VIP Chiropractic
Mark Lynch DC

222 Serpentine Drive
Bayville, NJ 08721
Ph: 732-269-2225 Fax: 732-237-9825

PRIVACY CONSENT FORM/REQUIRED BY FEDERAL HIPAA LAW #101-191
For Use or Disclosure of Private Health Information

Trust is the foundation of a doctor/patient relationship. The information that you provide us is kept in the strictest of confidence. While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:

1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes
4. The information used or disclosed pursuant to this Authorization may be subject to being disclosed again by the recipient and thus this information will no longer be protected by federal privacy regulations.
5. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

PLEASE NOTE:
We have a more detailed "Notice of Privacy for Private Health Information" and you have the right to review the detailed notice before you sign this consent form. We have the right to change our privacy practices as described in the detailed notice. If any changes occur in reference to our privacy practices you will be notified by a posting of the change in the office Or a notice will be sent to you in the mail. You may request a copy of our privacy notices at any time.

Patients Rights Under HIPAA LAW#101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
   a. All requests must be in writing.
   b. By law we are not required to agree with your restrictions HOWEVER
   c. If we agree with your restrictions, the restriction is binding on us.
2. You have the right to REVOKE your Authorization under certain conditions:
   a. It must be in writing.
   b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.

c. If you were required to give your authorization as a condition of obtaining insurance, the insurance may have the right to your private health information should they decide to contest any of your claims.

AUTHORIZATION FOR APPOINTMENT REMINDERS AND HEALTHCARE INFORMATION

There may be times when the doctor or members of the doctors team, may need to use your private health information, such as your name, address, phone number or clinical records in order to contact you in regards to:

1. **Appointment reminders or information about alternative treatment, or other health related information that may be of interest to you.**
2. **If you are not at home to receive an appointment reminder, a message could be left on your answering machine by signing the form, are giving us authorization to contact you with these reminders and /or information.**

YOUR RIGHTS

You may restrict the individuals or organizations to which your PHI is released, or you may revoke your authorization to us at any time with the following rules:

Your revocations must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if: If we have already released your private health information before we received your request to revoke the authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your private health information should they decide to contest any of your claims. Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone that has access to the reminder or other information and may no longer be protected by the federal privacy rules.

If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for services rendered to you.

You have the right to inspect or copy the information that we use to contact you for appointment reminders, information about treatment alternatives, or other health related information at any time.

I have read your consent policy and I fully understand this authorization form and all of its contents and agree to its terms. I also acknowledge that once I sign this consent form I will receive a copy of this completed form my own records. This authorization is valid as of the I have signed below and shall remain valid for a period of one year. This notice will expire seven years after the date upon which the record was created.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____
Initials: _____
Reason: _____

Clinical Records System

VIP Chiropractic, 222 Serpentine Dr., Bayville, NJ 08721
732-269-2225

Authorizations and Releases

Name_____ Case#_____

XConsent for Treatment

I, the undersigned, hereby authorize Dr. Lynch and whomever he/she may designate as his/her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary.

I, also, certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

Patient's Signature X_____ _____ **Date**___/___/___ **Witness** _____

XAuthorization to Release Medical Information

I authorize Dr. Lynch to release any medical information pertinent to my treatment plan to Alignis, Inc. or an authorized representative for review. This authorization for release of information shall remain valid for the term of my coverage under my current policy. I certify that all insurance information given to this clinic is correct and complete. I *also* know that I am entitled to receive a copy of this authorization form.

Patient's Signature X_____ _____ **Date**___/___/___ **Witness** _____

XRequest For Payment of Benefits To Provider of Care

I hereby authorize the _____Insurance Company/Insurance Administrator to pay by check, and for it to be mailed directly to: _____

the expense benefits allowable and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered. I have agreed to pay, in a current manner, any balance of said applicable charges. I agree that this office be given power of attorney to endorse/sign my name on any and all drafts for payment of my bill.

Patient's Signature X_____ _____ **Date**___/___/___ **Witness** _____

Attorney Representation and Protection of Balance

I, the undersigned patient am directing my attorney,_____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions herein contained to be irrevocable. I fully understand that I am directly responsible for all medical bills and this agreement is made *solely* for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but, will require me to make payment on a current status.

Patient's Signature_____ _____ **Date**___/___/___ **Witness** _____

Consent for Treatment of Minor

I hereby authorize Dr. Lynch and whomever he/she may designate as his/her assistant(s), to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as he/she deems necessary to my (indicate relationship to child) _____ (child's name) _____

Guardian's Signature _____ **Date**__/__/__ **Witness** _____

X-Ray / Medical Records Release

I have requested the release of records of (patients name)_____ which are a part of the records at (facility)_____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatic copies, abstracts or excerpts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: (Name)_____(address)_____

Patient's Signature_____ _____ **Date**___/___/___ **Witness** _____

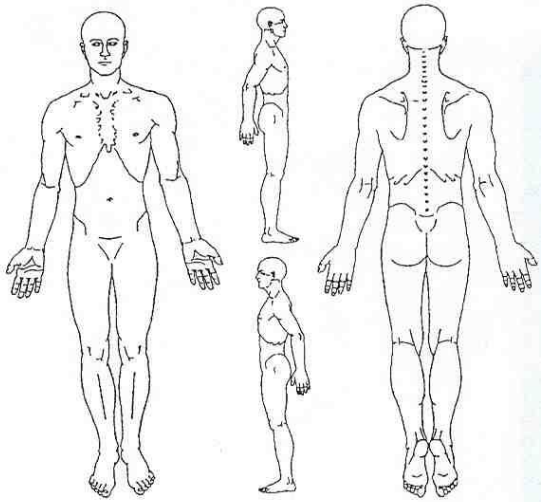
Healthy Pra
online hea

USE THE LETTERS LISTED BELOW TO INDICATE
THE *TYPE* AND *LOCATION* OF YOUR PAIN & SENSATIONS...

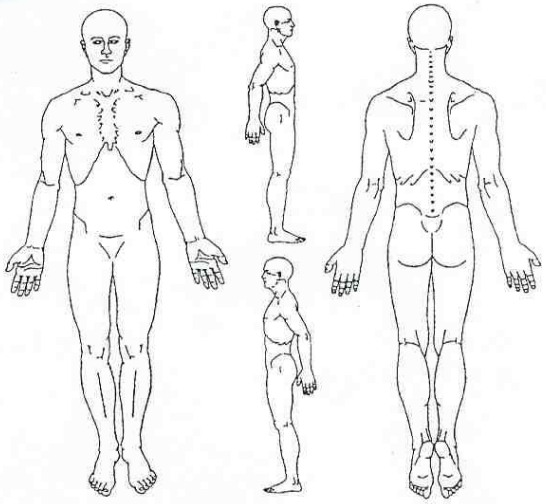
KEY

A = ACHE	**B = BURNING**	**S = STABBING**
N = NUMBNESS	**P = PINS & NEEDLES**	**O = OTHER**

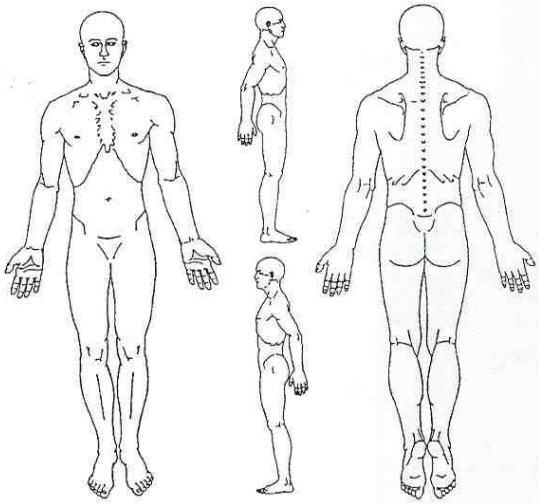
#1 DATE _____



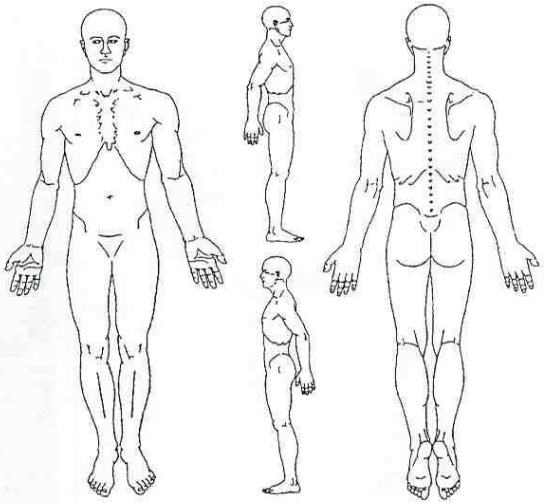
#2 DATE _____



#3 DATE _____



#4 DATE _____



VIP Chiropractic Care Patient Profile

PERSONAL HISTORY

(Please print)

Name _____ Address _____

City _____ St _____ ZIP _____ Home Phone _____

Cell Phone _____ Email Address _____

Social Security # _____ Date of Birth _____ Age _____ ☐ Male ☐ Female

☐ Married ☐ Single ☐ Divorced ☐ Widowed # of Children _____ Spouse's Name (or Parent) _____

Occupation _____ Employer _____ Work Phone # _____

Work Address: _____ City _____ St _____ ZIP _____

Name of Emergency Contact: _____ Their Phone #: _____

Referred to this Office By: _____

Do you have insurance? ☐ Yes ☐ No If yes, Name of Insurance Company _____

Are You the Policyholder? ☐ Yes ☐ No If no, relationship to policyholder ☐ Spouse ☐ Child ☐ Other

Policyholder's Name _____ DOB _____ Social Security #_____

CURRENT HEALTH CONDITION:

Purpose of this appointment: _____

Is this condition: ☐ Job Related Reported to Employer ☐ Yes ☐ No Date: _____

Is This Condition: ☐ Auto Related Reported to Insurance Carrier ☐ Yes ☐ No Date: _____

Date condition began or date of accident: _____

Have you retained and attorney? ☐ Yes ☐ No

Name: _____ Address: _____

Disabled from work please give dates: _____

Other Doctor's seen for this condition: _____

Medications you are now taking: ☐ Nerve Pills ☐ Pain killers/Muscle Relaxers ☐ Blood Pressure Medication ☐ Insulin

☐ Other: _____

PAST HEALTH HISTORY:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Broken Bones

☐ Other: _____

Descriptions: _____

Major accidents or falls: _____

Hospitalizations (other than above): _____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name: _____ Last Visit: _____

Have you been treated for any health condition within the past year? ☐ Yes ☐ No

If yes, Explain: _____

*(**Please continue on back)***

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

- ☐ Apendicitis
- ☐ Scoliosis
- ☐ Spina Bilida
- ☐ Multiple Sclerosis
- ☐ Pneumonia
- ☐ Pneumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Eczema
- ☐ Hepatitis
- ☐ AIDS

CHECK ANY OF THE FOLLOWING YOU NOW HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

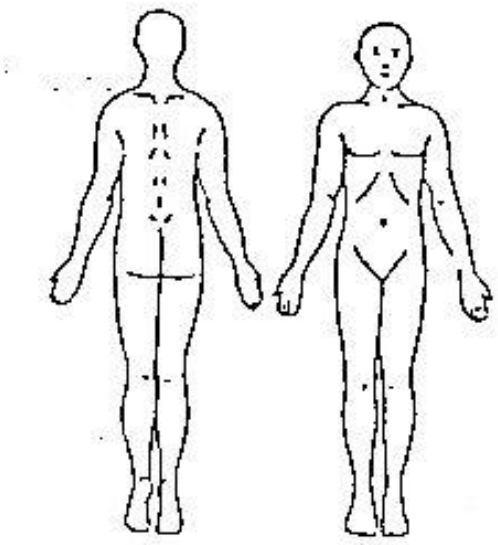
MUSCULO-SKELETAL CODE:
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Leg Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM
- ☐ Numbness
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL CODE
- ☐ Allergies
- ☐ Fever

GASTRO-INTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Gas/Bloating after Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool

GENITO-URINARY CODE
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine



Please Outline the diagram
in the area(s) of your discomfort(s)

C-V-R CODE
- ☐ Short Breath
- ☐ Ankle Swelling

EENT CODE
- ☐ Sore Throat
- ☐ Ear Aches

MALE/FEMALE CODE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

FEMALES ONLY:
When was your last period?
Are you Pregnant?
☐ Yes ☐ No ☐ Maybe

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly t the doctors 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 **X** _____ Date: _____

Guardian or Spouse's
Signature Authorizing Care **X** _____ Date: _____

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst.

Please ***circle the number*** which best describes how your typical level of pain affects these six categories of activities.

1. **FAMILY/AT -HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES –

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING –OUT AND ATTENDING OTHER SOCIAL FUNCTIONS WITH FRIENDS -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF -CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE -SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING -

0 1 2 3 4 5 6 7 8 9 10

COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

PATIENT NAME _____ DATE _____

SCORE _____ [60] BENCHMARK -5 = _____

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563