Report describe the condition or symptoms you are experiencing?
- Has a claim number been issued for this accident?
- Have you received any written denial of liability from either your Employer or Worker's Insurance Comp Payer?

**Additional Information Related to the Condition:**

Describe your pain:  Burning  Sharp  Dull  Ache

What caused it? \_\_\_\_\_

What aggravates it? \_\_\_\_\_

What relieves it? \_\_\_\_\_

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence?  Yes  No                      When? \_\_\_/\_\_\_/\_\_\_

**Describe:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate any other healthcare providers whom the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

- Headache
- Dizziness
- Light Bothers Eyes
- Diarrhea
- Head seems too heavy
- Neck Pain
- Loss of Memory
- Clumsiness



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- Feet Cold
- Neck Stiff
- Tingling in arms/hands
- Ears Ring
- Hands Cold
- Sleeping Problems
- Tingling in legs/feet
- Face Flushed
- Nausea
- Back Pain
- Numbness in arms/hands
- Buzzing in Ears
- Constipation
- Nervousness
- Numbness in legs/feet
- Loss of Balance
- Cold Sweats
- Tension
- Difficulty swallowing
- Fainting
- Shortness of Breath
- Fatigue
- Irritability
- Loss of Smell
- Sharp/shooting pain.
- Fever
- Chest pain/rib pain
- Jaw Pain
- Pain in arms/hands
- Pain in legs/feet
- Loss of strength - arms
- Burning muscle Pain
- Loss of strength - legs

Have you experienced changes to:

- Eyes (sight)
- Ears (hearing)
- Nose (smell)
- Mouth (taste)
- Bladder
- Bowels
- Sleep
- Emotion
- Appetite

Please Explain: \_\_\_\_\_

Have you missed work or school due to your injuries?  Yes  No

Do you smoke?  Yes  No      Number of packs: \_\_\_\_\_

Do you drink alcohol?  Yes  No      Number of Drinks \_\_\_\_\_

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



### Medical History

Have you ever been in our office before?  Yes  No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

2) \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

3) \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Surgeries/Hospitalizations: \_\_\_\_\_

Allergies (please list all): \_\_\_\_\_

Do you now have or have you ever had:

Heart Disease     Diabetes     Cancer     Stroke     High Blood Pressure

Thyroid Problems     Tuberculosis     Prostate Disorder

Kidney Problems     Asthma     Ulcer     Seizure Disorder

Other: \_\_\_\_\_



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PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION AS ACCURATELY AS POSSIBLE. THANK YOU.

How did you hear about our office?  Yellow Pages  Sign  Friend  Patient  Promotion \_\_\_\_\_

Other (Please specify) \_\_\_\_\_ If referred by a patient, WHOM? \_\_\_\_\_

### ABOUT YOU

Full Name \_\_\_\_\_ Prefer to be called \_\_\_\_\_ Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_

### PRIMARY INSURANCE

Company Name \_\_\_\_\_ ID Number \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_ Policy Holder's SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy

Holder's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_ Policy Holder's Employer \_\_\_\_\_

### SECONDARY INSURANCE (if applicable)

Company Name \_\_\_\_\_ Insured's Name \_\_\_\_\_

Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # (\_\_\_\_) \_\_\_\_\_ Insured's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Group # \_\_\_\_\_

### EMERGENCY CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

### PRIMARY CARE PHYSICIAN (MEDICAL DOCTOR)

Name \_\_\_\_\_ Office Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been to a chiropractor before?  No  Yes If "Yes", when? \_\_\_\_\_
2. Were you ever injured in an automobile accident either as a passenger or the driver?  No  Yes If "Yes", when? \_\_\_\_\_
3. Were you ever injured at work or as the result of employment?  No  Yes If "Yes", when? \_\_\_\_\_

### CHIEF COMPLAINT

What is the primary symptom that prompted today's visit? \_\_\_\_\_

What other symptoms are you experiencing, if any? \_\_\_\_\_

Have you seen anyone else for this condition?  No  Yes

If "Yes", who else have you seen? (Include hospital/E.R. visits and names of physicians. Please note details, if known. If you need additional space, use the back of this page. If any of these practitioners referred you here, please indicate that as well.) \_\_\_\_\_

When did you first experience the problem that prompted your visit? \_\_\_\_\_

Onset characteristics:  Occurred suddenly  Occurred gradually  Progressively worsened over time



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Do you have a personal or family history of cancer/malignancy?  No  Yes, personal  Yes, family

If "family", please indicate family relation: \_\_\_\_\_

Do you have any personal or family history of Diabetes?  No  Yes, personal  Yes, family

If "family", please indicate family relation: \_\_\_\_\_

Do you have any other pertinent personal or family history?  No  Yes, personal  Yes, family

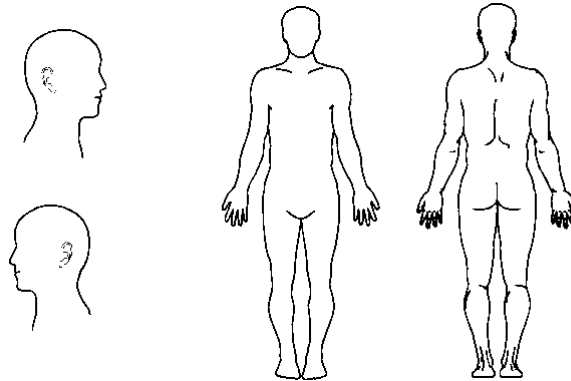
If "yes" please list: \_\_\_\_\_

**CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY AND CURRENT SYMPTOMS**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Ear Infections             | <input type="checkbox"/> Menstrual Pain/PMS |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Mid-back Pain      |
| <input type="checkbox"/> Arm/Shoulder Pain           | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Neck Pain          |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Fever                      | <input type="checkbox"/> Nervousness        |
| <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> Gallbladder Symptoms       | <input type="checkbox"/> Numbness           |
| <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> Head seems too Heavy       | <input type="checkbox"/> Pain down legs     |
| <input type="checkbox"/> Buzzing/Ringing Ears        | <input type="checkbox"/> Headaches/Migraines        | <input type="checkbox"/> Pinched Nerves     |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Hepatitis/liver symptoms   | <input type="checkbox"/> Poor Circulation   |
| <input type="checkbox"/> Chest Pain/Heart Trouble    | <input type="checkbox"/> Hip Pain                   | <input type="checkbox"/> Poor Posture       |
| <input type="checkbox"/> Cold, Tingling Extremities  | <input type="checkbox"/> Indigestion/Stomach        | <input type="checkbox"/> Scoliosis          |
| <input type="checkbox"/> Concentration Loss          | <input type="checkbox"/> Insomnia/Sleeping Problems | <input type="checkbox"/> Sinus              |
| <input type="checkbox"/> Constipation/Diarrhea/Colon | <input type="checkbox"/> Joint Pain                 | <input type="checkbox"/> Stress/Tension     |
| <input type="checkbox"/> Convulsions/Epilepsy        | <input type="checkbox"/> Kidney Problems            | <input type="checkbox"/> Tight Muscles      |
| <input type="checkbox"/> Cold Sweats                 | <input type="checkbox"/> Light bothers eyes         | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Loss of energy             | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Loss of memory             | <input type="checkbox"/> Vision Blurred     |
| <input type="checkbox"/> Disc Problems               | <input type="checkbox"/> Loss of smell/taste        | <input type="checkbox"/> Weight Loss        |
| <input type="checkbox"/> Dizziness                   | <input type="checkbox"/> Low Back Pain              | <input type="checkbox"/> Other _____        |

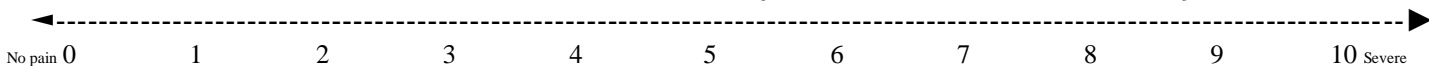
IF YOU CHECKED ANY OF THE ABOVE, PLEASE EXPLAIN: \_\_\_\_\_

**PLEASE OUTLINE ON THE DIAGRAMS BELOW THE AREAS OF YOUR DISCOMFORT**



- |                      |               |
|----------------------|---------------|
| A = Aching           | N = Numbness  |
| B = Burning          | R = Throbbing |
| C = Cold             | S = Stabbing  |
| H = Hypersensitivity | T = Tingling  |

**PLEASE RATE YOUR PAIN (PLACE AN "X" ON THE SCALE)**





# THE SPINE & HEALTH CENTER OF NEW JERSEY

**PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:**

- I have missed work because of my symptoms.
- The quality of my work/my productivity at work has been affected.
- I am unable to perform routine household chores.
- My social life has suffered because of my symptoms.
- I am unable to participate in recreational activities because of my symptoms.

Current Medications (and dosages, if known):  None

Previous Surgeries:  None

Previous Hospitalizations:  None

Previous Significant Illnesses:  None

Previous Injuries and Traumas:  None

Previous History of Similar Condition(s):  None

**ACCOUNT INFORMATION AND TERMS OF ACCEPTANCE**

I hereby give my authorization to treat me, or my minor child, as named herein on this form. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable at the regular rates, irrespective of any concessions made, discounts applied and/or other such arrangements I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. We do not offer to treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of an examination, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

**I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information.**

\_\_\_\_\_  
Patient Signature or Parent/Guardian if patient is a minor

\_\_\_\_\_  
Date Signed



# THE SPINE & HEALTH CENTER OF NEW JERSEY

## BLUE CROSS/ BLUE SHIELD PAYMENT POLICY

Dear Patient:

Recently our office received a notice that BC/BS will no longer be paying doctors directly for care. Instead they will only send insurance payments directly to patients.

For this reason, many doctors and hospitals will be requiring patients to pay at the time of service. For many, this will be a financial hardship. In an attempt to make our care more affordable and accessible to all of our patients, we will allow patients the courtesy of receiving payment from the insurance carrier first, and then forward those payment(s) to our office upon receipt.

Understand this is a courtesy and can be withdrawn at any time if we find a patient's account overdue.

By signing this letter you agree to forward all payments to our office immediately upon receipt. If we received payment within 10 days of your receiving them, endorsed and un-cashed, with documentation we will accept those insurance payments in full and you will not be responsible for any additional amounts should they pay less than anticipated. *(Understand this may not include deductible amounts or co-payments, which you may have to pay under your plan.)*

Should you fail to forward payments immediately, however, our office will make you responsible for all charges, even those not covered by the insurance company. After 30 days if we do not receive payment, your account will be sent to our collection agency, or your credit card on file will be billed.

*I agree to send all insurance payments received with 10 days of receipt.*

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

-----  
*Please retain your credit card number on file with us.*

**Credit Card:**  Master Card  Visa

Name on Credit Card: \_\_\_\_\_ Card Security ID Number: \_\_\_\_\_

Account Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_  
-----

**Remember:**

1. Send or bring all original checks to our office and **do not cash them**. Sign your name on the back of the check and write "Pay to the order of The Spine & Health Center of Montvale"
2. Include all paperwork sent with the check by the insurance company
3. Advise your spouse if they are the primary insured that payments meant for our office may be sent to their name, and to do the same as above.





# THE SPINE & HEALTH CENTER OF NEW JERSEY

## RELEASE OF MEDICAL RECORDS

PATIENT NAME: \_\_\_\_\_  
Please Print (Last Name) (First Name)

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

- I authorize the use or disclosure of the above named individual's health information as described below:
- The following individual or organization is authorized to make the disclosure:
- The Type of information to be used or disclosed is as follows: (included dates where appropriate)
  - Emergency Records** Date: \_\_\_\_\_
  - Operative Reports** Date: \_\_\_\_\_
  - Admission** Date: \_\_\_\_\_
  - X-ray & Imaging Reports** Date: \_\_\_\_\_
  - Consultation Reports** (Doctor's name): \_\_\_\_\_
  - Most Recent Discharge Summary**
  - Laboratory Results**
  - Entire Records**
  - Other** \_\_\_\_\_
- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or organization.

\_\_\_\_\_  
(Facility Name) (Facility Address)

**For the purpose of:** Investigating and pursuing a bodily injury case on my behalf.

- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524, I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

Signature of Patient X \_\_\_\_\_  
(Please sign here) (Date)

Signature of Witness X \_\_\_\_\_  
(Please sign here) (Date)

Any person who knowingly files a statement of claim containing any False or Misleading Information is subject to criminal and civil penalties



# THE SPINE & HEALTH CENTER OF NEW JERSEY

**TO OUR VALUED PATIENTS:**

Due to changing Governmental Regulations, we are required to gather additional information for all patients. Please answer the following questions. **ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.**

Thank you for your cooperation.

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Race (select one):**

Hispanic or Latino: \_\_\_\_\_

Not Hispanic or Latino: \_\_\_\_\_

Decline to answer: \_\_\_\_\_

**Ethnicity: (select one)**

American Indian or Alaska Native: \_\_\_\_\_

Asian: \_\_\_\_\_

Black or African American: \_\_\_\_\_

Native Hawaiian or other Pacific Island: \_\_\_\_\_

Other Race: \_\_\_\_\_

White: \_\_\_\_\_

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Alcohol Consumption (select one):**

None: \_\_\_\_\_

Yes: \_\_\_\_\_ # of drinks per day: \_\_\_\_\_

Occasional/Social: \_\_\_\_\_

**Do You Smoke Cigarettes?:**

Yes: \_\_\_\_\_ # packs per day: \_\_\_\_\_ # of cigarettes per day: \_\_\_\_\_

No: \_\_\_\_\_

**Did You Ever Smoke Cigarettes?:**

If Yes: \_\_\_\_\_ from when: \_\_\_\_\_ to when: \_\_\_\_\_

No: \_\_\_\_\_

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**PAYMENT POLICIES/ASSIGNMENT OF BENEFITS**

We are committed to providing you with the best possible care. Please read carefully and sign at the bottom of the page indicating your acceptance of our policies and procedures.

**1. PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.**

- a. Your insurance is a contract between you, your employer and the insurance company. We are not included in your contract.
- b. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover
- c. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
- d. If your account becomes past due and goes to our collections agency, you are responsible for all fees incurred.

**2. OUR OFFICE PRIDES ITSELF ON OUR ABILITY TO SEE PATIENTS IN A TIMELY MANNER.**

**THEREFORE, WE REQUIRE 24 HOURS NOTICE FOR ALL CANCELLATIONS. THERE WILL BE A \$25.00 NO-SHOW OR SAME DAY CANCELLATION FEE. REPEATED SAME DAY CANCELLATIONS OR NO-SHOWS WILL REQUIRE US TO TAKE A \$49 HOLD FEE VIA CREDIT CARD WHICH WILL BE CHARGED AT THE TIME THE APPOINTMENT IS MADE IN ORDER TO BOOK ANY FUTURE APPOINTMENTS. THIS \$49 WILL BE CREDITED TO YOUR ACCOUNT (CO-PAY, DEDUCTIBLE, NON-COVERED SERVICE) AFTER YOU COME IN FOR THE APPOINTMENT.**

- 1<sup>ST</sup> CANCELLATION: \$25.00 CANCELLATION OR NO-SHOW FEE.
- 2<sup>ND</sup> CANCELLATION: \$25.00 CANCELLATION OR NO-SHOW FEE
- 3<sup>RD</sup> + CANCELLATION: \$49 HOLD FEE TO BOOK FUTURE APPOINTMENTS (CREDITED TO PATIENT ACCOUNT AFTER VISIT)

**3. I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO THE SPINE AND HEALTH CENTER OF MONTVALE.**

- a. This is a direct assignment of my rights and benefits under my health insurance policy. I agree to pay any balance of professional services charged over and above this insurance payment.
- b. If my current policy prohibits payments directly to the doctor, I agree to mail the check (original or personal) as payment for services rendered.

**4. I HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.**

\_\_\_\_\_  
**Patient/Policy holder signature**

\_\_\_\_\_  
**Date**



# THE SPINE & HEALTH CENTER OF NEW JERSEY

## INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, Physical Therapy, Acupuncture and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic, Physical Therapists or Acupuncturists who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, physical therapy, acupuncture and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to; Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. Dizziness, nausea, and flushing; these symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**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 Spine and Health Center of Montvale is required by law to maintain the privacy and confidentiality of your protected health information.

**DISCLOSURE OF YOUR HEALTH INFORMATION**

**Treatment**—We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

**Payment**—We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

**Workers Compensation**— We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Emergencies**—We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

**Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

**Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceeding.

**Law Enforcement**

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Deceased Persons**

We may disclose your health information to coroners or medical examiners.

**Organ Donation**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

**Research**

We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

**Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

**Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

**Marketing**

We may contact you for marketing purposes or fundraising purposes. We may call you at home to remind you of appointments and may leave a message if there is no answer or you are not available. No health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.

**Change of Ownership**

In the event that The Spine and Health Center of Montvale, PC is sold or merges, your health information/record will become the property of the new owner.

**Your Health Information Rights**

You have the right to request restrictions on certain uses and disclosures of your health information. The Spine and Health Center is not required to agree to the restriction.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.

**Treatment**

This office uses both open and closed room adjusting and therapy. Per request, we will accommodate you to a closed room for adjusting and therapy.

**Changes to this Notice of Privacy Practices**

The Spine and Health Center of Montvale, PC reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact Dr. Wohl at 201-746-6577. If Dr. Wohl is not available, you may make an appointment to meet with him in person or via telephone within two working days.

**Complaints**

Complaints about how The Spine and Health Center of Montvale has handled your health information should be directed towards Dr. Wohl at 201-746-6577. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights; 200 Independence Ave, S.W.; Room 509F HHH Building; Washington, D.C. 20201. This notice is effective as of April 07, 2008.