TO THE New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to fill out this personal health history questionnaire.

STEP TWO:
A one-on-one consultation with the doctor will be done to discuss your health problems and to determine what may be the cause.

STEP THREE:
A comprehensive examination and evaluation including those tests necessary to determine the precise cause of your problem is given.

STEP FOUR:
The doctor will advise you if additional laboratory tests or x-rays are needed.

STEP FIVE:
You will be given a Report of Findings at which time the cause of your problem will be discussed. It includes a thorough explanation of how our treatment works and what results can be obtained. You will also be advised concerning how our office procedures work. If you are accepted for care, treatment will begin.

STEP SIX:
Over the next few visits, treatment will continue as we explain what we are finding. After several visits we will sit down and discuss the care necessary to become as healthy as possible.

STEP SEVEN:
An estimate of the future care that is needed will be given and upon your acceptance, care will continue until the personal maximum correction of your problem has been obtained.

STEP EIGHT:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Confidential Patient Health Record

DATE	I.D. NO.

PERSONAL HISTORY

Name: ______________________ Address: ______________________

City: ______________________ State ____________ Zip Code: ____________

Home Phone: ______________________ Birth Date: ____________ Age: ________ Sex: ☐ M ☐ F

Cell Phone: ______________________ E-mail Address: ______________________

Social Security # ______________________ Driver's License Number: ______________________

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer: ______________________ Type of Work: ______________________

Business Phone: ______________________

Name of Spouse ______________________ Spouse's Social Security # ______________________

Spouse's Employer ______________________ Business Phone ______________________

Type of Work ______________________ Name and Ages of Children ______________________

Referred To This Office By: ______________________ ______________________

Name and Number of Emergency Contact: ______________________ Relationship: ____________

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) ______________________ ☐ Health Card # ______________________

Insured Person's Name ______________________ Date of Birth ______________________

CURRENT HEALTH CONDITION

Unwanted Health Condition ______________________

Other Doctors Seen For This Condition: ☐ Yes ☐ No ____ Who? ______________________

Type of Treatment: ______________________ Results: ______________________

When Did This Condition Begin? ______________________ Has This Condition Occurred Before? ☐ Yes ☐ No

Is Condition: ☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: ______________________

Date of Accident: ______________________ Time of Accident: ______________________

Have You Made A Report of Your Accident To Your Employer: ☐ Yes ☐ No

Drugs You Now Take: ☐ Nerve Pills ☐ Pain Killers/Muscle Relaxers ☐ Blood Pressure Medicine

☐ Insulin ☐ Other ______________________

Do You Wear A Shoe Lift? ☐ Yes ☐ No

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us? ______________________

____

PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery

☐ Broken Bones ☐ Other ______________________

Major Accident or Falls: ______________________

____

Hospitalization (Other Than Above): ______________________

____

Previous Chiropractic Care: ☐ None ☐ Doctor's Name & Approximate Date of Last Visit ______________________

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

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

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

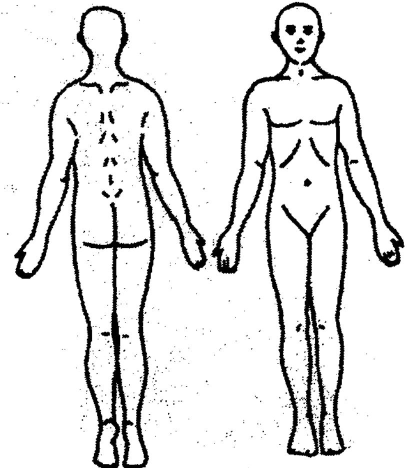
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

FEMALES ONLY:

When was your last period?______

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

____
Doctor's Signature

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

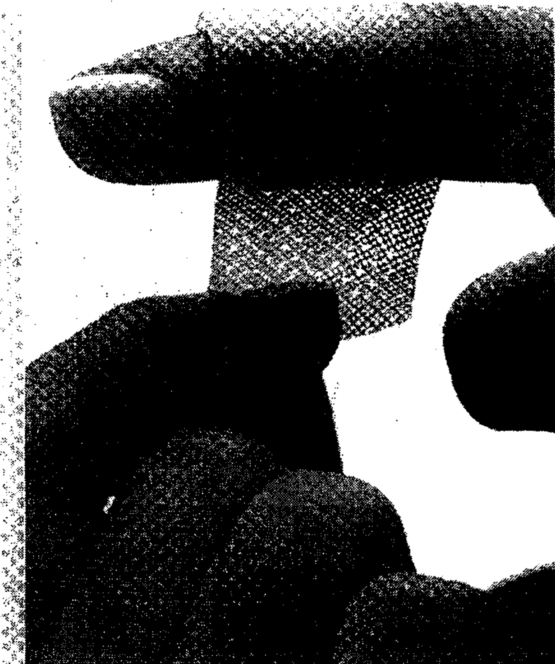
Please check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care
- ☐ Corrective Care
- ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

____________________ Date

____ Patient's Signature

If this is an accident related injury, please fill out the Accident Form. Thank You!



Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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 that any amount authorized to be paid directly to the Doctor's 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, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature ______________________________ *Date* ____________

Consent to Treat a Minor ______________________________ *Date* ____________

Guardian or Spouse's Signature of Authorizing Care ______________________________ *Date* ____________

Patient #: ____________

THE OSWESTRY QUESTIONNAIRE

Name: ____________ Today's Date: ____________

Date of Birth: ____________ Examiner: ____________

Please read carefully:
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only the ONE BOX which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the one box which most closely describes your problem.

SECTION 1 - Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

SECTION 2 - Personal Care
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but can manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than 1/2 hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 1/2 hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 - Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain restricts me from traveling except to the doctor or hospital.

OTHER COMMENTS:

OPTUM™

MN010-W120, PO Box 1459 | Minneapolis, MN 55440-1459 | Toll Free: (800) 873-4575 | Phone: (763)595-3200 | Fax (763) 595-3333

The STarT Back Musculoskeletal Screening Tool

Patient name: ________________________ Date: __________

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	Agree 1
1	My pain has **spread** at some time in the past 2 weeks	☐	☐
2	In addition to my main pain, I have had **pain elsewhere** in the last 2 weeks	☐	☐
3	In the last 2 weeks, I have only **walked short distances** because of my pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of my pain	☐	☐
5	It's really not safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time in the last 2 weeks	☐	☐
7	I feel that **my pain is terrible** and that **it's never going to get any better**	☐	☐
8	In general in the last 2 weeks, I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Originally developed by:
© Keele University 01/08/07
Funded by Arthritis Research UK

Genuine Care Health and Wellness Center
850 N. Cass Ave., Suite 101
Westmont, IL. 60559

Electronic Health Records Intake Form

In compliance with requirements from the government

First Name:________________________ **Last Name:**________________________

Email address: ________________@________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** __________________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Centers for Medicare and Medicaid Services requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date:______________

For office use only

Height:_______ Weight:__________ Blood Pressure:_____/_____

Please circle the answer that applies to you

1. Is your skin normal, oily, dry, sensitive or acneic?
2. Do you have skin irritation? YES NO

   If yes, when did it start? ______________________________

   What aggravates your skin? ______________________________
3. Do you have blocked pores, comedones, breakouts?

   If yes, at what age did they start? ______________________________

   What products do you use? ______________________________

   ____

   Have you had facials before? YES NO

   If yes, what type of facial? ______________________________

   Was the facial helpful? YES NO
4. Do you have breakouts, acne on your back? YES NO

   If yes, for how long? ______________________________
5. Do you have visible capillaries? YES NO

   Does this run in your family? YES NO

   What seems to aggravate them? ______________________________

   Do you have elevated blood pressure? YES NO
6. Do you have skin pigmentation? YES NO

   When did it start? ______________________________

   Is it progressing? YES NO
7. Is your skin aging? YES NO

   Fine lines, around your eyes, on forehead, around mouth, on chin?

   Do you wear foundation? YES NO
8. Do you have tired, swollen feet? YES NO

Which of the above situations do you want addressed?

1 2 3 4 5 6 7 8

AMEY J. MUZUMDAR, DC S.C. d/b/a
GENUINE CARE HEALTH AND WELLNESS CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Privacy Practices has been created by AMEY J. MUZUMDAR, DC S.C. d/b/a GENUINE CARE HEALTH AND WELLNESS CENTER ("Provider"), to inform you of how we may use your protected health information for treatment, payment and health care operations purposes and as otherwise permitted by law. Protected health information is information about you which can be used to identify you and which relates to your physical or mental condition, our provision of health care services to you, or the payment for health care services we provide to you. We are required by law to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with regard to accessing, amending and controlling the use of your protected health information and to provide with notice following a breach of unsecured protected health information.

We will abide by the terms of the Notice of Privacy Practices currently in effect. However, we reserve the right to change the terms of this Notice of Privacy Practices at any time as it applies to all protected health information in our custody. Upon the occurrence of any revision of the terms of the Notice of Privacy Practices currently in effect, you may obtain a revised copy of this Notice of Privacy Practices from our registration personnel at our office located at 850 N. Cass Avenue, Suite 101, Westmont, Illinois 60559 at your request.

The Privacy Officer for Provider is Amey J. Muzumdar. Please direct all questions and requests to the Privacy Officer in writing at the address listed in the preceding paragraph.

I. Uses and Disclosures of Your 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. We may use and disclose your protected health information in order for us to obtain payment for the health care services and goods which we provide to you. We may also use and disclose your protected health information in order to conduct the business of Provider.

The following are examples of the types of uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures we may make.

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 that has already obtained your permission to have access to your protected health information. For example, we would disclose your

protected health information, as necessary, to a hospital that provides care to you. We will also disclose protected health information to other physicians who may be treating 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.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care 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. We will disclose to your health insurance company information about the goods and services rendered to you in order to obtain payment from your insurance company.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employee review activities, marketing activities, and conducting or arranging for other business activities.

For example, we may share your protected health information with other physicians in the practice for quality assurance or peer review purposes. 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 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, as necessary, to contact you 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. You may contact our Privacy Officer to request that these materials not be sent to you. In the event we receive payment for making the communication, and the communication does not describe either a drug or biologic currently prescribed for you, we will not use your protected health information without an authorization signed by you.

We will 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.

Further, we are prohibited from selling your protected health information, without your authorization, in exchange for any sort of remuneration, including any in-kind remuneration.

II. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information for purposes other than treatment, payment and health care operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. For example, if you wish to have a life insurance company have access to your protected health information which is in our files, you will need to sign a written authorization permitting us to disclose such information. You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

III. Uses and Disclosures for Which You Have the Opportunity to Agree or Object.

We may use or disclose your protected health information, without seeking an authorization, provided we first give you an opportunity to object to such use or disclosure. If you are present, we may either obtain your agreement to use or disclose your protected health information as described below, or we may provide you with an opportunity to object and accept your failure to object as your agreement, or we may reasonably infer from the circumstances that you do not object. If you are not present or are unable to agree or object to such use or disclosure of your protected health information, we may use our professional judgment to determine whether the use or disclosure of your protected health information is in your best interest. All communications described in this Section III may be done orally.

A. Individuals Involved in your Care. Unless you object, we may disclose your protected health information to your family member, other relative or close personal friend or any other individual identified by you as being a person who is directly involved with your care or payment relating to your care or treatment.

B. Disaster Relief. Unless you object, we may use or disclose your protected health information to a public or private entity authorized to assist in disaster relief efforts for the purpose of coordinating with such entities the notification of your family or other persons involved in your care.

C. Notification of Family or Friends. Unless you object, we may use or disclose protected health information to notify or assist in the notification of a family member, a personal representative, or other person responsible for your care of your location and general condition.

IV. Uses and Disclosures of Protected Health Information Which Do Not Require Your Authorization or an Opportunity to Object

We are permitted to make the following uses and disclosures of your protected health information without having to obtain your authorization, or give you an opportunity to object:

1. Uses and Disclosures Required by Law. We may use or disclose your protected health information when the use or disclosure is required by law, as long as the use or disclosure meets all applicable requirements of such law.

2. Uses and Disclosures for Public Health Activities.

   A. Governmental Authorities. We may disclose your protected health information to a public health authority, including but not limited to: the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; the reporting of child abuse or neglect; reporting to the Food and Drug Administration adverse events, product defects or problems, any biological deviations, to track products, to enable product recalls, repairs or replacements, or to conduct post marketing surveillance to comply with Food and Drug Administration requirements; reporting a person who may have been exposed to a communicable disease or otherwise be at risk for contracting or spreading a disease or condition as authorized by law.

   B. Employers. We may disclose your protected health information to an employer if you are a member of the employer's workforce and we have been requested by the employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. This only applies if the employer needs such findings to comply with requirements of federal or state law regarding recording of illness or injury or to carry out responsibilities for workplace medical surveillance. In such an instance, we will provide you with written notice at the time we provide you health care that your protected health information relating to medical surveillance or the workplace and work-related injuries will be disclosed to the employer.

3. Uses and Disclosures about Victims of Abuse, Neglect or Domestic Violence. We may disclose your protected health information, to a governmental authority if we reasonably believe that you are a victim of abuse, neglect or domestic violence. Such disclosure is only allowed if it is required by law or if it is expressly authorized by law and certain other requirements are met.

4. Uses and Disclosures for Oversight Activities. We may disclose your protected health information to health oversight agencies (e.g., the U.S. Department of Health and Human Services) for oversight activities authorized by law, including

the following: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other appropriate oversight activities.

5. Disclosures for Judicial Proceedings. We may disclose your protected health information in a judicial or administrative proceeding if the request for such protected health information is made through or pursuant to: (A) an order from a court or administrative tribunal or (B) in response to a subpoena or discovery request from a party to the proceeding if certain assurance have been provided to us.

6. Disclosures for Law Enforcement Purposes. Under certain circumstances, we may disclose your protected health information to law enforcement officials.

7. Uses and Disclosures Concerning Decedents. We may disclose protected health information to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may also disclose protected health information to funeral directors to carry out their duties in accordance with applicable laws.

8. Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes. We may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation or transplantation.

9. Uses and Disclosures for Research Purposes. We may use or disclose your protected health information for research purposes, provided, the research has been approved appropriate oversight entities and sufficient privacy protections have been implemented.

10. Uses and Disclosures to Avert a Serious Threat to Health or Safety. We may disclose your protected health information if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is made to person(s) able to prevent or lessen the threat including the target of the threat; or the disclosure is necessary for law enforcement authorities to identify or apprehend an individual.

11. Military Activities. If you are a member of the Armed Forces we may use and disclose your protected health information for activities deemed necessary by appropriate military command authorities.

12. National Security and Intelligence Activities. We may disclose your protected health information to authorized federal officials for the conduct of lawful intelligence, counterintelligence and other national security activities authorized by the National Security Act or for the provision of protective services to the President.

13. Correctional Authorities. We may disclose protected health information of persons in the custody of correctional authorities under certain circumstances if requested by those authorities.

14. Workers' Compensation. We may disclose your protected health information as authorized to comply with workers' compensation laws.

V. Emergencies

We may use or disclose your protected health information in order to treat you or assist with coordinating your treatment in an emergency situation.

VI. Your Rights

With regard to your protected health information, you have the following rights:

1. The Right to Request Restriction of Uses and Disclosures. You have the right to request that we restrict the uses or disclosures of your protected health information to carry out treatment, payment or health care operations and to family members, other relatives or persons directly involved in your care or payment. We are not required to agree to any such restrictions, but if we do, we must comply with such restrictions, other than in emergency or certain other circumstances permitted or required by law. Notwithstanding the foregoing, we will comply with a requested restriction in the event that you wish to restrict disclosure of your protected health information to a health plan for payment or health care operations where the protected health information relates solely to a health care item or services for which you paid for out of pocket.

2. The Right to Confidential Communications. You have the right to request that we provide you with an alternative means of communication in the event you tell us that our customary methods of communication may not preserve the confidentiality of your information. You may request that we send such communications to you to alternative locations.

   This request must be made by you, in writing, to our Privacy Officer. The request must specify how or where you wish to be contacted. We will attempt to accommodate all reasonable requests.

3. The Right to Access Protected Health Information. You have a right to access to inspect and copy your protected health information, including protected health information contained in any electronic health records. Under certain circumstances, we may deny your request for access to inspect and copy your protected health information. Depending on the circumstances, our denial of your request for access may be reviewable by a licensed health care professional who was not involved in the original decision to deny your request to review your information.

   To request access to your protected health information in our custody, you must submit your request in writing to our Privacy Officer. If you request a copy of your information, to the extent permitted by law, we may charge a fee for the cost of copying, postage or other items or services involved with your request. You may not remove our records from the premises.

4. <u>The Right to Amend Protected Health Information</u>. You have the right to request that we amend your protected health information in our custody. We may deny your request to amend your protected health information if a) we did not create the information unless the individual or entity that created the information is no longer available to make the requested amendment, b) the information is not maintained by or in our custody, c) you do not have the right to access such information, or d) we have determined that such information is accurate and complete.

   You must submit a request for an amendment to your protected health information in writing to our Privacy Officer and explain the basis for your request.

5. <u>The Right to an Accounting of the Disclosures of Protected Health Information</u>. You have the right to an accounting of how we have disclosed your protected health information for the six (6) year period (three years for disclosures from the electronic health record) prior to the date of your request for the accounting.

   We are not required to account for uses and disclosures of your protected health information by us:

   1. To carry out treatment, payment or health care operations,
   2. To you pursuant to your rights to access your protected health information,
   3. To friends and family involved in your care and treatment or payment for your care and treatment, or for certain notification purposes,
   4. For national security or intelligence purposes,
   5. To correctional authorities with respect to persons in custody, or
   6. That occurred prior to April 13, 2003.

   Your request for an accounting must be made in writing to our Privacy Officer, Amey J. Muzumdar at 850 N. Cass Avenue, Suite 101, Westmont, Illinois 60559. Your first request in any twelve (12) month period will be provided to you at no charge, however, additional requests will be charged to you based on our cost to conduct the accounting. We will inform you of the fee for the additional accountings prior to our conducting the accounting so that you may consider whether to modify or withdraw your request before you incur any fees.

6. <u>Right to Receive Paper Notice.</u> If you have agreed to receive this notice electronically, you have the right to receive a paper copy of this notice at our located at 850 N. Cass Avenue, Suite 101, Westmont, Illinois 60559.

7. <u>Right to Opt out of Fundraising Communications</u>. We may contact you to raise funds for our entity and you have the right to opt out of receiving such communications.

8. <u>Right to Be Notified In the Event of Breach.</u> You have the right to and will be notified by us following a Breach of unsecured protected health information.

VI. Complaints.

If you believe your privacy rights have been violated or that we have not complied with this Notice of Privacy Practices, you may file a written complaint with our Privacy Officer at the Gurnee, Illinois address or with the Secretary of the Department of Health and Human Services. Our Privacy Officer can also be reached by calling (847) 662-1818, ext. 115. We will not penalize or charge you for filing a complaint with our Privacy Officer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge and agree that AMEY J. MUZUMDAR, DC S.C. d/b/a GENUINE CARE HEALTH AND WELLNESS CENTER (the “Practice”) has provided me with a copy of its Notice of Privacy Practices, which explains my privacy rights and how the Practice may use and disclose my protected health information.

If I have any questions regarding the Notice of Privacy Practices, I may contact the Practice’s Privacy Officer at 850 N. Cass Avenue, Suite 101, Westmont, Illinois 60559.

______________________________   ____________________
Signature   Date

______________________________   Address: ____________________________
Printed Name   ____________________________

____

INFORMED CONSENT TO TREATMENT

I, ________________________, hereby request and consent to: (1) the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physio therapy, therapeutic exercises, manual therapy and diagnostic X-rays; and (2) acupuncture procedures on me (or on the patient named below, for whom I am legally responsible) by AMEY J. MUZUMDAR, DC S.C. d/b/a GENUINE CARE HEALTH AND WELLNESS CENTER (the "Practice"). In addition, I hereby request and consent to receiving advice and recommendations on food supplements, including cleansing and detox programs and weight management programs.

I have had an opportunity to discuss with a physician of the Practice and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic medicine there are risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Practice to be able to anticipate and explain all risks and complications, and I wish to rely upon the Practice, through its employees and independent contractors, to exercise judgment during the course of the procedure which the Practice, through its employees and independent contractors, feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

______________________________ ______________________

Signature Date

______________________________ Address: ______________________

Printed Name ______________________

____

Insurance Authorization and Irrevocable Assignment of Benefits

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital. Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian provides for the irrevocable assignment of benefits to AMEY J. MUZUMDAR, DC S.C. d/b/a GENUINE CARE HEALTH AND WELLNESS CENTER (the "Practice"), authorizing this transfer of payment from the insured to the Practice.

I, ______________________, hereby irrevocably authorize the Practice to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and/or any governmental payor and that payments be sent directly to the Practice . I understand that it is the policy of the Practice to only bill my insurance company(ies) and/or governmental payors if the Practice participates in such networks and/or programs, and if the Practice does not, it will be my responsibility to bill my insurance company(ies) and/or governmental payor for reimbursement of my expenses. I understand that I am financially responsible to pay any charges at the time the service is rendered.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied the Practice with the up-to-date and correct insurance identification card(s) as well as supplied the Practice with all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied may result in denial of payment(s) to the Practice and resubmitted claims with corrected updated information that are still denied due to the fact that the corrected information was not supplied in a timely fashion to the Practice. In the event of such denial, I understand that it will be my responsibility to pay the Practice for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance or through workers' compensation.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees, court costs, and other expenses incurred as a result of said collection or court date.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorize the Practice to release any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. Furthermore, I permit a copy of this authorization to be used in place of the original.

I hereby agree that I will take any and all action necessary to assist the Practice in recovering any MedPay benefits to which the Practice may be entitled.

In the event that any part or provision of this authorization and assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this authorization and assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

I hereby agree that this Insurance Authorization and Assignment of Benefits is irrevocable.

______________________________ ______________________
Signature Date

______________________________ Address: ______________________
Printed Name ______________________
____