CONFIDENTIAL PATIENT INFORMATION

DATE OF VISIT:_____

NAME:_____ PHONE: HOME_____ WORK_____

STREET_____

CITY_____ STATE_____ ZIP_____

DATE OF BIRTH_____/_____/_____ AGE_____ SEX_____ MARITAL S M D W

E-MAIL ADDRESS_____

CHILDREN_____ NEAREST RELATIVE & PHONE_____

NAME OF EMPLOYER_____

ACCIDENT/INJURY: WORK_____ AUTO_____ DATE_____ LOST TIME_____

OTHER PHYSICIAN SEEN FOR THIS CONDITION_____

X-RAYS TAKEN? YES NO WHERE?_____ DATE_____

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____

INSURED NAME_____

DRIVERS LICENSE NUMBER_____

YOU SS#_____ INSURED SS#_____

PRIMARY INSURANCE _____ POLICY #_____

SECONDARY INSURANCE_____ POLICY #_____

ATTORNEY OR INS ADJUSTER_____

Office hours allow our patients convenience to schedule appointments before and after work as well as during lunch. We are available to immediately see new patients the same day or through our 24 hour, 7 day emergency service. As a courtesy for you, we will call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards, please let is know in writing for your file. Our staff will try and verify your insurance coverage & benefits for you and we will submit insurance forms and information to your insurance carrier. You are responsible for costs of any services rendered to you or your minor child. Please ask any questions you may have regarding your bill and/or our fees to our insurance and billing department.

SIGNATURE_____

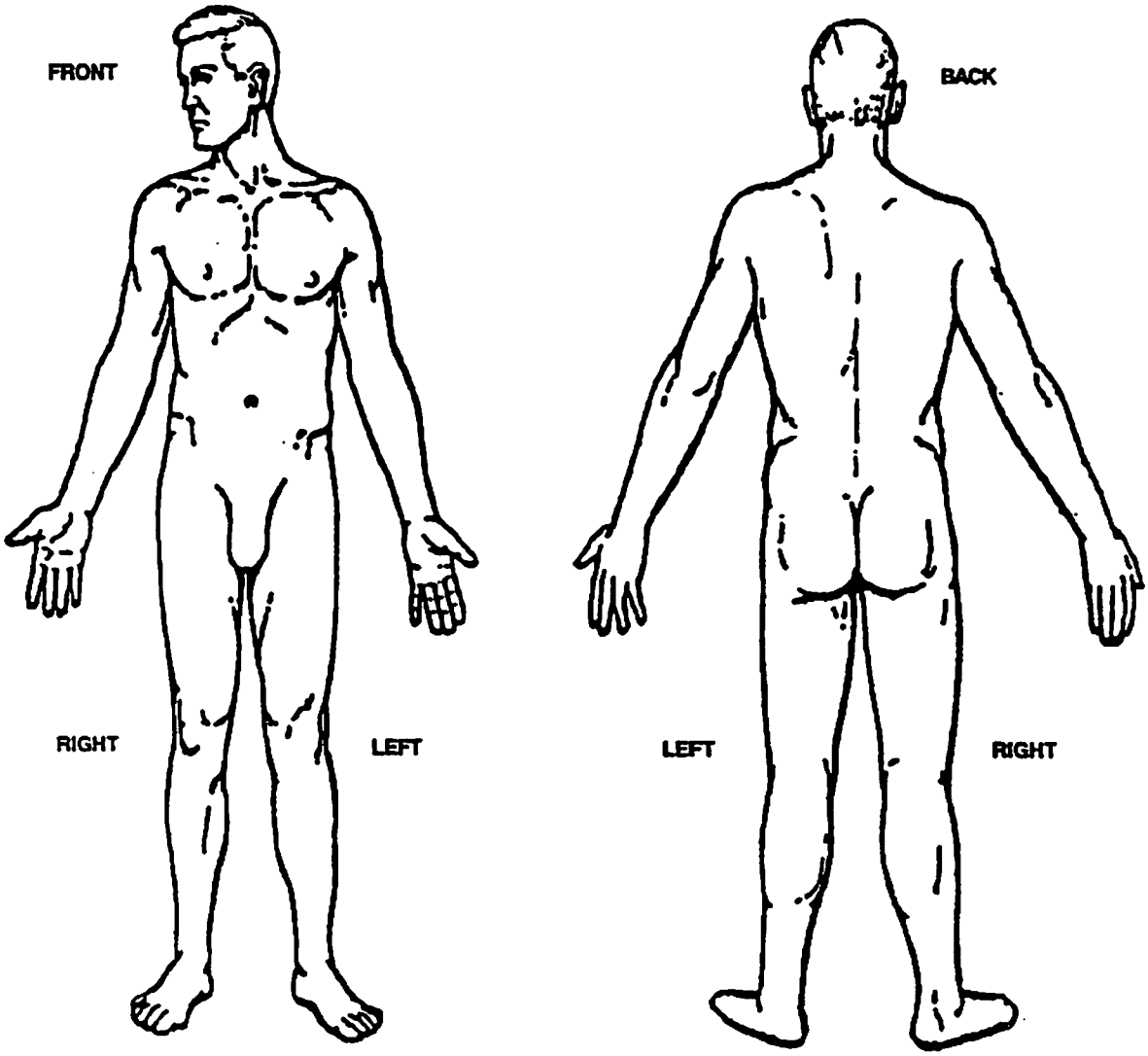
(if minor, parent must sign)

PAIN DRAWING

Name: _____ Date: _____

Mark the areas on your body where you feel the following sensations:

Aches ^^^ ^^^ ^^^ Numbness 000 000 000 Pins and needles ●●● ●●● ●●● Burning XXX XXX XXX Stabbing /// /// /// Other △△△ △△△ △△△



Indicate the severity of your pain by marking an "X" at the appropriate point on the pain line:

How bad is your neck pain now?

0 ——————————————— 10
No pain Worst possible

How bad is your back pain now?

0 ——————————————— 10
No pain Worst possible

How bad is your arm pain now?

0 ——————————————— 10
No pain Worst possible

How bad is your leg pain now?

0 ——————————————— 10
No pain Worst possible

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ Date of Birth: _____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider (Please insert name of provider) _____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information _____. Address or Fax # of the recipient or where my health information should be delivered:

_____.

Purpose: I understand that the specific purpose of this Authorization is

_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ☐ All of my health information described above except for the following:

  _____.
- ☐ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.) _____.

Term: This Authorization will remain in effect:

- ☐ From the date of this Authorization until the _____ day of _____, 200__.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/Representative Legal Relationship Date Witness

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

CONSENT TO SERVICE

I,_____, authorize the performance upon myself of the following procedure(s):

EXAMINATION AND/OR TREATMENT

1. Examination procedures are based upon clinical necessity. They may include vital signs, cranial nerves, examination of eyes, ears, nose and throat, lungs, ranges of motion, palpation, neurological/vascular/orthopedic testing,examination of thorax and abdomen (which may include breast, prostate or hernia evaluation, when clinically indicated) and examination of extremities. Additional physical examination procedures may be performed when clinically indicated and the nature of the procedure(s) will be described prior to their performance.

2. I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that may be considered necessary or advise able in the course of my health care.

3. The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications will be explained to me.

4. I acknowledge that there is no guarantee or assurance as to the results that may be obtained from treatment.

DATE:_____SIGNED:_____

WITNESS:_____RELATIONSHIP:_____

It is the policy of this office to charge for appointments that are not canceled within a 24 hour period, or missed. This is in fairness to our office and other patients who would have preferred that time slot. This charge will be billed directly to the patient and not to any insurance carriers.

Release of Medical Information

To _____

You are hereby authorized and requested to furnish to:

Any and all medical information, history, records, x-rays and reports. Further, I authorize release of records to their physicians/ facilities.

_____ _____

Signature Date

_____

Print Name

CONNECTICUT DIAGNOSTICS, LLC

Notice of Privacy Practices
Consent and Acknowledgement Form

I consent to the use or disclosure of my protected health information by Connecticut Diagnostics, LLC to any organization or person for the purpose of my treatment, obtaining payment for my health care bills or conducting certain healthcare operations.

My "protected health information" means health information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearing house. Protected health information may include HIV/AIDS, drug and alcohol, and psychiatric and other mental health treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand this consent is effective for as long as Connecticut Diagnostics, LLC, maintains my protected health information. I also understand that information regarding how Connecticut Diagnostics, LLC will use and disclose my information can be found in Connecticut Diagnostics, LLC, Notice of Privacy Practices.

By signing below, I understand and acknowledge the following:

1. I have read and understand this consent, and
2. I have received, reviewed, understand, and agree to the Notice of Privacy Practices currently in effect at Connecticut Diagnostics, LLC., which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative Date

If signed by personal representative, describe the legal authority of the representative to act on behalf of the individual: _____

In spite of making a good faith effort the Practice has been unable to obtain signed acknowledgement of receipt of our Notice of Privacy Practices and consent because:

_____ Individual refused _____ Individual unavailable

_____ Individual not able to sign due to incompetence or other medical reason

_____ Other_____

_____ _____ _____
Date Patient Name Connecticut Diagnostics, LLC Representative

Connecticut Diagnostics, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of March 24, 2003, and will remain in effect until we replace it.

CHANGES TO NOTICE:

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:

A. TREATMENT, PAYMENT, HEALTH CARE OPERATIONS: You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

B. AUTHORIZATIONS: You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.

C. DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES: We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

D. MARKETING: We will not use your health information for marketing communications without your written authorization.

E. USES OR DISCLOSURES REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

F. PATIENT AND THIRD PARTY PROTECTION: Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

G. LAW ENFORCEMENT/NATIONAL SECURITY: Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or

patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.

H. APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

A. ACCESS TO RECORDS: Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we supply records in that format if it is readily available. If you request copies, we will charge you $0.45 per page and the reasonable cost of labor involved in making the copies (not to include record handling or retrieval fees). If you request that the records be mailed we may charge you for postage. Additionally, we may charge you the amount necessary to cover the costs of materials for furnishing copies of x-rays. We will not charge you for records used to support a claim or appeal under the Social Security Act.

If you request records in an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies.

B. ACCOUNTING OF CERTAIN DISCLOSURES. Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

C. RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.

D. AMENDMENTS TO RECORDS: You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

E. ELECTRONIC NOTICES. If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file such a complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints:

Gary Italia, DC
Compliance Officer
PO Box 15
Rocky Hill, CT 06067
Phone (860) 257-7448
Fax (860) 257-9574