Albert Stabile, D.C., Jr., F.I.C.C., C.C.P.C.P.
Associates in Chiropractic Family Health & Wellness Center, PA
179 Cedar Lane Suite B
Teaneck, New Jersey 07666
Office Phone:201-591-3141 Mobil: 845-325-3586
Electronic Fax: 201-581-1891

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THE IMPORTANCE OF ATTENDING YOUR APPOINTMENTS ON A REGULAR BASIS

We have serious concerns regarding the frequency of missed appointments. The treatment plan that we recommended at your Report of Findings is a prescription for care that is no different than any other prescription from your medical doctor. If a Doctor of Medicine prescribes 3 pills per day for 12 days or a total of 36 pills, that is no different than our prescription for 3 treatments per week for 12 weeks or 36 treatments. The difference lies in the fact that you are taking the medication and in a sense self treating. The treatment we deliver can only be delivered by the doctor with you being present in our office. To have the best possible results you must follow the recommendations we made to you. If you miss a prescribed medication you slow down, stop your recovery or sometimes cause your condition to worsen. If you miss your chiropractic treatment you slow down or stop and sometimes cause your condition to worsen as well. Missing a treatment may take an additional few treatment to make up for the loss. The improper treatment or lack of treatment in the manner we recommended can often times cause the quality of your life to become compromised. This may cause difficulty performing necessary tasks which may affect your daily activities, entertainment, and work. Make your appointments for a time that you will not be having to cancel or change. We work by appointment in an effort to enable patients to spend as little time as possible receiving the necessary treatment. When you cancel or miss an appointment you not only lose out on the benefits of the treatment but affect others who could have taken that appointment time. Being late or early for an appointment without calling may cause increased waiting time for other patients who are on time for their appointments.

Missed Appointments

To enable us to efficiently attend to our patients, appointments for the following week are scheduled at the end of each week. Our Office Policy requires our patients to make appointments in advance. When an appointment time needs to be changed it is **COMMON COURTESY** that you make the change in person or by telephone prior to the scheduled appointment that is being changed. If you are running late or wish to come in earlier, we require that you call and change your scheduled appointment time. Missed appointments are required to be made up the same week or the following week. Missed appointments (i.e. "no show, no call") may result in a $50.00 charge after the first incident. Attending your appointments are to your advantage as they will enable you to heal faster and more completely preventing complications and long-lasting chronic problems.

Financial Plans:

If you have been given the Privilege of paying for your treatment with our Interest Free Financial Plan, you are being given the Privilege of receiving your necessary treatment in a manner that is to your financial advantage as noted in the Financial Agreement. You are receiving treatment that would cost you more than three to four times the fees included in your plan. We offer these Financial Plans to enable our patients to receive the necessary treatment and achieve optimal results without the burden of unknown costs. Enabling the cost of treatment to be distributed monthly over a one year time period results in reduced up-front payments.

Administering a practice is complicated and time consuming. The requirements imposed on the Doctor's Office by the Insurance Companies has become burdensome and takes time away from patient treatment. Contacting the Insurance Companies/Governmental Agencies requires that we leave a message and wait for a call back which can take days or even weeks. We must answer the call backs immediately or we lose the opportunity to receive answers to questions that affect our patient's treatment and payment. Unfortunately, many of these calls necessitate the doctor's attention and, in some instances, may require the patient to wait. Each of you may be in this situation at some time or another and we hope you can be patient and understand when this happens.

YOUR HEALTH IS OUR PRIMARY CONCERN AND IT SHOULD BE YOURS AS WELL. "WHEN YOU HAVE YOUR HEALTH, YOU HAVE EVERYTHING"! PLEASE MAKE EVERY EFFORT TO COMPLY WITH YOUR TREATMENT RECOMMENDATIONS!!!

I hereby state that I have read the above and understand its content and agree to abide by the Office Procedures and Rules.

__________________ ___________ ______________________ __________

Printed Name　　Date　　Signature　　Witness

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ASSIGNMENT OF INSURANCE BENEFITS

PATIENT'S NAME: ______________________________

DATE OF ACCIDENT: ____________________________

In consideration for services rendered to me or to be rendered to me in the future, I hereby authorize payment to the above-referenced provider of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event that the provider's charges are outstanding, I hereby assign and authorize the provider to institute arbitration proceedings or other litigation for the purpose of the provider realizing payment for services rendered. It is also my intent that the provider receives payment directly from the insurance carrier, whether payment is issued prior to or as a result of arbitration proceedings or litigation.

This authorization and assignment or photocopy thereof shall authorize you to furnish all information you may have concerning my condition while under your observation or treatment, including, but not limited to the history obtained, x-ray, MRI, physical findings, diagnosis and prognosis.

SIGNATURE: ____

RELATIONSHIP TO PATIENT: ____________________________________

DATED: _____________________________________

Claim # ________________________

First Date of Treatment _______________

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DOCTORS LIEN

TO: ATTORNEY/INSURANCE CARRIER
____
____

FROM:
Albert Stabile Jr., D.C.

REFERENCE: PATIENT RECORD'S AND DOCTOR'S LIEN

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of the case history, examinations, diagnosis, treatment and prognosis of myself in regard to my accident/illness which occurred or began on _________________.

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to directly pay said doctor such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately.

I understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me, and that this agreement is solely for said doctor's protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment or verdict by which I may eventually recover said fees.

PATIENT'S SIGNATURE ____________________**DATE** _______________

PATIENT'S NAME ________________________________

WITNESS SIGNATURE __________________**DATE** _______________

WITNESS NAME __________________________________

The undersigned, being attorney or insurance carrier's authorized representative for the above-named patient, does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

AUTHORIZED SIGNATURE _______________ **DATE** ______________

NOTE: PLEASE SIGN, DATE AND RETURN A COPY TO THIS OFFICE AT

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ONCE. KEEP ONE COPY FOR YOUR RECORDS.

Emergency Contact Information

In the rare case that an emergency involving you may occur I our office, we would like to know who to contact regarding your care; this person would be contacted immediately after we notify emergency services. For this reason, we wish to have an emergency contact on file for every patient in our office. Please provide us with the information for whom we may call in the event of an emergency.

Name of Emergency Contact: ______________________________________
Relationship: __________ Best way to contact: ____________________
Phone Number: _________________ Extension: ___________________

By signing this form, you are authorizing a representative of this office to contact the above mentioned person in case we deem an there is an emergency regarding your safety, as well as to disclose any information we may have that we deem medically necessary to th situation regarding your safety to th above mentioned person and necessary medical personnel.

___________________	_________________________	______________
Signature	Printed Name	Date

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GENERAL RELEASE OF RECORDS AND/OR RELEASE OF X-RAYS

KNOW BY ALL MEN THAT I HAVE REQUESTED THE RELEASE OF X-RAYS AND/OR RECORDS OF ______________________________, (Patient's Name) WHICH IS A PART OF THE RECORDS OF _______________________.

I hereby acknowledge the receipt of these x-rays and/or records. In consideration of the foregoing, I hereby release and forever discharge the aforesaid from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment.

_______________________________________ _______________
PATIENT OR LEGAL REPRESENTATIVE DATE

_______________________________________ _______________
WITNESS DATE

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INFORMED CONSENT
To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.
The nature of the chiropractic adjustment.
The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.
Analysis/Examination/Treatment
As part of the analysis, examination, and treatment, you are consenting to the following:
Patient should initial the procedures they are consenting to.

X Spinal Manipulation	X Palpation	X Vital Signs
X Range of Motion Testing	X Orthopedic Testing	X Basic Neurological Testing
X Muscle Strength Testing	X Postural Testing	X Ultrasound
X Hot/Cold Packs	X EMS	X Radiographic Studies

___Other (please explain) ____
The material risk inherent in chiropractic adjustment.
As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications of care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone, which I check during he is taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidence of stroke is exceedingly rare and are estimated to occur between one in one million and one in five million in cervical adjustments. The other complications are also generally described as rare.
The availability and nature of other treatment options.
Other treatment options for your condition may include:
Self-administered, over-the-counter analgesics and rest
Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and painkillers.
Hospitalization
Surgery
If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.
The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility, which may set up a pain reaction further reducing mobility. Over time the process may complicate treatment making it more difficult and less effective the longer it is postponed.
DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN.
I have read [X] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Stabile and have had my questions answered to my satisfaction. By my signature below I state that I have weighed the risks involved n undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated Dated

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____________________ ____________________
Patient Signature Doctor's Signature

NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)
Dr. Lori Ann G. Palumbo Chiropractic Physician and Dr. Albert Stabile Jr. Chiropractic Physician
FFECTIVE DATE OF THIS NOTICE: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAYBE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your .PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.
We realize that these laws are complicated, but we must provide you with the following important information:
· How we may use and disclose your PHI.
· Your privacy rights in your PHI.
· Our obligations concerning the use and disclosure of your PHI. .
The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in. the past, and for any of your records that we may create or maintain in the future. Our practice will always post a copy of our current Notice in our offices in a visible location, and you may request a copy of our most current Notice at any time.
B. IF YOU HAVE at QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Dr. Lori Ann G. Palumbo Chiropractic Physician and Dr. Albert Stabile Jr. Chiropractic Physician
C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS
The following categories describe the different ways in which we may use and disclose your PHI.
1. **Treatment.** The information in your medical records will be used to determine which treatment option best addresses your health needs. The treatment selected will be documented in your medial records so that other health care professionals can make informed decisions about your care. For example, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other, health care providers for purposes related to your treatment.
2. **Payment** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. **Health Care Operations**. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. **Appointments and Reminders**. Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment.
5. **Non-Medical Communications**. Our practice may use your PHI to contact you for non-medical reasons. For example,', we may send you a birthday card or a holiday greeting via mail.
6. **Health-Related Benefits and Services** Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you For example, we may send you newsletters that may include information about our practice, health related issues and products and services.

8. **Release of Information to**. Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
9. **Disclosures Required By Law**, Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. **USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The; following categories describe unique scenarios in which we may use or disclose your Identifiable health information.
1. **Public Health Risks**: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
A. Maintaining vital records, such as births and deaths.
B. Reporting child abuse or neglect
C. Preventing or controlling disease, Injury or disability.
D. Notifying a person regarding potential exposure to a communicable disease.
E. Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
F. Reporting reactions to drugs or problems with products or diseases
G. Notifying individuals of a product or device they may be using has been recalled.
H. Notifying appropriate government agency and authority regarding the potential abuse or neglect of an adult patient (Including domestic violence): however, we will only disclose this information if the patient agrees, or we are required or authorized by law to disclose this information; and
I**, Notifying your employer** Under limited circumstances related primarily to workplace Injury or Illness or medical surveillance.
2. **Health Oversight Activities**: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedure~ or actions; or other activities necessary for the government to monitor government programs, compliance With Civil rights laws and the health care system In general.
3. **Lawsuits and Similar Proceedings** Our practice may use and disclose your PHI In response to court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI In response to a discovery request, subpoena, or other lawful process by another party Involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
6. **Workers' Compensation**: Our practice may release your PHI for workers' compensation and similar programs.

E. **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you:
1. **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing your request must describe in a clear and concise fashion.
A. The information you wish restricted.
B. Whether you are requesting to limit our practice's use, disclosure or both; and
C. To whom you want the limits to apply.
3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your

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request must be made in writing and submitted Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666 You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the 'practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the billing department using your information to file your insurance claim in order to obtain an accounting of disclosures, you must submit your request in writing to Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

7. **Right to File a Complaint**. If you believe your privacy fights have been violated; you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for other Uses and Disclosures·** Our practice will maintain your Written authorization for uses and disclosures that are not Identified by this notice or permitted by applicable law Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing after you revoke your authorization, we VviI1 no longer use or disclose your PHI for the reasons described in the authorization. **Please note, we are required to retain records of your care.**

Again. If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Stabile Jr., D.C. at 179 Cedar Lane Suite B Teaneck, NJ 07666

I have read a copy of the notice of privacy practices document.

______________________	__________	_________________________
Signature of Patient or Legal Guardian	Date	Print Patient Name or Legal Guardian

HIPPA Waiver for Modalities:

I am aware of the HIPPA requirements for patient privacy and I am consenting to waive a portion of this privacy and consent to receive my various modalities in a multi- patient area.

______________________________	______________________
Patient Signature	Date
____________________________	____________________
Patient Name Printed	Witness

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OFFICE POLICY

PATIENT NAME: ____________________________DATE: ______________________

ADDRESS: ____

SOCIAL SECURITY NUMBER: ______________ DATE OF BIRTH: _____________

PLEASE READ ALL TEXT, IF YOU UNDERSTAND WHAT YOU HAVE READ, PLEASE SIGN WHERE INDICATED AT THE BOTTOM OF THIS FORM.

AUTHORIZATION TO RELEASE INFORMATION ---I hereby authorize any provider insurance company, physician, employer or organization to release any information regarding history, treatment, or benefits payable and related information concerning this claim, to the plan administrator or it's authorized agent, for the purpose of validating and determining benefits in connection with this claim and to any reviewer that Dr. Lori Ann G. Palumbo, Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician may deem necessary to perform a file review for the purposes of payment, rebuttal of treatment denial, retroactive review, current denial of care, payment or non payment of my claims.

PAYMENT AUTHORIZATION---I authorize payment of all benefits for services rendered from Dr. Lori Ann G. Palumbo, Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician and/or the offices known as indicated on the enclosed bills.

This statement applies to insurance assignment and/or an Attorney Lien against any settlement made in conjunction with the above named for condition or injuries which I am being treated for in the offices of the above named physicians.

OFFICE POLICY REGARDING APPOINTMENTS --- Multiple appointments may be given to you for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily schedule. Regardless of how many appointments are scheduled for you each week, please remember that it is frequency of the visits that is important, and not the days. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. IF YOU NEGLECT TO CALL TO RE-SCHEDULE AN APPOINTMENT THAT YOU CAN NOT MAKE, AND DO NOT SHOW UP FOR THAT APPOINTMENT, YOU WILL BE CHARGED. If you are late for an appointment you may have to wait for the next available opening. If you have any questions please ask the receptionist.

OFFICE POLICY REGARDING ASSIGNMENT ---Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in any way that we can. However, it must be fully understood that the Contract is between you and your insurance company and you are fully responsible for the amount that is not paid by your insurance company.

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Our Policy is as follows:

1. Since, by taking your insurance assignment, we have to wait for payment, this courtesy may be withdrawn at any time if the situation warrants it.

2. If you discontinue care without the doctor's consent, the balance of your account is due to be paid in full, even if insurance has been filed. (You will be reimbursed if your balance is zero)

3. Your insurance company should pay within 30 days. If they do not pay within 60 days, you must pay the balance due and be reimbursed by the insurance company.

4. We will bill your insurance company in 15-day cycles, for as long as you receive care.

5. All deductible payments MUST be made prior to insurance submittal. You are required to pay your co-payment as you go along.

6. You are required to sign for "Authorization to Pay the Provider" (above) and any other documents required by your insurance company, on your first visit.

7. Our office does not guarantee that your insurance company will pay. We will make every attempt to verify your coverage and collect, but all claims are ultimately your responsibility.

8. Since we do not own your policy, and occasionally, we have trouble in collecting from the carrier, we may ask for your active assistance in rectifying this situation.

9. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1½% per month. Charges may also be made for missed appointments and those canceled without 24 hours' notice.

10. All patients whose visitation schedule is once per month (or longer) will not be eligible for insurance assignment. Charges for services rendered will again be due as they are received.

11. This office does not promise that an insurance company will reimburse you for the usual and customary charges submitted by this office, nor will we enter into any dispute with an insurance company over the amount of reimbursement.

12. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. Any over payments will be refunded to you.

13. This office does not file for or accept co-payment for secondary Insurance coverage.

14. The privilege of Insurance assignment begins when our office receives your insurance forms and your insurance is "Qualified" for coverage. You are considered a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your policy.

15. Lastly, it is the goal of this office to provide you with the finest quality Chiropractic care available. If you have any questions with regard to your health care, or any of our policies, please let us know. We look forward to your referrals and to a doctor-patient relationship that works for our mutual benefit.

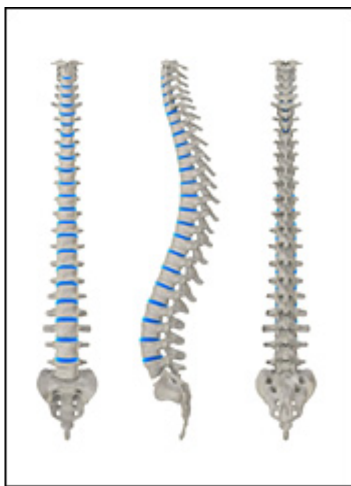
________________________ ____________ ________________
PATIENT SIGNATURE DATE Witness

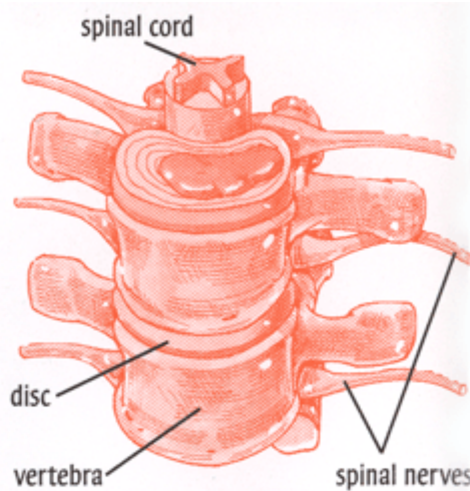
All accounts not paid within 90 days will automatically be put through your personal credit card for collection.

I_________________________ hereby authorize Dr. Lori Ann G. Palumbo, Chiropractic Physician and Albert Stabile Jr., Chiropractic Physician to charge my AMEX___ VISA___ MC ____Credit card account #__________________________ for the following services and or supplies:
____

_________________________ ________________________ ________________________
Signature, Please Print Name Date

Albert Stabile, D.C., Jr., F.I.C.C., C.C.P.C.P.
Associates in Chiropractic Family Health & Wellness Center, PA
179 Cedar Lane Suite B
Teaneck, New Jersey 07666
Office Phone:201-591-3141 Mobil: 845-325-3586
Electronic Fax: 201-581-1891





Based on our consultation, examination and testing we have determined that your condition falls within the Phase that is checked below. We have included all phases of degeneration so you will be familiar with them.

Degeneration

Spinal degeneration is often caused by long standing stress and Vertebral Subluxations in your spine.

When your spine degenerates, our spinal bones begin to deform, your discs swell, then shrink, your ligaments, tendons and muscles begin to harden and weaken, and your entire spinal column loses its balance, flexibility, stability and strength. Your nerves, body chemistry and internal organs can also be affected. Spinal degeneration can make it harder to adapt to the pressures of every day life.

Loss of Height
Most people believe they automatically lose height when they reach old age. However, the loss of height is silent, slow and gradual, and may begin in your 20s and 30s as one of the symptoms of spinal degeneration.

Spinal Decay
Spinal degeneration is like tooth decay - an often-painless process that goes on for years before any damage is detected. Simple day-to-day stress can cause your spine's many

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complex parts to deteriorate. Stress often causes the spinal vertebrae to shift from their proper places, or to become misaligned and irritate the surrounding nerves, bones, discs, ligaments and other soft tissues - resulting in a Vertebral Subluxation Complex that must be addressed before it causes significant damage.

The Phases of Degeneration

- ***Phase 1***
  First your spine loses its normal balance. There may be a loss of normal spinal curves. Your nerves may be affected and the vital life energy that flows over them is interrupted. Your joints, discs, nerves and posture are stressed and age more quickly. Surprisingly, there may be no pain other than occasional discomfort. Some individuals may also experience a slight lessening of energy and height loss. Response to spinal care at this stage is generally good.
- ***Phase 2***
  In the second phase of degeneration, there is a much greater degree of decay, disc narrowing and bone spurs (deformations). Postural changes are much more evident and spinal canal narrowing (stenosis) may occur. This phase is characterized by aches and pains, fatigue and a diminished ability to cope with stress. Height continues to decrease. This condition is very common - by age 40, 80% of males and 76% of females exhibit moderate disc degeneration. With chiropractic care at this stage, significant improvement is possible.
- ***Phase 3***
  In the third stage, individuals will experience significantly increased postural imbalances, nerve damage, permanent scar tissue, advanced bone deformation and the onset of physical and/or mental weakness or disability. Permanent losses of height and energy also occur. With care, some reversal is possible.
- ***Phase 4***
  During the fourth and most advanced stage of degeneration, the postural imbalance is severe and motion is limited. There is extensive nerve damage, permanent scar tissue is formed and bones may begin to fuse. Individuals experience pain, various degrees of physical or mental disability and continued loss of energy and height. At this stage, the condition is considered irreversible, although chiropractic care may give some symptomatic relief.

The Chiropractic Approach
You need not sit and passively watch your spine degenerate. Dr. Stabile's chiropractic care can slow and even reverse spinal degeneration by improving spinal balance and posture and keeping your joints, nerves and discs healthy and strong throughout your

lifetime. The restoration of motion can lead to restoration of normal function, and if identified in time, correction of a Vertebral Subluxation can allow the condition to reverse itself.

Prevention

The sooner chiropractic care begins, the better chance the patient has for its arrest and reversal. Of course, the best approach to spinal degeneration is to prevent it from occurring in the first place. Dr. Stabile recommends bringing your children for periodic spinal checkups to make sure that their spines are free of the Vertebral Subluxation Complex. Since stress, modern life and the environment take a toll on us, periodic spinal checkups to detect "silent" Vertebral Subluxations are of vital importance for everyone in your family. In addition, anytime anyone experiences a fall, accident or other trauma, he or she should have his or her spine checked.

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VERIFICATION OF NON-PREGNANCY

DATE ____________________________

PATIENT NAME: ______________________________________

ADDRESS: ____

____

TELEPHONE ____

SOCIAL SECURITY NUMBER ____________________________

By my signature on this form I ______________________________, do hereby state that, to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

___________________________ ____________________
PATIENT SIGNATURE DATE

___________________________ ______________________
WITNESS SIGNATURE DATE

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Consent to Treat Minor Children

I, ____, parent or legal guardian of ____, born ________________________,
do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said is under the care of Dr. Stabile and I am not reasonably available by telephone to give consent.

This authorization is effective from _____________________________ to the end of the assigned treatment.

____
Signature of Parent or Legal Guardian

____________________________________ ____________________________________
Witness Signature **Witness Name (Printed)**

This additional information will assist in treatment if it can be furnished with the consent

Family Address: ____
Telephone: Father __________________________
Mother: ________________________

Childs Birthdate: ___________________________

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Insurance Company: ___________________ Policy # __________________________

Insured: ____
Insured D.O.B: _______________________________________

PROFESSIONAL REFERRAL PRESCRIPTION

Patient Name: _______________________ Date of Request: ______________________

Please call the Specialist/s checked off below and make an appointment as soon as possible:

□ **Neurologist:** (consult reports, MRI films, MRI reports)
□ Theodore Joseph Conte, M.D. 22 Madison Ave. Ste. 206
Paramus, NJ 07652 Phone: 201-291-8489 Fax: 201-291-8487
Appointment Date ____________ Time_____________

□ Neurosurgeon: (consult reports, MRI Films, MRI Reports)
□ William L. Klempner, MD
225 Dayton Street
Ridgewood, NJ 07450
Phone: 201-612-0020
Appointment Date ____________ Time_____________

□ **Orthopedist:** (MRI films, MRI reports)
□ David M. Deramo, MD
370 Grand Avenue Englewood, NJ 07093
Phone: (201) 567-5700 Fax: (201) 567-8049
Appointment Date ____________ Time_____________

□ **Orthopedist:** Premier Orthopedics & Sports Medicine (MRI films, MRI reports)
□ Howard Baruch, MD
403 Grand Avenue
Englewood, NJ 07631
Phone 201-833-9500
Appointment Date ____________ Time_____________

□ **TMJ Specialist: (**insurance/referral information)
□ Jerald Friedman, DDS
315 Cedar Lane Teaneck, NJ 07666
Phone: 201-692-7737
Appointment Date ____________ Time_____________

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□ **Interventional Pain Management**
□ Nasar Shahid, M.D.
179 Cedar Lane Suite Teaneck, NJ 07666
Phone: 201-907-5094
Appointment Date _____________ Time______________

□ **Pain Management:**
Premier Orthopedics & Sports Medicine
403 Grand Avenue
Englewood, NJ 07631
Phone 201-833-9500
Appointment Date _____________ Time______________

□ **Clinical Psychologist**
□ Debra L Davis, Phd, LCASDC
179 Cedar Lane Suite C Teaneck, NJ 07666
Phone: 201-505-8972 Fax: 201-596-3630
Appointment Date _____________ Time______________

□ **Physical Medicine and Rehabilitation**
□ Mary Swajian, DO
680 Kinderkamack Road Suite 102 Oradell, NJ 07649
Phone: 201-265-6300 Fax: 201-265-6301
Appointment Date _____________ Time______________

□ Information/testing that should be taken with patient to referred source:
MRI films and reports:
□ Cervical
□ Thoracic
□ Lumbar
□ Other: ____________
□ X-rays
□ Referral sheet information
□ SEMG
□ Thermal Scans
□ Initial Examination
□ Last Re-examination
□ Consult reports ortho / neuro
□ Progress Notes last exam to today

If our office makes the appointments complete the following:
Date appointment was made: _____________Person making appointment ____________