

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment - If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure - You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made on or after April 14, 2003, and no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Right to Obtain a Copy of this Notice - You may obtain a paper copy of this Notice from us by requesting one or view it or download it electronically at our Practice's website at www.gardenstateortho.com.

Special Protections - This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, mental health information, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice.

Complaints - If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights. We will provide their address upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION: Our Privacy Officer is the Operations Manager and can be contacted at this office or by calling our telephone number: 201-710-5420. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.

This Notice is effective in its entirety as of April 14, 2003.

disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy - You may inspect and/or obtain a copy of your protected health information that is contained in a “designated record set” for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions - You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date.

If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment.

You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications - You may request that we communicate with you using alternative means or at an alternative

Military Activity and National Security - When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation - We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

Inmates - We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access - State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION

In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care - Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in

Health Oversight - We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, other regulatory programs, or civil rights laws.

Food and Drug Administration - We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review, as required.

Legal Proceedings - We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement - We may disclose protected health information for law enforcement purposes, including responses to legal proceedings; information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations - We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donations.

Research - We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety - Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations - We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may 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. For example, we will call your home telephone number to remind you of your next appointment and/or mail a postcard appointment reminder to your home address or we might call your home and leave a message regarding an outstanding balance.

We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practices. These business associates of our Practice will also be required to protect your health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you. For example, your name and address may be used to send you a newsletter about our Practice and our services.

Required by Law - We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health - We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with products.

Communicable Diseases - We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

We reserve the right to change this Notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures - By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

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 may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. This includes pharmacists who may be provided information on other drugs you have been prescribed to identify potential interactions.

In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment - Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

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 is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE - You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION - "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following:

1. Keep your protected health information private
2. Present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information
3. Follow the terms of the Notice currently in effect
4. Communicate to you any changes we may make in the Notice

HAVE YOU RECEIVED, OR ARE YOU ELIGIBLE FOR, PAYMENTS UNDER ANY WORKERS COMPENSATION, UNEMPLOYMENT LAW, MEDICAID OR MILITARY BENEFITS FOR THIS ACCIDENT? YES NO IF YES, SHOW AMOUNT: PER WEEK PER MONTH
 \$ _____

LIST NAME AND ADDRESS OF YOUR PRESENT EMPLOYER(S) AND GIVE YOUR OCCUPATION AND DATES OF EMPLOYMENT FOR EACH:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES NO IF YES, EXPLAIN:

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE _____
 (INJURED PERSON OR REPRESENTATIVE) DATE _____

- IMPORTANT: TO HELP US DETERMINE YOUR ELIGIBILITY FOR COVERAGE AND EXPEDITE THE HANDLING OF YOUR CLAIM PLEASE:**
1. COMPLETE AND SIGN THIS APPLICATION.
 2. SIGN THE AUTHORIZATION BELOW.
 3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

Claim Number: _____

I authorize any psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home or other healthcare facility, employer, pharmacy or other person to whom a signed or photocopy of this authorization is delivered, to furnish any information, reports or copies of records which may be requested by the State Farm Indemnity Company. The specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other medical information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information.

This authorization or photocopy thereof will also authorize the classes of medical providers identified above to release all information as specified above regarding my medical condition while under observation or treatment to Consolidated Services Group, Inc. (CSG) in its capacity as pre-certification vendor for State Farm Indemnity Company pursuant to New Jersey law.

SIGNATURE _____
 (INJURED PERSON OR REPRESENTATIVE. If a minor, parent or legal guardian shall sign.)

DATE _____ SOCIAL SECURITY NUMBER _____

APPLICATION FOR BENEFITS

DATE	POLICYHOLDER'S NAME	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE POLICYHOLDER'S INSURANCE CONTRACT, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

 CLAIM REPRESENTATIVE

1.	YOUR NAME	SEX	MAIDEN NAME	FOLD
	PHONE NUMBER () HOME	BUSINESS	IF MINOR, PARENT'S NAME	
2.	YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)			DATE OF BIRTH / /
3.	YOUR PERMANENT ADDRESS, IF DIFFERENT FROM ABOVE ENTRY - HOW LONG HAVE YOU LIVED IN THIS STATE?			SOCIAL SECURITY NUMBER
4.	DATE AND TIME OF ACCIDENT / /	A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)	
5.	BRIEF DESCRIPTION OF ACCIDENT AND VEHICLES INVOLVED:			
6.	DESCRIBE AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY RESIDING IN THE SAME HOUSEHOLD AS OF THE DATE OF THE LOSS. AUTOMOBILE AND ITS LOCATION AT TIME OF LOSS OWNER INSURER POLICY NUMBER			
7.	AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.			
	SIGNATURE: _____		DATE: _____	
	DESCRIBE YOUR INJURY:			
	NAME AND ADDRESS OF YOUR (APPLICANT'S) HEALTH INSURANCE CARRIER:			
	NAME AND ADDRESS OF YOUR (APPLICANT'S) PHARMACY:			
	WERE YOU TREATED BY A DOCTOR? YES <input type="checkbox"/> NO <input type="checkbox"/>	DOCTOR'S NAME AND ADDRESS		
	IF YOU WERE TREATED IN A HOSPITAL, WERE YOU AN <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT	HOSPITAL'S NAME AND ADDRESS		
	AMOUNT OF MEDICAL BILLS TO DATE \$	WILL YOU HAVE MORE MEDICAL EXPENSE? YES <input type="checkbox"/> NO <input type="checkbox"/>	WERE YOU ON THE JOB AT THE TIME OF YOUR ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	HAVE YOU BEEN ABLE TO CARRY OUT YOUR USUAL HOUSEHOLD TASKS? YES <input type="checkbox"/> NO <input type="checkbox"/>
	DID YOU LOSE WAGES OR SALARY AS RESULT OF YOUR INJURY? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, AMOUNT LOST TO DATE \$	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? \$	
	IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN		DATE YOU RETURNED TO WORK	

**MEDICAL AUTHORIZATION, ASSIGNMENTS OF BENEFITS AND
IRREVOCABLE VOLUNTARY PHYSICIAN'S LIEN**

BARTECK WELLNESS CENTER

DENNIS J. BARTECK, D.C.
36-42 NEWARK STREET, SUITE 301
HOBOKEN, NJ 07030
Phone: (201) 710-5420
Fax: (201) 710-5419

Pip Carrier:
Claim #:
D.O.A:
Policy #:
SS #:
D.O.B:
Attorney:

Patient Name & Address: _____

MEDICAL AUTHORIZATION

N.J.S.A. 2A: 84A-22.2
Established a physician-patient privilege which prohibits the physician from disclosing any information with respect to the patient unless the patient provides consent to the disclosure of such information. I hereby authorized my physician to release to my attorneys any information requested by them with respect to my medical treatment.

ASSIGNMENT OF BENEFITS

For consideration received, I assign to the above physician all my rights and interest in the personal injury protection portion of the automobile liability insurance policy or other insurance policy listed above.

This assignment is given with respect to all treatment, care, and diagnostic testing given by this office. By assigning these benefits, I have expressly agreed that the following rights are assigned to my treating physician:

1. The right to collect from the insurer the proceeds of the policy with respect of the P.I.P. Benefits mentioned above.
2. The right to file a lawsuit directly against the insurance company in the name of the treating physician as Assignee, and to designate an attorney of the choosing of the treating physician for the purpose of filing said lawsuit.
3. I agree to fully cooperate with the assignee in the collection of the personal injury protection claim from the insurance carrier, including, full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at a trial, if any attendance is required.

VOLUNTARY PHYSICIANS LIEN

I hereby provide an irrevocable Lien to the physician names above against any settlement judgment of verdict arising out of my automobile accident on the date state above. I agree never to rescind this document and that recession will not be honored by my attorney. I further instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Lien and deem plaintiff enforceable as if he executed it. Upon settlement, judgment, and verdict and prior to the disbursements of any funds to myself, I hereby direct my attorney to pay to the doctor stated above any and all sums that may be due and owing to said physician. Furthermore, I understand that I am primarily responsible to the physician for any and all bills, which I incur. I have been advised that if my attorney does not wish to cooperate in protecting the physician's fees, the physician will not await payment, but will require me to make payments each time I receive treatment.

Dated: _____ Patients Signature: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named.

Date: _____ Attorneys Signature: _____
(Put firm stamp below)

Please sign, date and return one copy to doctor's office. Keep one copy for your records.



BARTECK WELLNESS CENTER

36-42 NEWARK STREET, SUITE 301, HOBOKEN, NJ 07030

Phone: (201) 710-5420 Fax: (201) 710-5419

CONSENT/AUTHORIZATION FORM

Date: _____

CONSENT FOR TREATMENT I authorize Barteck Wellness Center to perform the treatment/procedure (s) described below. I have been informed of the reasons for the treatment/ procedure (s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

The treatment/procedure (s) was explained to me in detail and all my questions were fully answered. Understanding this, I authorize Barteck Wellness Center to perform such examinations, treatments, laboratory tests, and to administer such medications as, in his or her opinion, are necessary or advisable for me

(or _____)
Name of the patient if minor

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION I request that payment of authorized benefits be made to Barteck Wellness Center for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare an its agents, any insurance company, any other third party payer, state medical assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits for related services. I agree to pay for all charges not covered by a third party payer. I authorize a copy of this authorization to be used in place of the original.

Signed: _____
Patient or person authorized to consent for patient

Date: _____