Sussex County Total Health 40 Moran Street Newton, NJ 07860

Confidential Patient Health Record

Date:____________ ID #:____________

Name:______________________________ DOB:____________ Age:____ SS#:____________

Address:______________________________ E-mail:______________________________

City:______________ State:____ Zip:________ Home Phone #:____________ Cell Phone #:____________

Driver's License #:______________________________ Male or Female Race ____________

Employer:______________________________ Occupation:______________________________

Work Phone #:______________________________ Marital Status: Single Married Divorced Widow/Widower

Name of Spouse:______________________________ Spouse's Occupation:______________________________

Spouse's Employer:____________________ Business Phone #:____________ Spouse's SS#:____________

Name of Emergency Contact:____________________ Phone #:____________ Relationship:____________

Whom May We Thank for Your Referral:____________________ Primary Care Physician:____________________

Person Responsible for your bill: You/Spouse Worker's Comp Auto Insurance Medicare Major Medical

Insurance Company:______________________________ ID Number or Claim #:______________________________

Insured Person's Name:______________________________ Insured's Date of Birth:______________________________

CURRENT HEALTH Main Complaint(s):____

How did this condition start?____

When did this condition begin?:____________________ Has this condition occurred before?:____________________

Have you seen other Doctor's for this condition?____________ Who?:______________________________

Type of Treatment:______________________________ Results:______________________________

Is Condition: Job Related Home Injury Auto Accident Fall Other:____________________

Date of Accident:______________________________ Time of Accident:______________________________

Was the Accident reported to your employer and/or insurance company?:______________________________

Medication you are currently taking: Nerve Pills Pain Killers Muscle Relaxers Blood Pressure Medicine

Insulin Other:____

Do you suffer from any condition other than that which you are now consulting us?______________________________

Patient: Height __________ Weight __________ Right handed Left handed Primary Language ____________

Children #:__________ Ages of Children:____

Past Health History **(Please Check and Describe)**

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

Broken Bones Other:____

Major Accidents or Falls: ____________________ Hospitalization (Other than above):____________________

Previous Chiropractic Care: None Doctor's Name & Date of Last Visit:______________________________

Below is 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.

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD:

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

Have you been tested HIV positive? ☐ Yes or ☐ No

INTAKE:
Coffee
Tea
Alcohol
White Sugar
Cigarettes - Never
Former
Current:
If current: ☐ Occasional ☐ Daily

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

MUSCULO-SKELETAL:
Low Back Pain
Pain between Shoulders
Neck Pain
Arm Pain
Joint Pain/Stiffness
Walking Problems
Difficulty Chewing/Clicking Jaw
General Stiffness

NERVOUS SYSTEM:
Nervous
Numbness
Paralysis
Dizziness
Forgetfulness
Confusion/Depression
Fainting
Convulsions
Cold/Tingling Extremities
Stress

GASTRO-INTESTINAL:
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:
Bladder Trouble
Painful/Excessive Urination
Discolored Urine

C-V-R:
Chest Pain
Shortness of Breath
High Blood Pressure
Irregular Heartbeat
Heart Problems
Lung Problems/Congestion
Varicose Veins
Ankle Swelling
Stroke

MALE/FEMALE:
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

GENERAL:
Fatigue
Loss of Sleep
Fever
Headaches
Allergies – Please list ______________
____

ENT:
Vision Problems
Dental Problems
Sore Throat
Ear Aches
Hearing Difficulty
Stuffed Nose

FAMILY HISTORY:
The following members have a similar problem as I do:
Mother
Father
Brother
Sister
Spouse
Child
Other ______________________

Sussex County Total Health 40 Moran Street Newton, N.J. 07860

Patient's Complaints

Name:______________________ Age______ Date:______________ Chart ID#:________

HISTORY: New complaint: ☐ Current complaint: Improving? ☐ Same? ☐ Worse? ☐
Explain: *area(s) of body affected*

____
____
____

Explain: What happened and When to cause or worsen your symptom(s): *date, days, weeks ago, etc.*?

____
____
____

Explain: What activities are affected by your complaint(s):

____
____
____

Neck complaints:
Pain quality: achy burning dull sharp stiff throbbing grabbing
Pain level average: (1 is least, 10 is worst) (*circle one*): 1 2 3 4 5 6 7 8 9 10
What is the least pain?: 1 2 3 4 5 6 7 8 9 10 worst pain?: 1 2 3 4 5 6 7 8 9 10
How often does problem occur: (*circle one*): 75% – 100% of the time, 50% - 75%, 25% – 50%, 0 – 25%
Does pain radiate? Yes No If yes, where does it spread or radiate to? ______________________
When is it worse? constant, as day progresses, AM, afternoons, PM, sleeping, not affected by time
What makes it worse? turning head, looking down / up, sitting, standing, walking, coughing, sneezing
When does it feel better? morning, afternoon, evening, sleeping, as day progresses, never does
What do you do to relieve the problem? cold packs, hot packs, medication, exercise, rest, Chiropractic, sleep, change position, stretch, other:________________
Do you have numbness in your arms or hands? yes / no where? left / right / both
Do you have weakness in your arms or hands? yes / no where? left / right / both

- -

Lower back complaints:
Pain quality: achy burning dull sharp stiff throbbing grabbing
Pain level average: (1 is least, 10 is worst) (*circle one*): 1 2 3 4 5 6 7 8 9 10
What is the best it gets?: 1 2 3 4 5 6 7 8 9 10 worst it gets?: 1 2 3 4 5 6 7 8 9 10
How often does problem occur: (*circle one*): 75% – 100% of the time, 50% - 75%, 25% – 50%, 0 – 25%
Does pain radiate? Yes No If yes, where does it spread or radiate to? ______________________
When is it worse? constant, as day progresses, AM, afternoons, PM, sleeping, not affected by time
What makes it worse? bending forward / back, twisting, sitting, standing, walking, coughing, sneezing
When does it feel better? morning, afternoon, evening, sleeping, as day progresses, never does.
What do you do to relieve the problem? cold packs, hot packs, medication, exercise, rest, Chiropractic, sleep, change position, stretch, other:________________
Do you have numbness in your legs or toes? yes / no where? left / right / both
Do you have weakness in your legs or toes? yes / no where? left / right / both

<see other side for more areas>

Headaches:
Location: (*circle*) front of head, side(s) of head, temples, back of head, other area: ______________
Part of day: morning afternoon evening sleeping (wake up with it) as day progresses
How often does problem occur: (*circle one*): 75% – 100% of the time, 50% - 75%, 25% – 50%, 0 – 25%
If not constant, how often (circle): 1, 2, 3, 4+ time(s) per (circle) hour; a day; a week; a month?
Level Now: circle one: 1 is least, 10 is worst 1 2 3 4 5 6 7 8 9 10
How long do they last? (circle) ½ 1 2 3 4 5 6 6+ (circle) minutes hours

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Upper back:
Pain quality: achy burning dull sharp stiff throbbing grabbing
Pain level average: (1 is least, 10 is worst) (*circle one)*: 1 2 3 4 5 6 7 8 9 10
What is the best it gets?: 1 2 3 4 5 6 7 8 9 10 worst it gets?: 1 2 3 4 5 6 7 8 9 10
How often does problem occur: (*circle one*): 75% – 100% of the time, 50% - 75%, 25% – 50%, 0 – 25%
Does pain radiate? Yes No If yes, where does it spread or radiate to? ______________________
When is it worse? constant, as day progresses, AM, afternoons, PM, sleeping, not affected by time
What makes it worse? turning, reaching, bending, sitting, standing, walking, coughing, sneezing
When does it feel better? morning, afternoon, evening, sleeping, as day progresses, never does.
What do you do to relieve the problem? cold packs, hot packs, medication, exercise, rest, Chiropractic, sleep, change position, stretch, other:___________________

Mid back:
Pain quality: achy burning dull sharp stiff throbbing grabbing
Pain level average: (1 is least, 10 is worst) (*circle one)*: 1 2 3 4 5 6 7 8 9 10
What is the best it gets?: 1 2 3 4 5 6 7 8 9 10 worst it gets?: 1 2 3 4 5 6 7 8 9 10
How often does problem occur: (*circle one*): 75% – 100% of the time, 50% - 75%, 25% – 50%, 0 – 25%
Does pain radiate? Yes No If yes, where does it spread or radiate to? ______________________
When is it worse? constant, as day progresses, AM, afternoons, PM, sleeping, not affected by time
What makes it worse? turning, reaching, bending, sitting, standing, walking, coughing, sneezing
When does it feel better? morning, afternoon, evening, sleeping, as day progresses, never does.
What do you do to relieve the problem? cold packs, hot packs, medication, exercise, rest, Chiropractic, sleep, change position, stretch, other:___________________

Other area: ____________________________ right / left / both
Pain quality: achy burning dull sharp stiff throbbing grabbing
Pain level average: (1 is least, 10 is worst) (*circle one)*: 1 2 3 4 5 6 7 8 9 10
What is the best it gets?: 1 2 3 4 5 6 7 8 9 10 worst it gets?: 1 2 3 4 5 6 7 8 9 10
How often does problem occur: (*circle one*): 75% – 100% of the time, 50% - 75%, 25% – 50%, 0 – 25%
Does pain radiate? Yes No If yes, where does it spread or radiate to? ______________________
When is it worse? constant, as day progresses, AM, afternoons, PM, sleeping, not affected by time
What makes it worse? _______________, sitting, standing, walking, coughing, sneezing
When does it feel better? morning, afternoon, evening, sleeping, as day progresses, never does.
What do you do to relieve the problem? cold packs, hot packs, medication, exercise, rest, Chiropractic, sleep, change position, stretch, other:___________________

if there are additional areas please ask for an additional page

Neck Index

Patient Name ______________________ Date __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score ______

Back Index

Patient Name ______________________________ ***Date*** ____________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score ☐

Sussex County Total Health
40 Moran St. Newton, N.J. 07860
Dr. Thomas Walaszczyk

Activity Evaluation

Patient:______________________________ Chart ID#:________ Date:__________

Please indicate which activities are affected by your condition.
Circle any word (activity) you have difficulty with. Fill in blanks where appropriate.

Looking up:	difficult	cannot perform	pain level:	from 1-10 _____
Looking down:	difficult	cannot perform	pain level:	from 1-10 _____
Turning head:	difficult	cannot perform	pain level:	from 1-10 _____
Reaching:	difficult	cannot perform	pain level:	from 1-10 _____
Holding, grasping:	difficult	cannot perform	pain level:	from 1-10 _____
Twisting:	difficult	cannot perform	pain level:	from 1-10 _____
Bending:	difficult	cannot perform	pain level:	from 1-10 _____

Getting dressed: Upper Garments Lower Garments
Grooming: Brush/wash hair In/out bathtub
Walking: difficult How many minutes can you WALK without pain? 1, 5, 10, 30, 60
Sitting: How many minutes can you SIT without pain? 1, 5, 10, 30, 60
Standing: How many minutes can you STAND without pain? 1, 5, 10, 30, 60
Sitting to standing: difficult painful need assistance
In/Out of Bed: difficult painful need assistance
Lifting: difficult How much weight can you lift without pain: 1, 5, 10, 20, 30, 40, 50 lbs.
Climbing stairs: Difficult going UP Difficult going DOWN Need Railing Assistance
Housework: taking care of pets; taking care of children; house cleaning; gardening; laundry; ironing/folding clothes; meal preparation; wash dishes; vacuuming; grocery shopping; making beds; cleaning a bathtub
Driving: How many minutes can you DRIVE without pain? 1, 5, 10, 30, 60, 90
Getting in/out of car: difficult painful need assistance
As a Passenger: How many minutes can you TRAVEL without pain? 1, 5, 10, 30, 60, 90
Exercise: How many minutes can you EXERCISE without pain? 1, 5, 10, 30, 60
bicycling; bowling; dancing; golf; gymnastics; lift weights; martial arts; team sports; running; swimming; tennis; walking
Sleeping: pain worse at night difficulty falling asleep difficulty staying asleep
How long do you normally sleep? ______________________________
How many interruptions in sleep per night?______________________
Describe what affects your sleep?______________________________
Sleep in a: bed; hospital bed; water bed; couch; recliner; floor; other:_________
Occupational: driving lifting typing writing grasping reaching bending
Devices: cane (type __________); crutches; orthopedic shoe; prosthesis; walker; wheelchair

Lifestyle modifications: *(describe how your condition has altered some aspect of your life)*

____
____
____
____
____
____

Thomas Walaszczyk, DC LLC
Sussex County Total Health
40 Moran Street – Newton, NJ 07860
Phone# 973-579-1660 fax# 973-579-9185
newtonpainrelief.com

FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Even with insurance, most patients will experience some out of pocket expense. Sussex County Total Health (**SCTH**) will verify your eligibility and benefits however verification of coverage is not a guaranty of payment. If payment is not received within 60 days or your insurance company denies payment, it is your responsibility to follow up with your carrier. SCTH will not enter into a dispute.

MEDICARE

We are a participating provider with Medicare. Medicare only pays for a manipulation of the spine. Medicare pays 80% of the allowable fee after the deductible has been met. You are required to pay the deductible and the remaining fees for services not covered by Medicare. Non-covered services include, but are not limited to x-rays, examinations, therapies, nutritional supplements and supplies. Secondary insurance may or may not cover the non-covered services. For patients that do not have additional coverage we offer an affordable option through **ChiroHealth USA**.

NON PARTICIPATING INSURANCE PLANS

At no additional charge to you, we will complete and submit a claim on your behalf to your insurance company. Payment is due at the time of service for all deductibles, coinsurance/copays and non-covered services unless prior arrangements have been made with the office. In the event the insurance payment is mailed directly to you, you are responsible to forward the endorsed check along with the "Explanation of Benefits" to this office.

UNINSURED PATIENTS

SCTH is a participating provider with **ChiroHealth USA**, a Discount Medical Plan Organization. Patients who are uninsured or underinsured (limited chiropractic benefits) may join **CHUSA** through this office. The yearly membership fee for your entire family is $49.00. Payment for services is made at the time of service unless prior arrangements have been made with this office.

INDIGENT - FINANCIAL HARDSHIP

We offer discounts for patients who meet state and/or federal poverty guidelines or other special circumstances. Verification will be required to qualify for a financial hardship discount.

ADDITIONAL BILLING FEES

Late Fee – Past due bills will be subject to an additional fee of 2% monthly.

Interest Fee – Insurance checks that are received by you and not forwarded in accordance with our policy will be subject to an additional 18% monthly charge.

Collection Fee – Should your account be referred to an outside collection agency, you will be responsible for the 30% collection fee. (ex. Outstanding bill is $100.00. You will be charged an additional $30.00 to cover the agency's fee.)

Legal Fee - In the event we are forced to begin legal proceedings, you will be responsible for legal fees.

Patient Signature______________________________

****Additional billing fees can be avoided by authorizing payment by credit card.**

_____Any insurance checks that I receive will be endorsed and promptly brought or mailed to the office. Failure to do so within 7 days of receipt of the insurance check by me authorizes you to use my credit card listed below.

_____If my insurance company fails to pay any portion of my bill, and I do not make payment within 28 days of your invoice, you are authorized to use my credit card listed below.

_____I understand that should I terminate treatment prior to being released from care by SCTH, I am responsible for any and all outstanding balances on my account within 30 days. If I do not make payment within 28 days of your invoice, you are authorized to use my credit card information below.

The signed credit card is to be used for services provided by this office. SCTH agrees not to add charges directly to my account other than as outlined in this agreement.

_____I have read and understand the financial policy of SCTH

Patient Name____

Credit Card MasterCard [ ] Visa [ ] American Express [ ]

Credit Card Number ________________________ Expiration Date__________

Card Holder's Signature____________________________________Date__________

ASSIGNMENT OF BENEFITS & AUTHORIZATION
TO PURSUE APPEAL &/OR DENIAL OF BENEFITS

Patient Name_______________________________ Insurer_____________________________________
Claim #_____________________________________

In consideration of the professional services rendered by Sussex County Total Health, their shareholders, employees, contractors, agents of assigns ("SCTH"), I, hereby irrevocably direct, authorize, assign, and consent to the following:

1) The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for insurance benefits with regard to the above-captioned claim to SCTH, including but not limited to chiropractic fees, durable medical equipment fees, supplies, x-ray fees, and any other fees related to my claims.
2) The authorization of SCTH to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim.
3) The authorization of SCTH to initiate and prosecute any and all appeals and/or arbitration or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, as well as arbitrations.
4) The authorization of SCTH to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5) The authorization of SCTH to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6) The authorization for payment of any and all insurance benefits directly to SCTH to which I might be entitled under the above-captioned claim.

- ***IT IS MY RESPONSIBILITY TO ENDORSE AND FORWARD PROMPTLY AND DIRECTLY TO SCTH ANY INSURANCE PAYMENT/CHECK ISSUED DIRECTLY TO ME FOR SERVICES PROVIDED BY SCTH.***
- ***I AM RESPONSIBLE FOR COPAY/COINSURANCE AND DEDUCTIBLES IN ACCORDANCE WITH MY INSURANCE POLICY UNLESS OTHER ARRANGEMENTS HAE BEEN MADE WITH SCTH.***
- ***I UNDERSTAND THAT SHOULD I TERMINATE TREATMENT PRIOR TO BEING RELEASED FROM CARE BY SCTH, I AM RESPONSIBLE FOR ANY AND ALL OUTSTANDING BALANCES ON MY ACCOUNT WITHIN 30 DAYS.***
- ***IF PAYMENT IS NOT RECEIVED BY SCTH WITHIN 30 DAYS OF THEIR STATEMENT, I WILL BE SUBJECT TO AN 18% MONTHLY INTEREST FEE.***

PATIENT:

By:_______________________________ Dated:___________________________

WITNESS:

By:_______________________________

Original on file

PRIVACY CONSENT

Please answer all of the following questions. Do we have permission to:

	YES	NO	N/A
Leave a message on your answering machine at home?	___	___	___
Leave a message at your place of employment?	___	___	___
Send/receive medical information to/from consulting physicians?	___	___	___
Discuss medical conditions with any member of your Household? If yes, whom? ____________________	___	___	___

This notice is effective September 23, 2013 and any altercations or amendments made hereto will expire seven years after the date upon which the record was created.
My signature below acknowledges that I have been offered or received a copy of the privacy notice.

________________________	________________________	__________
Patient Name (print)	Signature	Date

If patient is a minor, or being represented by another party:

________________________	________________________	__________
Parent/Guardian Name (print)	Signature of Parent/Guardian	Date