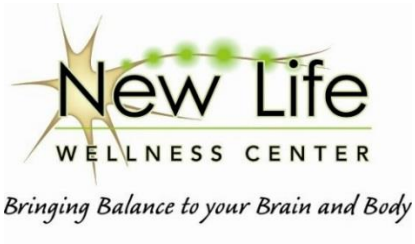


PATIENT REGISTRATION

Who may we thank for referring you to New Life Wellness Center?			Date:
Full Name	DOB	Age	☐ Male ☐ Female
Address			
City	State		Zip Code
Home Telephone ☐ Primary Contact	Work Telephone ☐Primary Contact		Mobile ☐Primary Contact
Social Security Number	Email Address		
Emergency Contact Name	Relationship		Emergency Contact Number

INSURANCE INFORMATION ☐ **MEDICARE**

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: ☐ Self ☐Spouse ☐ Parent ☐Other	
Name	Social Security Number
Address	
Telephone	Email Address

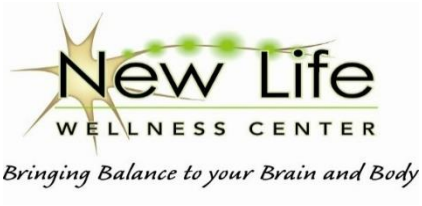
OPTIONAL CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize New Life Wellness Center and/or staff at 323 Middle Country Road, Smithtown, NY 11787 or 279 Central Park West, NYC 10024, to change my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify New Life Wellness Center of any changes regarding this credit card authorization.

Name on Card	Signature/Date	
Credit Card Type ☐ MasterCard ☐Visa ☐Discover	Credit Card Number	
Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

Signature:_____ Date: _____



AUTHORIZATIONS & ACKNOWLEDGEMENTS

While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:

TREATMENT AUTHORIZATION: I (print name) _____ authorize Chiropractic Care, including spinal adjustment, acupuncture services or neurofeedback therapy for myself or my minor child by the Doctors and staff at New Life Wellness Center.

INFORMED CONSENT: Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke. Prior to receiving chiropractic care at this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and your spinal health. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care. Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

I understand that methods of treatment, may include but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the Wellness Center uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the Wellness Center to be able to anticipate and explain all possible risks and complications of treatments. I understand that results are not guaranteed.

I understand the Wellness Center staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor:_____ Location (city):_____

When was your last treatment: _____ Have you had x-rays taken? _____

MEDICAL DOCTOR: New Life Wellness Center believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physicians listed below:

NAME:_____ **SPECIALTY:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CANCELLATION AND/OR NO-SHOW POLICY: New Life Wellness Center urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 48 hours' notice for new patients, 24 hours for existing patients, excluding Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a $100 charge (new patients) or $50 charge (existing) for each occurrence. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to New Life Wellness Center on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to New Life Wellness Center within five (5) days of receipt of payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL NEW LIFE WELLNESS SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, New Life Wellness Center will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for New Life Wellness Center to take action to secure payment of an outstanding balance owed.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: New Life Wellness Center is a participating provider of Medicare; as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office, you are responsible to pay your deductible to New Life Wellness Center. After your deductible is satisfied, Medicare will reimburse us 80% of their standard fee for Chiropractic Adjustments Only. Therefore, your payment responsibility is 20% of the standard Medicare fee for Chiropractic Adjustments. I understand that, in certain circumstances, Medicare may find that Chiropractic treatments are not "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charges incurred.

NO GUARANTEES: I recognize that the practice of Chiropractic is as much an art as a science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment and/or therapy rendered at New Life Wellness Center.

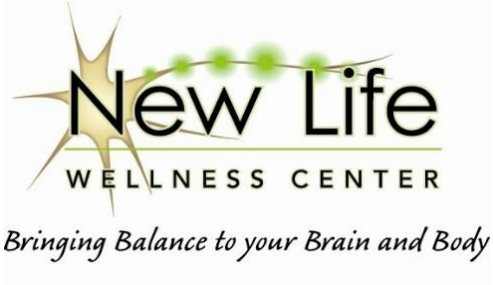
REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGEMENT: I certify that the information I provide to my doctors, therapists, and insurance company is correct. I certify that I am here to receive medical care and for no other purposes. I do not represent a third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including my individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the Chiropractic treatments offered or recommended to me by my Doctor. I intend this consent to apply to all my present and future Chiropractic care.

Patient's Signature	Date
Office Signature	Date



Acknowledgement of Receipt

Notice of Privacy Practices

By signing and dating this form I acknowledge that I have received a copy of New Life Wellness Center's Notice of Privacy Practices:

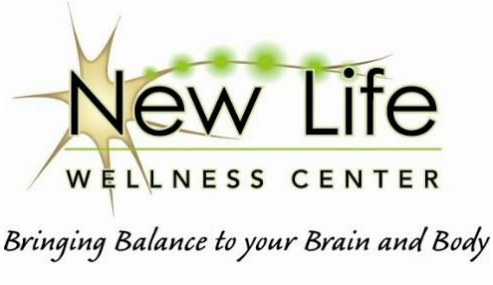
Patient's Name *(Please print)*	Last four digits of your Social Security Number:
Patient's Signature	Date

If executed by a patient's personal representative, please complete the information in the space below:

Personal Representative's Name *(Please print)*	Relationship
Personal Representative's Signature	Date

If executed by a patient's legal guardian, please complete the information in the space below:

Legal Guardian's Name *(Please print)*	Relationship
Legal Guardian's Signature	Date



HIPPA NOTIFICATION
ELECTRONIC MAIL (EMAIL) COMMUNICATIONS

The goal of New Life Wellness Center is to make communications between you and our offices as easy for you as possible. As such, you have the right to request that we communicate with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.

Email communications are a two-way communication. However, responses and replies to emails sent to or received by either you or New Life Wellness Center may be hours or days apart. As such, acute conditions should never be addressed using email communication.

Although New Life Wellness Center will make every effort to maintain privacy, email messages, on any device, have Internet privacy risks, as there is no way to ensure an email is completely tamper resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential.

In order to forward and/or process and/or respond to your email, individuals at New Life Wellness Center, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all communications, may become part of your New Life Wellness medical record.

PATIENT REQUEST FOR EMAIL COMMUNICATION

Please complete the information below if you wish to communicate New Life Wellness Center via email, knowing there are inherent privacy risks.

Patient Name: _____ Date of Birth:_____

Email Address: _____

Please initial each line and sign below:

_____The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

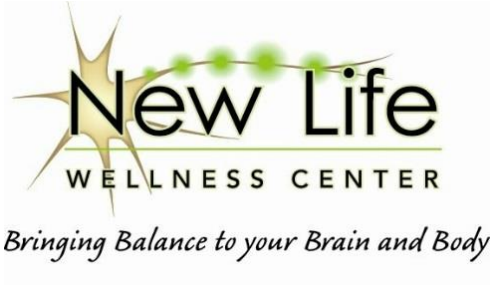
_____I have read, reviewed, and received a copy of this HIPPA Notification: Electronic Mail Communications.

_____I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

_____ I agree to hold *New Life Wellness Center* and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communications.

☐Patient does not consent to email communication.

Patient Signature: _____ Date:_____



CONFIRMATION PREFERENCE SHEET

Patient Name:_____

Please circle which you prefer for appointment confirmations:

TEXT MESSAGE **E-MAIL**

- For text message reminders, please indicate your cell service provide: _____ (ATT, Verizon, Sprint, etc.)

- For email reminders please indicate your preferred e-mail address below:

  _____

I consent to the use of either my e-mail address or cell phone number for appointment confirmations at New Life Wellness Center.

Patient Signature: _____ Date:_____