Patient Introduction

General Information

Today's Date_____

Patient name: _____

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

Patient Sex: *M F* Marital Status: *S M W D* Number of Children _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell:_____

Patient E-Mail Address: _____

Employer:_____ Occupation:_____

Employer Address:_____ Phone:_____

Emergency Contact: Name:_____Phone: _____

Have you ever seen a chiropractor before? YES/NO

If you answered YES, when was your last visit? _____

Have you ever had an acupuncture treatment? YES/NO

If you answered YES, when was your last visit? _____

How did you find out about our office? _____

Are you or have you ever been a member of Eastpointe Health and Fitness (GYM)?

YES or NO

PLEASE TURN OVER

Health History

Describe your current complaint: _____

Have you ever had prior treatment for this issue?_____

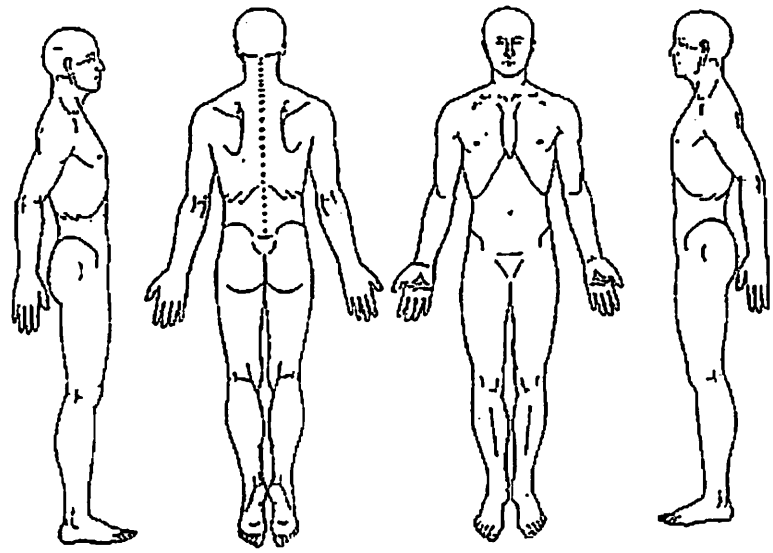
How did it begin? _____

How long have you had it?_____

Please rate your pain level: 0 1 2 3 4 5 6 7 8 9 10

(no pain) (moderate pain) (terrible pain)

Please shade the areas where you feel pain.



Below is a listing of symptoms, conditions or habits. **Please check all that apply:**

Symptoms	Past	Present	Symptom	Past	Present		Past	Present
Neck pain	[ ]	[ ]	High blood pressure	[ ]	[ ]	Tobacco use	[ ]	[ ]
Shoulder pain	[ ]	[ ]	Heart condition	[ ]	[ ]	Alcohol use	[ ]	[ ]
Arm/elbow pain	[ ]	[ ]	Respiratory condition	[ ]	[ ]	Caffeine use	[ ]	[ ]
Hand pain	[ ]	[ ]	Digestive problems	[ ]	[ ]	Pregnancy	[ ]	[ ]
Upper back pain	[ ]	[ ]	Kidney/bladder problem	[ ]	[ ]	Surgery	[ ]	[ ]
Lower back pain	[ ]	[ ]	Menstrual problems	[ ]	[ ]	Please List _____		
Pain in upper leg or hip	[ ]	[ ]	Breast soreness/lumps	[ ]	[ ]	_____		
Pain in lower leg or knee	[ ]	[ ]	Sinus condition	[ ]	[ ]	_____		
Pain in ankle or foot	[ ]	[ ]	Allergies/asthma	[ ]	[ ]	_____		
Jaw pain	[ ]	[ ]	Cancer	[ ]	[ ]	_____		
Swelling/stiffness of joints	[ ]	[ ]	Stroke	[ ]	[ ]	_____		
Headaches	[ ]	[ ]	Excessive weight loss/gain	[ ]	[ ]	_____		
Dizziness	[ ]	[ ]	Skin condition	[ ]	[ ]	_____		
Fainting spells	[ ]	[ ]	Arthritis	[ ]	[ ]	_____		
Convulsions	[ ]	[ ]	Diabetes	[ ]	[ ]	_____		
General prolonged fatigue	[ ]	[ ]	Prostate condition	[ ]	[ ]	_____		
Condition of uterus/ovaries	[ ]	[ ]						

Patient Consent to X-Ray

I authorize the performance of diagnostic x-ray examination of myself which Eastpointe Chiropractic may consider necessary or advisable in the course of my examination and treatment.

Signed _____ Date _____

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray of this minor which Eastpointe Chiropractic may consider necessary or advisable.

Signed _____ Date _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am not pregnant, and Eastpointe Chiropractic has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signed _____ Date _____

HIPAA Notice of Privacy Practices

Eastpointe Integrated Healthcare
2397 HWY 36
Atlantic Highlands, NJ 07716
732-872-6595

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.

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

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

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

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

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

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

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

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

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

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

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

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

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

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

Complaints

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

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

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Dear Valued Patient,

We feel our status as an out of network provider allows us to give you the best care possible. Certain insurance companies regardless of a properly executed assignment of benefits form continue to send the patient's checks for services rendered here at the office. We understand that it is inconvenient and we do everything possible to avoid this happening. ***Your insurance company may be recognized as one of the companies engaging in the practice.*** So if it does happen, please follow the instructions below:

1. **DO NOT cash the check.**
2. As soon as possible, please bring **all the paperwork** to the office. In the event that a portion of the check is for another provider and not Eastpointe Integrated Healthcare, please bring the paperwork in and be prepared to make a payment in the amount due to us.
3. In the event that you are not an active patient, or do not visit frequently, pre-addressed, postage paid envelopes can be provided to make sending the check easier.
4. Call your insurance company and complain about such practices. They are designed to make receiving quality care a hassle.
5. **As part of this policy, we require a credit card to keep on file in our encrypted server.** Once our office has been notified that a check has been sent to your address, our front desk team will give you 3 reminder calls to bring them in. In the event that we do not receive a response from you after the 3 calls, we will charge the card on file for the amount that the check was issued for. Our front desk team may also charge the card on file to settle any outstanding copays that were not collected on the date of service.

Signed_____ Date_____

CC#_____ Exp_____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient _____ SS# _____ DOB _____

Insured Information:
Insured Name _____ Policy ID# _____ Relation to Insured _____

PLEASE CHOOSE SECTION THAT APPLIES & CHECK ONLY 1 LINE

Spouse / Partner:

_____ I am the patient AND the insured AND I have no other insurance coverage.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner _____. I am employed at _____ but have no coverage through that employer.

_____ I am the patient & have my own coverage – the following is my coverage information:
Primary Ins_____ Insured Name_____ Insured DOB_____
Secondary Ins_____ Insured Name_____ Insured DOB_____

_____ _____
Signature Date

Dependent Child Over 18: (covered under parent's policy)

_____ I am a FT student & have 1 policy. Attached is my current school schedule.
Primary Ins _____ Insured Name_____ Insured DOB_____

_____ I am a FT student & have 2 policies. Attached is my current school schedule.
Primary Ins_____ Insured Name_____ Insured DOB_____
Secondary Ins_____ Insured Name_____ Insured DOB_____
**determining primary/secondary is usually based on the 'birthday rule'.

_____ _____
Signature Date

Dependent Child Under 18: (covered under parent's policy)

_____ I am a minor dependent and only covered under one policy:
Primary Ins _____ Insured Name_____ Insured DOB_____

_____ I am a minor dependent and covered under two policies:
Primary Ins_____ Insured Name_____ Insured DOB_____
Secondary Ins_____ Insured Name_____ Insured DOB_____
**determining primary/secondary is usually based on the 'birthday rule'.

_____ _____
Parent or Guardian Signature Date

ASSIGNMENTOF BENEFITS / ERISA AUTHORIZATION FORM
Eastpointe Integrated Healthcare / CB&C / L. Contreni

Financial Responsibility

I have requested professional services from Eastpointe Integrated Healthcare on behalf of myself and/or my dependents, and understand that by making this request; I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Eastpointe Integrated Healthcare / CB&C, Inc. I certify that the health insurance information that I provided to Eastpointe Integrated Healthcare is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Eastpointe Integrated Healthcare / CB&C / L.Contreni to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Eastpointe Integrated Healthcare, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Eastpointe Integrated Healthcare directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Eastpointe Integrated Healthcare, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Eastpointe Integrated Healthcare / CB&C / L.Contreni upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Eastpointe Integrated Healthcare.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Eastpointe Integrated Healthcare are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Eastpointe Integrated Healthcare / CB&C / L.Contreni to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Eastpointe Integrated Healthcare / CB&C / L.Contreni to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Eastpointe Integrated Healthcare and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

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

_____ _____

Print Name Date

_____ _____

Signature Date

Date: _____

Dear Insurance Carrier:

I, _____, am currently receiving care at Eastpointe Integrated Healthcare. Please know that this care is *not related* to any auto accident, workers' compensation injury or any other type of injury, which would render a third party liable for these bills.

I trust this statement will clarify this matter and there should be no delay in processing any claims submitted to you by this facility. If you have any questions, do not hesitate to contact me personally.

_____
Print Name

_____ _____
Signature Date

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, Eastpointe Integrated Healthcare and other patients) safer from exposure and sickness. If you do not adhere to these safeguards, it may result in our decision to discharge you. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let the staff know. ___
- If a resident of your home tests positive for the infection, you will immediately let the staff know. ___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

Commitment to Minimize Exposure
Eastpointe Integrated Healthcare has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts in the office. Please let me know if you have questions about these efforts.

If You or We Are Sick
You understand that we are committed to keeping you, me, Eastpointe Integrated Healthcare and all of our families safe from the spread of this virus. If you show up for an appointment and any staff believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately.

If anyone at Eastpointe Integrated Healthcare tests positive for the coronavirus, we will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If we have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about your treatments. By signing this form, you are agreeing that I may do so without an additional signed release.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient Date

_____ _____

Eastpointe Employee Date