

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below 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 there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor 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.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION

MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary: This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking and signing below, agree to:

- Representation by Flemington Chiropractic Center in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-II , and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.
- Release of personal health information to DOBI , its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process . My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____

Date: _____

Relationship to Patient (check):

_____ I am the Patient

_____ I am the Personal Representative (provide contact information on back)

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- If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form .

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE I has been completed, signed and dated.

ASSIGNMENT OF BENEFITS | ERISA AUTHORIZATION FORM

Flemington Chiropractic Center | CB&C | L.Contreni

Financial Responsibility

I have requested professional services from Flemington Chiropractic Center on behalf of myself and/or my dependents, and understand that by making this request; I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Flemington Chiropractic Center | CB&C, Inc. I certify that the health insurance information that I provided to Flemington Chiropractic Center is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Flemington Chiropractic Center | CB&C | L.Contreni to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Flemington Chiropractic Center, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Flemington Chiropractic Center directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to

Flemington Chiropractic Center, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Flemington Chiropractic Center | CB&C/ L.Contreni upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Flemington Chiropractic Center.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Flemington Chiropractic Center are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Flemington Chiropractic Center | CB&C | L.Contreni to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in

the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Flemington Chiropractic Center I CB&CI L.Contreni to the full extent

permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Flemington Chiropractic Center and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement , and any other applicable remedy, including fines.

A photocopy of this AssignmenUAuthorization shall be as effective and valid as the original.

Print Full Name: _____

Signature: _____

Date: _____

Date: _____

Dear Insurance Carrier,

I understand you may be holding up payment of my claims because you are waiting to update your records regarding my status and my coverage. The following is my updated information:

Name of patient: _____ #DOB _____

Insured Name _____ Policy ID # _____

Relation to insured _____

PLEASE CHOOSE FROM SECTIONS BELOW & CHECK ONLY ONE STATEMENT THAT APPLIES TO YOUR INSURANCE COVERAGE- YOU MUST SIGN THAT SECTION:

Self:

_____ I am the patient AND the insured AND I have no other insurance coverage

Signature: _____

Date: _____

Spouse / Partner:

_____ I am the patient, BUT the insured is my spouse/partner

_____ I am not employed and therefore have no other insurance coverage of my own.

_____ I am the patient, BUT the insured is my spouse/partner

_____ I am employed but have no cover through that employer.

_____ I am the patient & have my own coverage - the following is my coverage information:

Primary Ins _____ Insured Name _____ Insured DOB _____

Secondary Ins _____ Insured Name _____ Insured DOB _____

Signature _____ Date _____

Dependent Child Over 18: (covered under parent's policy)

_____ I am student & have 1 policy. Attached is my current school schedule.

Primary Ins _____ Insured Name _____ Insured DOB _____

_____ I am a FT student & have 2 policies. Attached is my current school schedule.

Primary Ins _____ Insured Name _____ Insured DOB _____

Secondary Ins _____ Insured Name _____ Insured DOB _____

**Determining primary/secondary is usually based on the 'birthday rule'.

Signature _____ Date _____

Dependent Child Under 18: (covered under parent's policy)

_____ I am a minor dependent and only covered under one policy:

Primary Ins _____ Insured Name _____ Insured DOB _____

_____ I am a minor dependent and covered under two policies:

Primary Ins _____ Insured Name _____ Insured DOB _____

Secondary Ins _____ Insured Name _____ Insured DOB _____

**Determining primary/secondary is usually based on the 'birthday rule'.

Parent/Guardian Signature _____

Date _____

Revised 10125108