Affiliated Physicians Network – Personal Information Sheet

Today's Date___________________________

Patient's Name __________________________E-mail___________________________

Address____

City______________________________State____________Zip_________________

HomePhone_______________WorkPhone_______________CellPhone______________

Social Security ____________________Birthdate_____________Age______________

Sex M F Height ________Weight____________
Single_____Married_____Divorced_____Widowed_____

Employer/School____
Occupation____
Employer Address____

Spouse/Parent Name____
Spouse/ParentHomePhone______________Spouse/ParentWorkPhone______________
Spouse/ParentEmployerName/Address____

InsuredName____________________________InsuredBirthdate__________________
Patients Relationship To Insured: Self______Spouse___________Other____________
Insurance____________________Policy/Group#_______________________________

Is this Injury Related to - Auto______________ Work___________________________
Date Your Illness/Problem/Injury Began ____________________________________
In your own words describe your Injury/Problem/Illness__________________________

____

____

Present Medications____
Allergies____
Are you currently under a physicians care? Yes______________ No______________
PreviousChiropractor__________________________MD_________________________

Referred By____

I hereby authorize payment of medical benefits to Affiliated Physicians Network for services rendered by me. I also authorize Affiliated Physicians Network to release information regarding my injury/ problem/ illness to my referring physician and/or attorney and/or insurance company.

Patient's Signature___________________________________Date________________
Parent's Signature (if patient is a minor) ______________________________________

Assignment of Benefits Form

Affiliated Physicians Network
740 Mantua Pike
Woodbury Heights, NJ 08097

Date ____________

Patient: ____

Employer: ____

Claim Group: ____

SS# / ID#: ____

I hereby instruct and direct ____________________ Insurance Company to pay by check made out and mailed to:

Affiliated Physicians Network/ Probe Chiropractic
740 Mantua Pike
Woodbury Heights, NJ 08097

or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Affiliated Physicians Network
740 Mantua Pike
Woodbury Heights, NJ 08097

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. 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, in a current manner, any balance of said professional service charges over and above this insurance payment. If payment is mailed directly to me I will bring in the check and explanation of benefits within 1 week of receipt.

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, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner or my health care provider for any reason on my behalf.

Dated at ______________________________ this ________ day of ___________________, 20

____
Signature of Policyholder

____________________________________Signature of Claimant, if other that Policyholder.

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Affiliated Physicians Network

T. Leonard Probe, D.C. - Chiropractic Director, Certified Chiropractic Spinal Trauma
Dennis Casterline, D.C. - Chiropractic Services, Certified Chiropractic Spinal Trauma
Roberto Yanez, M.P.T. - Physical Therapy Services

PREGNANCY RELEASE

Date:______________________________

Patient's Name:____

By signing this form, I state that to the best of my knowledge, I am not pregnant and that I have no reason to suspect that I might be pregnant.

____
Patient's Signature

____
Witness

740 & 750 Mantua Pike, Woodbury Heights, NJ 08097
(856) 845-2225 • (856) 853-1119 • FAX (856) 845-1881

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Affiliated Physicians Network
Consent to Treat a Minor Child

Date________________________________

Patient's Name____

I hereby authorize the physicians of Affiliated Physicians Network and whomever they may designate as their assistants to administer care to my ______________________________(Indicate Relationship of Child).

____
Signature of Parent/Guardian

____
Witness

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PATIENT – DOCTOR AGREEMENTS

The purpose of this agreement is to allow us to more completely serve you and to get the best results in the shortest amount of time. Our experience is that those patients who adhere to the following get the best results.

EXTENDED HEALTH ORIENTATION
It is mandatory that all new patients attend our introductory orientation. This class explains how the body functions, how chiropractic works and how results are produced. Family and friends are welcome. There is no charge for the class. Classes are held Wednesday evenings at 6:oopm. Please notify one of our staff members which date best suits your schedule.

PAYMENT OF BILLS
Whatever arrangements you make with our office, we expect you to honor it. If you cannot fulfill your arrangement in this area, please let our financial manager know immediately so new arrangements can be made. Accounts past due may be charged a handling fee. Failure to communicate after three billings in the form of payment or explanation will result in your account being sent to our collection agency.

CANCELING OR CHANGING APPOINTMENTS
We have set up a specific course of treatment for your care. A certain amount od chiropractic care is required in a set amount of time. When setting your appointments please advise our front desk of the day and time you will be able to make up any missed appointments in the event you are unable to keep your set schedule. If you cannot keep a scheduled appointment please call us as sson as possible so we may adjust our appointment book accordingly.

UPSETS
Please communicate directly to your doctor any upsetting matter such as waiting too long, rudeness by any staff member, failure to understand your care, need for extended consultation, etc. We are here to serve you. Your comments will help us to help youa s well as others.

GENERAL
If there is anything we can do to better assist you, please bring it to our attention. Your health and your well being are very important to us.

Thank You!

____
Sign and Date

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Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote;

c) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this Consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

Dated this __________ day of __________________, 20_____.

______________________________ ______________________________

Patient Signature (or Legal Guardian) **Signature of Witness**

Patient Name: ________________________ **Witness Name:** ________________________

(please print) **(please print)**

Prior Chiropractic Treatment Information

Name of Chiropractor:______________________________ Location (city):______________________

When was your last treatment?______________________ Have you had x-rays? ______________

HIPAA Notice of Privacy Practices

Affiliated Physicians Network / Probe Chiropractic
740 / 750 Mantua Pike
Woodbury Hts., NJ 08097
(856)845-0360

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

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 or to reschedule a missed 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