KAPLAN
BRAIN & BODY

Welcome to Kaplan Brain & Body!

Achieving Optimal Health with Unique, Customized Functional Neurology Care Catering to Your Individual Needs

ABOUT YOU

Today's Date: _____/_____/_____

Patient Name: _____

What You Prefer To Be Called: _____

☐ Male ☐ Female

Birthday___/_____/_____ Age: _____

SS# (optional): _____

Mailing Address: _____

_____

_____

(CITY) (STATE) (ZIP)

Home Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

Work Phone: (_____) _____-_____Ext: _____

E-mail Address: _____

Referred By: _____

Employer: _____

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

ACCOUNT INFO

Person ultimately responsible for account

☐ Self
☐ Other – please provide information below

Name: _____
Relation: _____
Billing Address: _____
_____

PAYMENT INFO

For your convenience, please complete the information below if you would like to keep a credit card on file for payment.

I hereby authorize Kaplan Brain & Body to keep my credit card on file and run payments at the end of each visit. _____

_____
Credit Card Number

Exp: _____ CVC: _____ Billing Zip: _____

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____-_____

Work Phone #: (____) _____-_____ Ext: _____

Cell Phone #: (____) _____-_____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____-_____

° We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. We do not offer refunds for paid services whether the services have been used or unused. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

° I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform of any changes of information I have provided.

Signature: _____ **Date:** ____/____/_____ ☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Patient Health Questionnaire

What type of regular exercise do you perform? •None •Light •Moderate • Strenuous

What is your height and weight? _____ _____

(Height} (Weight)

For each of the conditions listed below,
please place a check mark if you currently have or had the condition in the past.

__ Headache
__ Neck Pain
__ Upper Back Pain
__ Mid Back Pain
__ Low Back Pain
__ Shoulder Pain
__ Elbow/Upper Arm Pain
__ Wrist Pain
__ Hand Pain
__ Hip/Upper Leg Pain
__ Knee/Lower Leg Pain
__ Ankle/Foot Pain
__ Jaw Pain
__ Joint Swelling/Stiffness
__ Arthritis
__ Rheumatoid Arthritis
__ General Fatigue
__ Muscular Incoordination
__ Visual Disturbances
__ Dizziness
__ High Blood Pressure
__ Heart Attack
__ Chest Pain
__ Stroke
__ Angina

__ Kidney Stones
__ Kidney Disorders
__ Bladder Infection
__ Painful Urination
__ Loss of Bladder Control
__ Prostate Problems
__ Abnormal Weight Gain/Loss
__ Loss of Appetite
__ Abdominal Pain
__ Ulcer
__ Hepatitis
__ Liver/Gall Bladder Disorder
__ Cancer
__ Tumor
__ Asthma
__ Chronic Sinusitis
__ Diabetes
__ Excessive Thirst
__ Frequent Urination
__ Smoking/Use Tobacco Products
__ Drug/Alcohol Dependence

__ Allergies
__ Depression
__ Systemic Lupus
__Epilepsy
__ Eczema/Rash
__ HIV/AIDS
__ Joint Swelling/Stiffness
__ Neurological Disorders
__ Anxiety
__ Tics
__ Sleeping Difficulties
__ Parkinson's Disease

Females Only
__ Birth Control Pills
__ Hormonal Replacement
__ Pregnancy

Other Heal Problems/Issues
_____
_____
_____
_____
_____
_____

Indicate if an immediate member has had any of the following: o Rheumatoid Arthritis o Heart Problems o Diabetes o Cancer o Lupus o Neurological Disorders o Other: _____

List all prescription and over the counter medications, and nutritional/herbal supplements you are taking:

_____

List all surgical procedures you have had and times you have been hospitalized: _____

_____

Patient Signature _____ **Date** _____

Doctor's Additional Comment: _____

_____

Doctors Signature _____ **Date** _____

KAPLAN
BRAIN & BODY

Appointment Cancellation Policy

We strive to render excellent care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **24 hours** notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If less than 24 hours notice is given for cancellation of an appointment, we reserve the right to charge a **$25.00** cancellation fee per appointment. If you are scheduled for multiple sessions in a single day, you will be charged **$25.00 per session**; this fee cannot be billed to your insurance company and will be your direct responsibility.

If you miss an appointment without contacting our office within the required time, this is considered a *missed appointment* and a fee of **$50.00** will be charged to you. If you are scheduled for multiple sessions in a single day, you will be charged **$50.00 per session**; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$50.00** cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), acknowledge I have been notified of the Kaplan Brain and Body Appointment Cancellation Policy.

_____ _____

Signature of Patient **Date**

KAPLAN BRAIN & BODY

DR. ERIC KAPLAN DC, DACNB, FACFN, FABVR, FABCDD

BOARD CERTIFIED FUNCTIONAL NEUROLOGIST

25 Downing St. Suite A, New York, NY 10014 | 85 Kinderkamack Road, Emerson, NJ 07630

Tel: 212-620-8121~Fax: 212-620-9909

Informed Consent to Rehabilitation, Work Hardening, Work Conditioning, Pain Management, Chiropractic Care, Occupational Therapy, Diagnostic Testing, Examination Procedures and Nutritional Therapy Patient

Name:_____ Date:_____

The primary treatment used by a doctor or therapist at this facility is the art and philosophy of rehabilitation and diagnostics by any qualified means which may be necessary. Pictures of you and your condition may be taken and video reproduction of examinations and treatment may be done for any number of reasons. We at times do like to keep a photographic journal of your case and findings. If you ever have a problem with this, please let us know.

The Nature of applied treatments at our facility

The doctors and or therapists at this facility will use any means such as stretching, weight training, work simulation therapy, cardiovascular training, soft tissue therapy or manipulation or psychologic counseling by trained personnel to help you the patient. There may be a number of receptor based therapies provided to better serve you. They may also be the usage of certain electrical modalities or adjunct therapy to help your condition. At any time if you have questions about your therapy, please talk to the therapist or doctor. There may be procedures done such as Interferential therapy, Ultrasound, Microcurrent Therapy, High Volt and low Volt Therapy or traction of a particular joint or body part. There may also be situations in which taping or stabilization or bracing of a joint is necessary in order to get the bodies desired healing effect. Vitamins, herbs and homeopathic remedies may be recommended. There may at times be recommendations to other specialist for your condition.

The Materials Risk Inherent to the above Therapy

As with any health care procedure there are certain complications which may arise during any of the treatment listed above. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strains, soft tissue injuries, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and seperations. There is also a risk of stroke with various manipulative procedures, especially to the neck or cervical spine. There could also be complications from burns, spread of infections, spread of malignancies, allergic reactions, skin reactions or other complications from the usage of the adjunct therapy that was listed above as well as diagnostic procedures. Upon signature of this document you give the therapists or practitioner at this facility the rights to perform the necessary procedures for treatment and diagnosis which includes a physical examination. During the examination you may be gowned so that the injured area can properly be assessed.

The Dangers and Risks of Remaining Untreated

Remaining untreated allows the possible formation of adhesions and reduces the mobility which sets up a pain reaction further reducing mobility and normal function. Over time this process may complicate, prolong or prevent proper treatment making it more difficult and less effective the longer a condition is postponed. The probability that no\n-treatment will complicate a later rehabilitation is very high.

Necessary Referrals for Testing or Outside Consults

As a result of your history, physical examination or other factors you may need to be referred out for other testing procedures and or referrals may need to be made to other practitioners. Upon signature of this document I understand that this is a possibility and agree to follow any and all recommendations made by the referring practitioner. If the decision is made not to participate in any referrals made it is agreed that the referring doctor will be notified immediately upon the time of that decision. You as the patient should know that you always have the right to choose your own doctor or specialist or diagnostic company or facility if such referrals are made. We may make suggestions but you the patient have the right of choice.

Informed Consent Sheet for Neurologic Services

You may have been referred by your treating or rendering doctor for a neurologic consultation and or correlating neuro diagnostic studies. The following information will help you understand the procedures to be performed and risks involved so you can be an informed patient. You should understand that you always have the choice not to participate in this test and or choose another practitioner to perform this study. Upon signature of this documentation you are also giving Dr. Kaplan and other employees of Village Chiropractic as well as any and all dictating entities or requested outside reviewing doctors of our choice the right to review any and all of your related medical records and dictated digital materials in regards to your case.

The studies to be performed typically include a physical examination of the injured and related body parts. Upon signature of this document you are giving the examining doctor permission to do that examination and inspect, photograph and examine and ask questions about those body parts injured and other related or pertinent body parts or regions. Upon signature the treating or examining doctor also has the right to take your personal photograph for records. If you feel uncomfortable during this portion of the test you may tell the examining doctor or ask questions at any time.

Part of your neuro diagnostic study may include a nerve conduction velocity study which is a study that tests part of the nerves ability to function. This test will include some discomfort as a result of a variable, controlled electric shock. You of course always have the right to stop, refuse or ask questions during testing. Some risks of this form of testing include discomfort, possible allergic reaction to gel, electrodes or conduction paste.

Part of your neuro diagnostic study may include electromyographic studies. This test also helps determine the function of nerves and the musculo-skeletal system. This test may include the insertion of a small pin electrode through the surface of your skin. This pin electrode is disposable and pre-packaged as sterile and never pre-used. During this portion of the testing you may choose to stop the test or ask any questions. Some risks that may occur as a result of this testing are bruising, discomfort, bleeding, or skin discomfort and possible infection. Please tell the doctor if you take any blood thinning Medications.

During the course of the evaluation as already stated you may at times feels some discomfort and we are not responsible for any emotional distress or anger as a result of the discomfort felt during testing. It is understood that there is an inherhent amount of discomfort during this testing which is typically very tolerable by the vast majority of our patient's. Please understand that discomfort may be unavaoidable.

There may also be various forms of balance testing provided. The risks of this type of testing is possible falling, nausea and feelings of unsteadiness. If this type of testing is performed and you have discomfort, please tell the rendering practitioner.

Please read and answer the questions below.

Do you have a past history of Diabetes, Heart Disease, Cancer or Thyroid Disease? Y / N

Have you been diagnosed with HIV, Hepatitis or Tuberculosis Y / N

Are you pregnant Y / N

Do you have any implanted metallic devices Y / N

Do you have an implanted cardiac defibrillating device Y / N

Do you have any other know diseases or impairments, if so please inform the examining doctor Y /N

Do you have an indwelling catheter Y / N

Are you a hemophiliac Y/N

Do you take blood thinning medication Y / N

HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. AProtected health information@ is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician=s practice, and any other use required by law. Treatment We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations We may use or disclose, as needed, your protected health information in order to support the business activities of your physician=s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical/chiropractic students, licensing, marketing and fund- raising activities, dictation and transcription, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical/chiropractic students that see patients at our office. In addition, we may use a sign-in-sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Director, and Organ Donor Research: Criminal Activity: Military Activity and National Security: Workers= Compensation: inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization , at any time, in writing, except to the extent that your physician or the physician=s practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also disclose request that any part of your personal health information not be disclosed to family members or friends who may be involved in your care or for notification

purposes as described in this Notice of Privacy Protection. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or to an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided this notice. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices: * Please check the appropriate block and sign below.

I have read ( ) or have had read to me ( ) the above material and explanations of the possible therapy, treatment or diagnostic procedures that could be related to my situation. I feel I have had and will make the proper effort to discuss my entire condition with a doctor at this facility and will be honest and complete on the entire part of my condition. I will ask any and all questions about my condition and will make an attempt to get and follow through with the proper treatment. I understand that if I do not I may be dropped from care or referred to another practitioner or poor results from partial care may result. Upon signature I also state that I have made a good attempt to have all my questions answered about the related services and procedures. By signing below I state that I have weighed the risks involved in undergoing treatment and or diagnostic procedures and have myself decided that it is in my best interest (or said minors interest) to undergo the treatment recommended or to be recommended. Having been informed of the risks I hereby give the doctors and personnel at this facility the right to examine, diagnose by the proper means and treat my specific condition fully understanding and acknowledging that there is no guarantee or assurance as to the results that may be obtained from this treatment that has been given to me.

Date:_____

Patient Signature:_____

Witness: Signature:_____

Signature of Parent or Guardian:_____

If Interpreted, Signature of Interpreter:_____