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 you 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: _____

CONFIDENTIAL HISTORY FORM

In order to give you the highest quality care, please take a few minutes to complete the following questions about your MEDICAL HISTORY. This will become part of your permanent medical record. Thank you.

Name _____ Date: _____

CURRENT COMPLAINTS:
□ Headaches □ Neck Pain □ Arm Pain □ Arm/Hand Numbness □ Mid Back Pain □ Chest Pain □ Low Back Pain
□ Buttock Pain □ Hip Pain □ Leg Pain □ Leg/Foot Numbness □ Other: _____

ONSET (How did your pain start?): □ Unknown □ Woke-up with it □ Bending □ Twisting □ Slip/Fall □ Accident

Explain:_____
_____
_____

PAST MEDICAL HISTORY: Please check each box if you have had the following problems:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer –Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

FAMILY MEDICAL HISTORY:

Mother:	Age: _____	( ) Living	( ) Deceased
Father:	Age: _____	( ) Living	( ) Deceased
Siblings:	Age: _____	( ) Living	( ) Deceased

Please check each box with if any family member (mother, father or siblings) has had any of the following:

□ Angina	□ Angioplasty	□ Arrhythmia	□ Arthritis	□ Asthma	□ Bypass
□ Cancer –Where? _____			□ Diabetes	□ Dialysis	□ Diverticulosis
□ Emphysema	□ Hypertension	□Headaches	□ Heart Attack	□ Heart Disease	□ Heart Failure
□ Hemophilia	□ Hemorrhoids	□ High Cholesterol	□ Impotence	□ Kidney Stone	□ Kidney Prob.
□ Leg Swelling	□ Liver Problems	□ Murmur	□ Obesity	□ Pacemaker	□ Pass out
□ Pneumonia	□ Reflux	□ Rheumatic fever	□ Rheumatoid	□ Sleep Apnea	□ Stroke
□ Surgeries: _____				□ Thyroid	□ Tuberculosis
□ Ulcer	□ Varicose Veins	□ Other: _____			

CURRENT MEDICATIONS: Please list all current medications below or provide us with a list of medications

Name of Medicine	Strength	Dosage

List of known ALLERGIES: _____

( ) Tobacco ( ) Type: _____ ( ) Alcohol Type: _____
( ) Year begun: _____ How often: _____
( ) Still smoking How much: _____
( ) Year quit: _____ How many years: _____
( ) Packs per day: _____

( ) Exercise ( ) None ( ) light ( ) Moderate ( ) Heavy

Other: _____

REVIEW OF SYSTEMS: Do you have (had) the following?:
Check the appropriate box(s)

GENERAL:	◻ Weight gain	◻ Weight loss	◻ Fever	◻ Hair loss
	◻ Weakness	◻ Other: _____		
EYES:	◻ Eye strain	◻ Wear glasses or contact lenses		◻ Sensitivity to light
EAR, NOSE,THROAT	◻ Ringing in ears	◻ Hearing loss	◻ Discharge or pain	◻ Dizziness
	◻ Runny nose	◻ Difficulty breathing through nose		◻ Sinusitis
	◻ Painful teeth, gums, or palate		◻ Growths in the mouth	
	◻ Pain or difficulty swallowing		◻ Hoarseness	
CARDIOVASCULAR	◻ Palpitations	◻ Chest pain	◻ Fainting	◻ Dizziness
	◻ Varicose veins	◻ Difficulty climbing Stairs		◻ Pain in the legs
	◻ Cold Feet/Hands		◻ Shortness of breath	
RESPIRATORY	◻ Shortness of breath while walking		◻ Cough with or without phlegm	
	◻ Asthma/Wheezing		◻ Spit up blood	
	◻ Other: _____			
GASTROINTESTINAL	◻ Abdominal pain	◻ Nausea	◻ Vomiting	◻ Diarrhea
	◻ Hemorrhoids	◻ Change in shape or color of stool		
GENITOURINARY	◻ Discharge	◻ Pain	◻ Frequent urination	◻ Pain with urination
MUSCULOSKELETAL	◻ Weakness	◻ Back Pain	◻ Neck Pain	◻ Leg Pain
	◻ Arm Pain	◻ Shoulder Pain	◻ Numbness	◻ Headaches
	◻ Other: _____			
SKIN	◻ Jaundice	◻ Dry skin	◻ Pigment Change	◻ Growths
	◻ Moles that have changed color, shape, or bleed			
NEUROLOGIC	◻Tremors	◻ Weakness	◻ Numbness	◻ Memory Loss
	◻ Confusion	◻ Other: _____		

PHYSICAL EXAMINATION

NAME: _____ **AGE:** _____ **DATE:** _____

☐ Initial Examination ☐ Re-examination ☐ Update Examination ☐ Discharge Examination
☐ New Injury ☐ MVA ☐ Work Comp. Injury ☐ IME

PRESENT COMPLAINTS:

☐ Neck Pain ☐ Mid Back Pain ☐ Low Back Pain ☐ Hip Pain ☐ Headaches ☐ Dizziness
☐ Arm Pain ☐ Leg Pain ☐ Numbness UE ☐ Numbness LE ☐ Jaw Pain ☐ Bal. Prob
☐ Tremors ☐ Weakness ☐ Bladder/Bowel Prob ☐ Blurred Vision ☐ Mood Change ☐ Mem. Loss
Other: _____

OBSERVATION:

☐ Acute Distress ☐ Deformity ☐ Laceration/Bruise ☐ Edema ☐ Minor's Sign
Posture ☐ Normal ☐ Antalgia ○Left ○Right ○ Flexion ☐ Scoliosis ○Levo ○ dextro
☐ Elevated Shoulder ○Left ○Right ☐ Elevated Shoulder ○Left ○Right
Gait ☐ Normal ☐ Shuffle ☐ Slow ☐ Guarded ☐ Limp ○Left ○Right ☐Assistance ○Personal ○Cane ○Walker
☐ Other: _____

Mental Status: ☐ Alert & Cooperative ☐ Orientation X3 ☐ Memory loss- ○Recent ○Remote ☐ Other
Explain: _____

VITAL SIGNS:

Height: ____ Weight: ____lbs. B.P.: ____/____ (LA) ____/____ (RA) Pulse: ☐ Norm. ☐ Abn. Rate:___
Respiration: ☐ Normal ☐ Abnormal V.A.S.: ☐ Neg. ☐ Pos. R L Carotid Bruit ☐ Neg. ☐ Pos. R L

GRIP STRENGTH: **Dominance:** ☐ Right ☐ Left **Measurements:** Right: ___, ___, ___ kg Left ___, ___, ___ kg

NEUROLOGICAL EXAMINATION:

REFLEX	Right	Left
Biceps	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus
Triceps	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus
Brachioradialis	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus
Patellar	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus
Achilles	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus	○0 ○1+ ○ 2+ ○ 3+ ○ Clonus

☐ All Normal
☐ All Upper Ext. Normal
☐ All Lower Ext. Normal
☐ BABINSKI: ☐ Negative ☐ Positive

Posterior Column Assessment ☐ All Normal

Test	Positive	Negative
Rebound		
Finger to Nose		
Heal Toe		
Rhomberg's		
Rapid Motion		

Peripheral Nerve Assessment ☐ All Normal

Test	Positive	Negative
Tinnels Sign		
Phalens Sign		
Toe Walk		
Heel Walk		

CRANIAL NERVES: ☐ I – XIII WNL ☐ Abnormal Nerve: _____

SENSATION: ○Pinwheel, ○Touch, ○Vibration ○Temp ☐ All Normal ☐ All Upper Normal ☐ All Lower Normal

REGION	Dermatome Levels	Normal	Abnormal
LUE			☐ Hypoesthesia ☐ Hyperesthesia ☐ Anesthesia ☐ Pain
RUE			☐ Hypoesthesia ☐ Hyperesthesia ☐ Anesthesia ☐ Pain
LLE			☐ Hypoesthesia ☐ Hyperesthesia ☐ Anesthesia ☐ Pain
RLE			☐ Hypoesthesia ☐ Hyperesthesia ☐ Anesthesia ☐ Pain

NAME: _____ **DATE:** _____

MUSCLE ATROPHY(Girth): Upper Arm: Rt ___ Lt ___ Forearm: Rt ___ Lt ___ Thigh: Rt ___ Lt ___ Calf: Rt ___ Lt ___

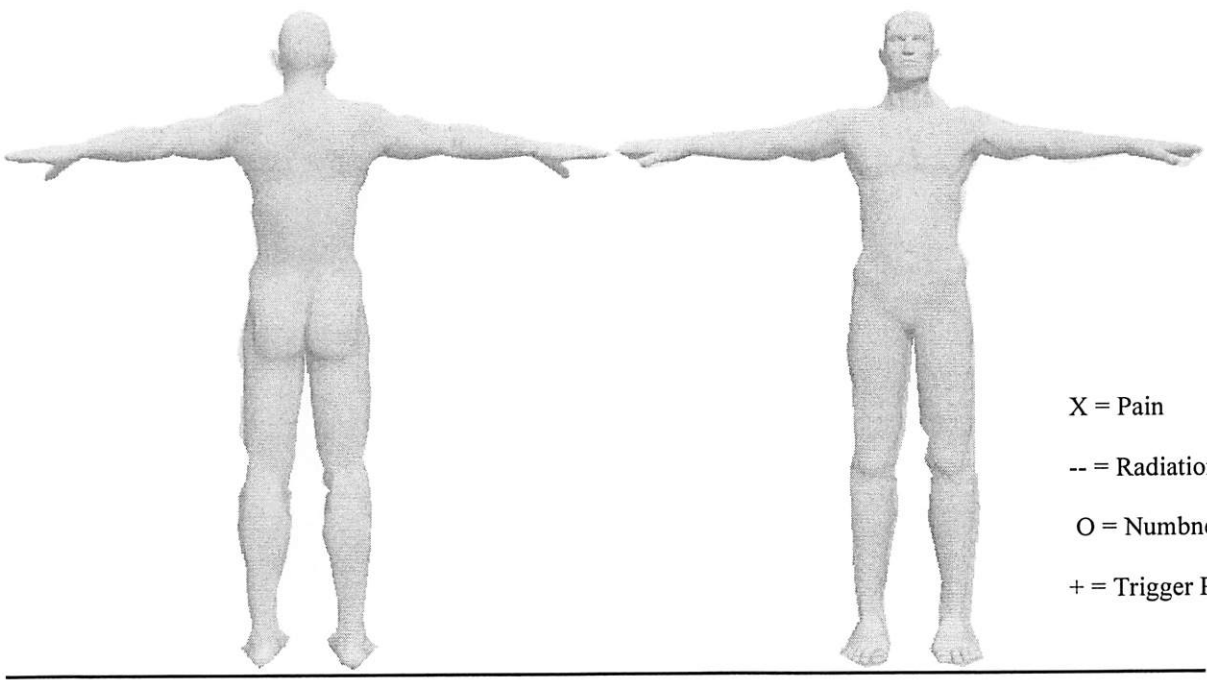
MUSCLE TEST: ☐ **All Normal** ☐ **All Upper Normal** ☐ **All Lower Normal**

Muscle	Left Grade	Level	Right Grade	Comments
Rhomboid	o1 o2 o 3 o 4 o 5 oPain	**C4-5**	o1 o2 o 3 o 4 o 5 oPain	
Ant. Deltoid	o1 o2 o 3 o 4 o 5 oPain	**C5-6**	o1 o2 o 3 o 4 o 5 oPain	
Med. Deltoid	o1 o2 o 3 o 4 o 5 oPain	**C5-6**	o1 o2 o 3 o 4 o 5 oPain	
Post. Deltoid	o1 o2 o 3 o 4 o 5 oPain	**C5-6**	o1 o2 o 3 o 4 o 5 oPain	
Biceps	o1 o2 o 3 o 4 o 5 oPain	**C5-6**	o1 o2 o 3 o 4 o 5 oPain	
Triceps	o1 o2 o 3 o 4 o 5 oPain	**C6-7-8**	o1 o2 o 3 o 4 o 5 oPain	
Iliopsoas	o1 o2 o 3 o 4 o 5 oPain	**L1-2-3**	o1 o2 o 3 o 4 o 5 oPain	
Quadriceps	o1 o2 o 3 o 4 o 5 oPain	**L2-3-4**	o1 o2 o 3 o 4 o 5 oPain	
Hamstrings	o1 o2 o 3 o 4 o 5 oPain	**L5-S1-2**	o1 o2 o 3 o 4 o 5 oPain	
Gastrocnemius	o1 o2 o 3 o 4 o 5 oPain	**L5-S1-2**	o1 o2 o 3 o 4 o 5 oPain	
Ext. Hal. Longus	o1 o2 o 3 o 4 o 5 oPain	**S1-2**	o1 o2 o 3 o 4 o 5 oPain	
Flex. Hal. Longus	o1 o2 o 3 o 4 o 5 oPain	**S2-3**	o1 o2 o 3 o 4 o 5 oPain	

POSTURAL ANALYSIS:

Head	☐ Normal	☐ Abnormal	☐ Anterior	☐ Other: _____
Cervical Lordosis	☐ Normal	☐ Abnormal	☐ Hypo	☐ Hyper: _____
Shoulder Level	☐ Normal	☐ Abnormal	☐ Elev. R	☐ Elev. L _____
Pelvic Level	☐ Normal	☐ Abnormal	☐ Elev. R	☐ Elev. L _____
Scoliosis	☐ Normal	☐ Abnormal	☐ Left	☐ Right: _____
Thoracic Kyphosis	☐ Normal	☐ Abnormal	☐ Hypo	☐ Hyper: _____
Lumbar Lordosis	☐ Normal	☐ Abnormal	☐ Hypo	☐ Hyper: _____

PAIN DRAWING:



X = Pain

-- = Radiation of Symptom

O = Numbness

+ = Trigger Point

INITIAL CONSULTATION FORM

NAME: _____ DATE: _____

Dominant Hand ☐ Right ☐ Left ☐ Both

☐ Initial Examination ☐ Re-examination ☐ Update ☐ Discharge Examination

Description/Onset: _____

PRESENTING CONDITION

Primary Complaint: _____

Date of Onset: _____ Type of Onset: ☐ Sudden ☐ Gradual ☐ Traumatic ☐ Chronic ☐ Unknown

Type of Pain: ☐ Dull Ache ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Throbbing ☐ Burning

Pain Frequency: ☐ Constant (76-100% of the day) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Pain Intensity: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild/Mod ☐ Moderate ☐ Mod/Severe ☐ Severe

Pain Rating (1-10): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Radiation: ☐ Head __ ☐ Neck__ ☐ Shoulder __☐ Arm __ ☐ Hand _ ☐ Buttock __ ☐ Hip___ ☐ Thigh__☐ Leg__☐ Foot___

Aggravated by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Cough/Sneezing ☐ Stress ☐ Walking

Relieved by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Nothing

Affects: ☐ Work ○ Disabled ○ Partial ○ Limited ☐ Personal Care ☐ Social Life ☐ ADL's Rate: _____(1-10)

Explain: _____

Second Complaint: _____

Date of Onset: _____ Type of Onset: ☐ Sudden ☐ Gradual ☐ Traumatic ☐ Chronic ☐ Unknown

Type of Pain: ☐ Dull Ache ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Throbbing ☐ Burning

Pain Frequency: ☐ Constant (76-100% of the day) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Pain Intensity: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild/Mod ☐ Moderate ☐ Mod/Severe ☐ Severe

Pain Rating (1-10): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Radiation: ☐ Head __ ☐ Neck__ ☐ Shoulder __☐ Arm __ ☐ Hand _ ☐ Buttock __ ☐ Hip___ ☐ Thigh__☐ Leg__☐ Foot___

Aggravated by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Cough/Sneezing ☐ Stress ☐ Walking

Relieved by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Nothing

Affects: ☐ Work ○ Disabled ○ Partial ○ Limited ☐ Personal Care ☐ Social Life ☐ ADL's Rate: _____(1-10)

Explain: _____

Third Complaint: _____

Date of Onset: _____ Type of Onset: ☐ Sudden ☐ Gradual ☐ Traumatic ☐ Chronic ☐ Unknown

Type of Pain: ☐ Dull Ache ☐ Sharp ☐ Shooting ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Weakness ☐ Throbbing ☐ Burning

Pain Frequency: ☐ Constant (76-100% of the day) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (0-25%)

Pain Intensity: ☐ Minimal ☐ Slight ☐ Mild ☐ Mild/Mod ☐ Moderate ☐ Mod/Severe ☐ Severe

Pain Rating (1-10): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Radiation: ☐ Head __ ☐ Neck__ ☐ Shoulder __☐ Arm __ ☐ Hand _ ☐ Buttock __ ☐ Hip___ ☐ Thigh__☐ Leg__☐ Foot___

Aggravated by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Cough/Sneezing ☐ Stress ☐ Walking

Relieved by: ☐ Sleeping ☐ Bending ☐ Twisting ☐ Standing ☐ Sitting ☐ Lifting ☐ Rest ☐ Medication ☐ Ice ☐ Heat ☐ Nothing

Affects: ☐ Work ○ Disabled ○ Partial ○ Limited ☐ Personal Care ☐ Social Life ☐ ADL's Rate: _____(1-10)

Explain: _____

Additional Complaints: _____

Past History of Condition (s) _____

Doctors seen for this treatment: _____ Date of Last Visit: _____

What treatment did you receive/ results? _____

What test have you had for this condition? ☐ X-rays ☐ MRI ☐ CT Scan ☐ Other: _____

Comments: _____

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
www.brunswickchironj.com

_____ _____
Patients Name **Social Security Number**

_____ _____
Address **Date of Birth**

_____ _____
City, State and Zip Code **Date of Records**

_____ _____
Patient's Signature **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

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 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

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

1, _____ 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

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

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_____

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

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: _____

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