Registration Form

Please complete this form, print it out and bring to your appointment.

PATIENT NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP:

DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____

AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY # _____

EMPLOYER: _____ ☐ FULL TIME ☐ PART TIME

ADDRESS: _____

WORK PHONE: _____ E-MAIL: _____

OCCUPATION: _____ DRIVERS LIC. #: _____

How did your hear about our office? _____

SPOUSE/EMERGENCY CONTACT: _____

ADDRESS: _____ HOME PHONE: _____

RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

PRIMARY MD NAME: _____ PHONE #: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY COVERAGE (IF MOTOR VEHICLE ACCIDENT –LIST MOTOR VEHICLE INS. FIRST)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

SECONDARY COVERAGE (PLEASE WRITE "NONE" IF THERE IS NO SEC. INSURANCE)

NAME OF INSURANCE CO.: _____

ADDRESS: _____ PHONE: _____

CONTACT PERSON (ADJUSTER): _____

POLICYHOLDER'S NAME & RELATIONSHIP: _____

GROUP #: _____ ID / POLICY #: _____

Check If Applicable: ☐ Motor Vehicle Accident ☐ Work Injury Date of Accident: _____

Automobile Accident Questionnaire

Please answer all questions Completely

Dear patient: this information is considered confidential. If we need this information to better understand the events surrounding your unfortunate trauma, and your answers will help us determine if chiropractic care can help you. In order for us to understand your condition of, please be as need an accurate as possible what we need is for. Thank you.

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
DATE OF BIRTH _____ HOME PHONE: _____ CELL PHONE: _____
AGE: _____ MARITAL STATUS: _____ SOCIAL SECURITY # _____
E-MAIL: _____
EMPLOYER: _____ □ FULL TIME □ PART TIME
ADDRESS: _____ WORK PHONE: _____
OCCUPATION: _____ DRIVERS LIC. #: _____
SPOUSE/EMERGENCY CONTACT: _____
ADDRESS: _____ HOME PHONE: _____
RELATIONSHIP TO PATIENT: _____ WORK PHONE: _____

Accident Information: Date of Accident: _____ City of Accident: _____
Police Report: □ Yes □ No (If yes, please provide us with a copy of the police report)

Accident Description:

1. Your Vehicle

□ Car □StationWagon
□ Van □ Pickup Truck
□ Bus □ Large Truck

2. Your Position in Vehicle

□ Driver □ Front Passenger
□ Left Rear
□ Right Rear

3. What was your vehicle doing?

□ **Stopped** □ Intersection □ in traffic □at Light
□ Turning □ right □ Left □ Parking
□ Proceeding along □ Slowing down □ Accelerating

4. Time/Speed/Damage

Time:
Your Vehicle's Speed _____ MPH
Other Vehicle's Speed _____ MPH
Damage to your vehicle
□ Mild □ Moderate
□ Totaled

5. Details of Accident

Visibility at time of accident
□ Poor □ Fair □ Good

Who hit who/what?
□ You hit other vehicle
□ Other vehicle hit you
You hit...(object):

6. Road Conditions

Road conditions at time of accident
□ Icy □ Wet □ Sandy □ Dark □ Clean and dry

Point of impact
□ Head-on □ Left Front □ Right Front
□ Rear-end □ left Rear □ Right Rear
□ Right Side (Passenger) □ Left Side (Driver)

7, Body Position

Did you see the accident coming? □ Yes □ No
Were you braced for the impact? □ Yes □ No
Did you have a seat belt on? □ Yes □ No
Did you have a shoulder harness on? □ Yes □ No
Did your airbag deploy □ Yes □ No

8. Does your vehicle have headrest? □ Yes □ No

What was the position of your headrest?
□ Even with top of head □ Even with bottom of head
□ Middle of neck
What was the direction of your head?
□ Facing straight forward □ Turned to the right
□ Turned to the Left

9. During and after the Accident:

Did your body strike the inside of your vehicle □ Yes □ No
If yes, describe: _____
Did you lose consciousness? □ Yes □ No
If yes, how long? _____
Vehicle's estimated damage: _____
Emergency Room:
Where did you go after the accident?
□ Home □ Work □ Hospital ER □ Private Doctor
How did you get there?
□ Drove Self □ Somebody else □ Ambulance □ Police

10. After the accident:

□ Headache □ Dizziness □ Mid back pain
□ Neck Pain □ Nausea □ Low back pain
□ Neck Stiff □Confusion □ Nervousness
□ Fainting □ Fatigue □ Loss of taste
□ Ring in ears □ Tension □ Constipation
□ Loss of smell □ Irritability □ Cold hands
□ Eye Pain □ Anxious □ Chest pain
□ Numbness: □Arms □ Hands □ Legs □ Feet
□ Problems Sleeping □ Shortness of Breath
Others:

11. Treatment History:

Hospital: Date of Visit: _____
xrays: □ Neck □ Head □ Mid Back □ Low Back □ Chest
Lab Work _____
Medications _____
Treatments □ Medication □ Brace □ Injection
Other:

Doctor: _____ Date of Visit: _____
xrays: □ Neck □ Head □ Mid Back □ Low Back □ Chest
Lab Work _____
Medications _____
Treatments □ Chiropractic □ MD □ PT □ Pain Man
Explain:

Continued on Back ⇨

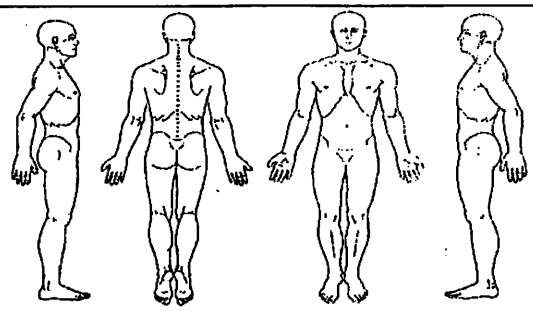
Additional Accident Information: _____

_____

_____

Current Locations of Pain (Mark all that apply):
□ Head □ Neck □ Arms □ Upper Back □ Mid Back □ Chest □ Ribs □ Low Back □ Buttock □ Legs □ Feet
Other: _____

Type of Current Symptoms:
□ Dull pain □ Sharp pain □ Burning pain □ Throbbing pain □ Shooting pain □ Cramping □ Spasm □ Stiffness
□ Numbness Arms/hands □ Numbness Legs/feet □ Dizziness □ Spinning sensation □ Lightheaded □ Nausea
Other: _____



Mark Your Pain on the Above Diagram

On the scale below, rate your pain intensity by circling the appropriate number: 0= no pain, 10 = unbearable pain.

1	2	3	4	5	6	7	8	9	10

How often do you experience your symptoms?

□ Constantly (76-100% of the day) □ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day) □ Intermittently (0-25% of the day)

To what degree do your symptoms interfere with your daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms		Mild Forgotten with activity		Moderate interferes with activity		Limiting Prevents Full activity		Intense preoccupied with pain		Severe no activity possible

My symptoms interfere with my: □ Sleep □ Work □ Personal Care □ Social life □ Recreation □ None of these

Currently your pain is aggravated by:

□ Coughing □ Neck Movements □ Bending □ Walking
□ Sneezing □ Reaching □ Lifting □ other:_____
□ Straining at Stool □ Sitting □ Standing □ None of these

Have you ever had complaints in the involved areas before? □ Yes □ No
Have you ever had prior treatment for any same or similar condition? □ Yes □ No
Before the accident were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work or daily activities restricted as a result of this accident? □ Yes □ No
Since the injury are your symptoms □ Improving? □ Getting worse? □ Same?

I understand and agree that health and accident policies are in arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assisting in making collection from the insurance company and that any amount authorized to be paid to 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.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT FORM

(TWENTY ONE DAY NOTICE)

(N.J.A.C. 11:3-25, et seq)

TREATING HEALTH CARE PROVIDER INFORMATION:

NAME: BRUNSWICK CHIROPRACTIC CENTER OF NJ, LLC
PROVIDER: Ivan B. Kosin, DC/ Neil I. Kosin, DC
ADDRESS: 1594 Route 130
North Brunswick, NJ 08902
PHONE: 908-753-5454 FAX: 732-821-7580

PATIENT INFORMATION:

NAME: _____
ADDRESS: _____
_____

INSURED INFORMATION (IF DIFFERENT THAN PATIENT):

NAME: _____
ADDRESS: _____
_____

INSURER INFORMATION:

NAME: _____
ADDRESS: _____
_____

POLICY NUMBER: _____
CLAIM NUMBER: _____
DATE OF ACCIDENT: _____
FIRST TREATMENT DATE: _____

ASSIGNMENT OF PIP MEDICAL BENEFITS FORM

PATIENT AUTHORIZATION:

I am the Patient described above and I authorize and direct the Insurer described above to pay the Treating Health Care Provider described above, the amount due under the terms of the policy described above for any PIP medical benefits rendered by the Treating Health Care Provider described above and/or all staff associated with that office.

I further authorize the Treating Health Care Provider described above to file a Demand For Arbitration (PIP) against the Insurer described above for any Payment Dispute for PIP medical benefits rendered by the Treating Health Care Provider described above and/or all staff associated with that office.

Payment Dispute shall include a denial and/or non-payment by the Insurer described above for PIP medical benefits rendered by the Treating Health Care Provider described above and/or all staff associated with that office. Payment Dispute shall also include a denial and/or refusal to authorize by the Insurer named above any recommended medical benefits

as part of the Treatment Plan of the Treating Health Care Provider described above and/or all staff associated with that office.

Release For Medical Records: It is understood that certain privacy rights attach to my medical records as created by federal and/or state legislative bodies and/or federal and/or state regulatory bodies. In order to prove the medical necessity, reasonableness and/or causal relationship of the treatment rendered to me, and/or proposed to be rendered to me, I authorize release of the medical records to the assignee and/or its agents as necessary for any Demand For Arbitration (PIP). A photocopy of this document shall serve as an original.

Release for IME Report: I authorize the Release of any IME Report and/or any Paper Review, prepared by any examining doctor, and/or any reviewing Medical Director, shall be released to my Treating Health Care Provider described above.

_____

Patient

TREATING HEALTH CARE PROVIDER REPRESENTATION:
I am the Treating Health Care Provider described above and provide the following representations to the Insurer named above in order for the Assignment of Benefits executed by the Patient named above to be honored. Specifically:

- All requirements of the Decision Point Review Plan and/or Pre Certification Plan of the Insurer named above that are in accordance with the regulations promulgated by the Department of Banking and Insurance (DOBI) shall be complied with; and
- In the event of a failure to comply with the aforementioned requirements, the Patient described above will not be held financially liable for any additional imposed penalty; and
- In the event of any dispute with the Insurer, resolution of the dispute shall be adjudicated by the filing of a Demand For Arbitration (PIP) through the administrator appointed by DOBI.

It is understood that an Insurer may apply to DOBI pursuant to N.J.A.C. 11:3-4.9 (a) for "approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage." As such, please provide me within ten days of receipt of this Form with any documentation required to effectuate the intent of the Patient described above. Failure to provide any documentation will be construed as a constructive acceptance of this Form and the intent of the Patient described above.

_____

Ivan B. Kosin, DC or Neil I. Kosin, DC

PATIENT REQUEST FOR RECORDS

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby authorize the release of my_____ or copies of such and request that thery be transferred to:

BRUNSWICK CHIROPRACTIC CENTER OF NJ, LLC
1594 ROUTE 130
NORTH BRUNSWICK, NJ 08902
(908) 753-5454
FAX: (732) 821 7580

_____ **Patients Name**

_____ **Address**

_____ **City, State and Zip Code**

_____ **Patient's Signature**

_____ **Social Security Number**

_____ **Date of Birth**

_____ **Date of Records**

_____ **Date of Accident**

Brunswick Chiropractic Center of NJ, LLC

Neil I. Kosin, DC Ivan B. Kosin, DC
1594 Route 130 North Brunswick, New Jersey 08902
Phone (908) 753 5454 Fax (732) 821 7580
www.brunswickchironj.com

RE: Doctor's Lien

Pt: _____

I do hereby authorize **Brunswick Chiropractic Center of NJ, LLC** (now referred to as doctor) to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills, including interest, on the unpaid balance of my account, that are due his office and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly responsible to said doctor for all medical bills submitted by him for services rendered my and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Dated:_____ Patient's Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agree to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said doctor above named.

Dated: _____Attorney's Signature: _____

Please date, sign and return one copy to doctor's office.
Keep one copy for your records.

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties in the original copy.

Brunswick Chiropractic Center of NJ, LLC

Neil I. Kosin, DC Ivan B. Kosin, DC
1594 Route 130 North Brunswick, New Jersey 08902
Phone (908) 753 5454 Fax (732) 821 7580
www.brunswickchironj.com

INFORMED CONSENT

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. Dr. Neil Kosin or Dr. Ivan Kosin will use that procedure to treat you. It may involve usage of our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me. Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

Other treatment options for your condition may include: self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalization and surgery. If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with either Dr. Neil Kosin or Dr. Ivan Kosin. I have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

Dated: _____

_____
Neil Kosin, D.C. and or Ivan Kosin, D.C.

_____
Signature

Brunswick Chiropractic Center of NJ, LLC

Neil I. Kosin, DC Ivan B. Kosin, DC
1594 Route 130 North Brunswick, New Jersey 08902
Phone (908) 753 5454 Fax (732) 821 7580
www.brunswickchironj.com

Patient Authorization for appointment reminders and scheduling related matters

It is our desire for our staff to use your name, address, and telephone number, post cards and /or e-mail for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose not to authorize this information, your decision will have no adverse effect on your care from **BRUNSWICK CHIROPRACTIC CENTER FO NEW JERSEY, LLC** or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Name (printed)	Signature	Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization... Please allow a reasonable processing time for the change in our system to be completed.

Brunswick Chiropractic Center of NJ, LLC

Neil I. Kosin, DC Ivan B. Kosin, DC
1594 Route 130 North Brunswick, New Jersey 08902
Phone (908) 753 5454 Fax (732) 821 7580
www.brunswickchironj.com

PATIENT PRIVACY NOTICE

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

In the course of your care as a patient at Brunswick Chiropractic Center of New Jersey, LLC, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine, e-mail address, text message or via mail. In addition, you are authorizing our office to utilize your e-mail address to send newsletters and articles pertaining to your health. Our office will not distribute your e-mail address. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide carte to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you but in our professional judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.
We normally provide information about your health to you in person at the time you receive Chiropractic care from us.

We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information ad may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our policy practices or any aspect of our privacy activities you should direct your complaint to:
Dr. Neil I. Kosin or Dr. Ivan B. Kosin

If you would like further information about our privacy policies and practices please contact: **BRUNSWICK CHIROPRACTIC CENTER of NEW JERSEY, L.L.C. (908) 753-5454**

This notice is effective as of April 14, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name (Printed please) _____ Signature _____ Date _____

If you are a minor, or if you are being represented by another party

Personal Representative Printed _____ Personal Representative Signature _____ Date _____

Description of this authority to act on behalf of the patient

Brunswick Chiropractic Center of NJ, LLC

Neil I. Kosin, DC Ivan B. Kosin, DC
1594 Route 130 North Brunswick, New Jersey 08902
Phone (908) 753 5454 Fax (732) 821 7580
www.brunswickchironj.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that you have been given a copy of our Privacy Notice, which explains how your health information will be handled in various situations.

I,_____, acknowledge that I have been provided with a copy of the Notice of HIPAA privacy.

_____

Signature of Patient or Representative

_____

Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR FROM PRIVATE HEALTH GROUP AND/OR ACCIDNET INSURANCE

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed directly to:

BRUNSWICK CHIROPRACTIC CENTER OF NEW JERSEY, LLC
1594 ROUTE 130 NORTH
NORTH BRUNSWICK, NJ 08902
TAX ID# 90-0672418

If my current policy prohibits direct payment to the doctor, I hereby recognize I am financially responsible for payment of all services to me at the **Brunswick Chiropractic Center of New Jersey, LLC.** I also understand I am responsible to bring my payments received from my insurance company, along with the accompanying explanation of benefits form attached to the check for services rendered to me at the **Brunswick Chiropractic Center of New Jersey, LLC.**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional services charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjustor and/or attorney involved in this case.

I also authorize the Brunswick Chiropractic Center of New Jersey, LLC to disclose in narrative format or any other format, the results of any permanency and impairment rating evaluation. I completely understand, this is a comprehensive medical picture and may be submitted for administrative and judicial opinions.

Dated this ___day of _____, 20__

_____
Signature of patient/policyholder/claimant

_____
Signature of witness

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Brunswick Chiropractic Center of New Jersey, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Brunswick Chiropractic Center of New Jersey, LLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Brunswick Chiropractic Center of New Jersey, LLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Brunswick Chiropractic Center of New Jersey, LLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

Brunswick Chiropractic Center of NJ, LLC

DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health and New Jersey Department of Banking & Insurance require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

We are out-of-network with the following plans:

- GHI
- CIGNA
- ASHN (American Specialty Health Network)
- All Medicaid Programs with the exception of Horizon NJ Health
- Magnacare
- All Workers Compensation Managed Care Plans
- Amerihealth

Our Practice Participates With (However participation and coverage will be verified prior to treatment):

- UHC with the exception of UHC Community Plan Medicaid
- Aetna
- Blue Cross Blue Shield Blue Card
- BC/BS Omnia (Tier 2)
- Horizon NJ Health
- Medicare
- Qualcare
- Multiplan
- Humana
- Coventry
- ChoiceCare

If the patient's plan is not listed above, the physician and/or facilities providing services may not participate with the patient's health plan. Every attempt to verify participation will be made prior to treatment coverage. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Mandatory Disclosures:

1) I understand that the healthcare professional that I am seeking healthcare services from is "out-of- network" and does not participate with my health insurance plan;

   Patient's Initials_____

2) I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request;

   Patient's Initials_____

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Neil I. Kosin, DC Ivan B. Kosin, DC
1594 Route 130 North Brunswick, New Jersey 08902
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3) I understand that I may request from the provider an estimated charge for the services proposed and Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount estimated or the amount that the health care professional will bill the covered person for the service and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

   Patient's Initials_____

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

   Patient's Initials_____

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

   Patient's Initials_____

The healthcare provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The healthcare provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the healthcare services takes place, the network status of any healthcare professional changes as it relates to the patient's health benefit plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures- **OUT OF NETWORK PATIENTS**

I the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, services providers, or at alternative health care facilities that may participate with my plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure and do so upon my free will.

By: _____ DATE: _____

Print Name: _____

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