Name _____Date _____

Address _____

City _____State _____Zip Code_____

Home Phone _____ Work Phone_____

Cell Phone _____ Cell Phone Co: □T-MOBILE □SPRINT □VERIZON □AT&T OTHER_____

Age _____ Birth Date_____/_____/_____ Sex: □ MALE □ FEMALE

Your Occupation _____

Email _____ Marital Status: □S □M □D □W

Spouse's Name _____ Occupation _____

Most patients are referred to our office by a caring family member or friend.

What made you decide to visit our office? Friend/Family Member Name _____

□ TELEPHONE CALL □ WELLNESS EVENT □ SIGN □ WEBSITE □ PRESENTATION □ E-MAIL

_____ I am here to optimize my Life. I have no complaints.

_____ I am here for a Chiropractic Subluxation Assessment

Subluxation: (Interference to Nerve Function) causes most of the unwanted health conditions people suffer from everyday. Subluxation affects your nervous system, which affects your LIFE and HEALTH.

Why are you here? *(most important 1st)* *(Please explain how and when this became an issue)*

1. _____ :_____

2. _____ :_____

3. _____ :_____

4. _____ :_____

What LIFE activities that you value are being affected? Mark an "X" on all that apply

O Gardening
O Cooking
O Walking
O Being a better Artist
O Creativity
O Physical Health
O Earning Potential
O Golf
O Tennis
O Fishing
O Hunting
O Bocce Ball
O Taking out the Garbage
O Feeling Normal
O Have More Vitality
O Exercise
O Work
O Lifting Weights
O Tolerance with your children
O Tolerance with your spouse
O Resistance to Disease
O Reaction Times
O Enjoying a day at the beach
O Energy to be active
O Concentration
O Breathing Well
O Deep Relaxation
O Quality Sleep
O Un-Balanced Posture
O Emotional well being
O Strength
O Endurance
O Reflexes
O Steady Hand Movement
O Freedom from Pain
O Playing with your Children
O Playing with your Grand Children
O Reduce or Elimination from Pain
O Relationships with Family/Friends
O Overall health improvement

LIST WHAT YOU AND ANY HEALTHCARE PROVIDERS HAVE DONE TO TRY TO CORRECT THESE ISSUE(S) AND THE RESULTS.

1.

2.

3.

4.

5.

PAST MEDICAL HISTORY & SURGERIES, PROCEDURES AND PREVIOUS MOTOR VEHICLE ACCIDENTS/OTHER ACCIDENTS.

MY CURRENT DOCTORS *(Includes all Health Care Providers you currently see)*

1.

2.

3.

4.

5.

6.

MEDICATIONS- LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING **ALLERGIES- LIST ALL**

1.	6.	1.
2.	7.	2.
3.	8.	3.
4.	9.	4.
5.	10.	5.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY AND SIGN. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent
You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, 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 may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Testimonials: I give Little Silver Family Wellness permission to, use my testimonial with or without my name, photograph, and/or video testimonial: in ads, brochures, on the Web site, and in other promotions used to market their services, in the interest of telling others about the benefits of chiropractic.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open setting with other patients where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used if we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency. In addition we may occasionally video tape our front desk or open adjustment area for training purposes. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You nay revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

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.

You have the right to inspect and copy your 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, health operations or additional uses listed above in paragraph 8. 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 chiropractor is not required to agree to a restriction that you request. If your chiropractor 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. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

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 electronically.

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. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dennis Hupka, Chiropractor (732) 530-4088 Fax (888) 634-2457
200 White Rd. Suite 111 Little Silver NJ 07739

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dennis J. Hupka, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. "You May Refuse To Sign This."
I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON January 1, 2009.

Printed Patient Name _____ **Date** _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____