Louis R. Vita, D.D.S., F.A.G.D. **Angelo Colavita D.C., BCAO**

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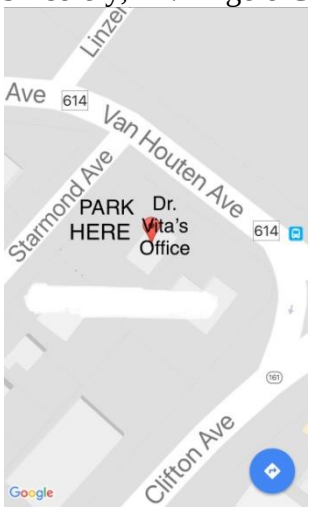
Welcome!
You have been referred for evaluation of your Atlas bone position and neck pain. The Atlas bone is at the very top of your spine that directly supports your head. There may be clinical evidence that an injury has occurred to this area and it is contributing to your symptoms or you may simply be coming to our office for a screening to determine if the Atlas Orthogonal therapy is appropriate for you.

Our goal is to provide you with the highest level of care in the treatment of your condition. After a 15 minute appointment for a screening to determine if you are a candidate for our treatment, your initial visit will include a comprehensive examination and evaluation. It will also be necessary to take proper x-rays which will enable us to analyze the displacement and calibrate our unique instrument for treatment.

Payment and Insurance: This office does not participate in your medical insurance or Medicare plan. You are required to pay for services at the time of the service and you will be given a form for your submission to your insurance for reimbursement. Treatment will include an adjustment of your Atlas bone; a hands off approach which is painless. Positive changes are often immediately noticed. Please print, complete and sign all of the Atlas/Neck forms and bring them with you to our office on your initial visit along with any past x-rays, MRI's or reports for our review.

We look forward to meeting with you.

Sincerely, Dr. Angelo Colavita & Staff



ATLAS PATIENT INFORMATION

*The following information is needed in order to better serve you. Please complete **all** questions. If you need help, please ask the receptionist. **PLEASE PRINT**.*

Today's Date: _____

Full Name: _____ Home Phone: _____ Cell Phone:_____

E- mail address:_____

Street Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____/_____/_____ Marital Status: M S W D No. of children: _____

Referred by: _____ Your SS#:_____

Your Employer Name: _____ Occupation: _____

Employer Address: _____ City:_____ State _____ Zip: _____

Office Phone: _____ Your Work Hours: _____

Do you have health insurance? Yes No Do you have Medicare? Yes No **Insured's** Name:_____Date of Birth:__/__/___

Insurance company NAME and claim mailing ADDRESS:_____

Insurance ID#:_____ Insurance Group#: _____

Name of Spouse or Parent: _____ Spouse/Parent Birth Date: _____/_____/_____

Is your condition due to an accident? Yes No Date of accident: _____

Type of accident? Auto Work/Job At Home Other: _____

Describe the **major** complaints that bring you to our office:

_____

Have you ever been treated for this problem? ( )Yes ( )No If yes, by ( ) General Practitioner

( ) Chiropractor ( ) Physical Therapist ( ) Neurologist ( ) Orthopedist

List treatments and results obtained: _____

_____

List your current Physician(s)/Therapist(s): _____

List any traumas and their dates: _____

_____

List all surgeries and their dates: _____

_____

Have you had an MRI regarding this condition? If so, date: _____ CAT Scan? Date _____

What type of care are you interested in?
( ) I just want to get out of pain and am not interested in maintaining the health of my spine.
( ) I want correctional care to treat my symptoms and maintain spinal health.

HEALTH REVIEW

Please check all the conditions you have or have had:

( ) Bruise Easily
( ) AIDS
( ) Hepatitis
( ) Appetite poor
( ) Alcoholism
( ) High Cholesterol
( ) Blood in urine
( ) Anemia
( ) High blood pressure
( ) Bleeding gums
( ) Appendicitis
( ) Kidney Disease
( ) Change in moles
( ) Arthritis
( ) Liver Disease
( ) Diarrhea
( ) Bleeding Disorders
( ) Multiple Sclerosis
( ) Difficulty swallowing
( ) Bloating
( ) Migraine
( ) Excessive hunger/thirst
( ) Blurred vision
( ) Miscarriages
( ) Earache
( ) Bowel changes
( ) Mononucleosis
( ) Ear discharge
( ) Breast lump
( ) Nausea
( ) Gas
( ) Bronchitis
( ) Nervousness
( ) Hay fever
( ) Nosebleeds
( ) Hoarseness
( ) Cancer
( ) Numbness
( ) Hives
( ) Cataracts
( ) Pacemaker
( ) Indigestion
( ) Chemical Dependency
( ) Prostate Problems
( ) Itching
( ) Chest pain
( ) Painful urination
( ) Irregular heart beat
( ) Chills
( ) Poor circulation
( ) Loss of sleep
( ) Constipation
( ) Rapid heart beat
( ) Loss of weight
( ) Crossed eyes
( ) Rectal bleeding
( ) Lack of bladder control
( ) Diabetes
( ) Ringing in ears
( ) Low blood pressure
( ) Difficulty sleeping
( ) Rash
( ) Loss of hearing
( ) Dental problems
( ) Scars
( ) Persistent cough
( ) Depression
( ) Sinus problems
( ) Frequent urination
( ) Dizziness
( ) Stomach pain
( ) Gout
( ) Double vision
( ) Swelling in ankles
( ) Headaches
( ) Eating Disorders
( ) Sweats
( ) Weight gain
( ) Ear pain
( ) Sore that won't heal
( ) Vision flashes or halos
( ) Emphysema
( ) Stroke
( ) Venereal diseases
( ) Epilepsy
( ) Tiredness
( ) HIV positive
( ) Fainting
( ) Varicose veins
( ) Vomiting
( ) Fever
( ) Vomiting blood
( ) Forgetfulness

Are you pregnant? Yes No _____ Please initial

VITA PAIN RELIEF CENTER

NECK, BACK, EXTREMITIES Check all current symptoms: Please circle R for right and L for left

NECK

( ) Pain in neck R L
( ) Neck Stiffness
( ) Neck weakness
( ) Pinched nerve in neck
( ) Neck feels out of place
( ) Muscle spasms in neck
( ) Grinding/popping sounds in neck
( ) Herniated/Bulging disc confirmed by MRI

SHOULDERS

( ) Pain in shoulder joint R L
( ) Pain across shoulders
( ) Can't raise arm R or L either
  ( ) above shoulder level or
  ( ) over head
( ) Tension in shoulders
( ) Pinched nerve in shoulder R or L

MID-BACK

( ) Mid-back pain
( ) Pain from front to back
( ) Mid back stiffness
( ) Muscle spasms in mid-back
( ) Pain between shoulder blades

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ARMS & HANDS please circle R for right or L for Left

( ) Pain in upper arm R or L
( ) Pain in elbow R or L
( ) Pain in forearm R or L
( ) Pain in hand R or L
( ) Pain in fingers R or L
( ) Pins & needles in arm R or L
( ) Pins & needles in fingers R or L
( ) Numbness in arm R or L
( ) Numbness in fingers R or L
( ) Weakness in arm R or L
( ) Weakness in hand R or L
( ) Hands cold R or L

LOW BACK

( ) Low back pain
( ) Low back stiffness
( ) Low back weakness
( ) Pinched nerve in low back
( ) Low back feels out of place
( ) Muscle spasms in low back
( ) Herniated/Bulging disc confirmed by MRI

HIPS, LEGS, & FEET

( ) Pain in buttocks R or L
( ) Pain in hip joint R or L
( ) Pain down leg R or L
( ) Pain in knee R or L
( ) Pain in ankle R or L
( ) Pain in foot R or L
( ) Weakness of leg R or L
( ) Weakness in knee R or L
( ) Leg cramps R or L

Any other symptoms related to this issue?

_____

_____

_____

I (we) agree to pay for services rendered for the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Notice to our new patients: Please understand that this office does NOT accept insurance as payment for care. Full payment for services rendered is due at the end of each visit, however, we are more than willing to complete your insurance forms so that you will be reimbursed by your insurance carrier. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor for treatment.

*Patient's Signature:*_____ *Date:* _____

Guardian's Signature (for minors): _____ *Date:* _____

VITA HEAD, NECK & FACIAL PAIN RELIEF CENTER
Louis R. Vita, D.D.S., Angelo Colavita, DC, BCAO
991 Van Houten Avenue Clifton, NJ 07013

INFORMED CONSENT

I hereby authorize Dr. Vita and/or Colavita to examine me and suggest additional diagnostic testing. I understand that a patient seeking treatment at our office gives consent to his doctor to provide care in accordance with tests, analysis and diagnosis. It is rare that adjustments or other clinical procedures cause any problem, however, underlying physical defects, deformities and pathologies may render the patient susceptible to injury. The patient is responsible to truthfully disclose all pertinent information to the treating doctor regarding any illnesses, injury or adverse physical condition from which he/she is suffering or has experienced in their medical/dental history. While the doctor may advise the patient to seek diagnosis and treatment for a non-related condition, it remains the sole responsibility of the patient to do so.

The doctor and/or staff have advised me that this treatment regimen must be strictly followed. I agree that the doctor may terminate the doctor/patient relationship if he determines that I have not followed or am unlikely to follow the treatment regimen completely as it is critical to the success of my treatment. In the event that I am dismissed from care, or I, myself end treatment, it becomes my sole responsibility to seek and find treatment and further diagnostic testing from other healthcare providers. I will not hold the doctor of the Vita Head, Neck & Facial Pain Relief Center liable in any way whatsoever for such discontinued treatment or lack of follow up to another physician.

Neither the doctor nor any member of his staff has made any guarantees that his treatment will cure or benefit me in any way. I release the Vita Pain Relief Center, Dr. Louis Vita, Dr. Angelo Colavita and their staff and heirs from any and all claims or damages arising out of my treatment or omission to treat and diagnose, treatment outcome, or any aspect of care and result or lack thereof. I fully agree that I will not take any legal action against or toward Dr. Louis Vita, Dr. Angelo Colavita or their staff and heirs. I fully agree that I will not make negative or disparaging comments about any or all parties and care heretofore rendered. This includes written and verbal actions or comments.

I consent to have Dr. Vita/Dr. Colavita evaluate all of my available records and discuss with my physicians and dentists all past information that will assist in my care. I authorize Dr. Vita and/or Dr. Colavita to disclose any and all pertinent information to other healthcare providers and any other individual for my benefit within the confines of the Federal Privacy Practices Law. A copy of the Federal Privacy Practices Law is available at the office and will be furnished to me upon request at any time.

I give my permission to the doctors to share information about my case with other researchers as needed for statistical purposes and for possible scientific publication in medical journals. I also agree that my health information may be shared with governmental and/or regulatory agencies. I give my permission to Dr. Vita and/or Dr. Colavita to present my case, diagnosis and treatment outcome for teaching purposes and to include non-identifying photographs in presentation. I understand that in any publication, specific identifying information such as names and addresses will not be used. **(Patient's/Guardian's initials required)** _____

This office does not participate in any insurance plan other than Delta Dental for its dental patients only. Therefore payment will be made at the time of the service. Insurance reimbursement is solely and contractually between my insurance company and me. This office makes no claims of reimbursement from any insurance carrier for services rendered by the doctors. Payment for all services remains my sole responsibility. If I do not pay the provider's outstanding balance due and owing and the provider must send this matter to an attorney for collection, I agree to be responsible for reasonable attorney fees (to be calculated at the rate of 25% of the outstanding balance due and owing), costs of collection as well as interest charges (to be calculated at the rate of 1.5% per month for a total of 18% per annum. I also agree to be bound by the jurisdiction of the courts of the State of NJ.

I authorize the release and transmission of my medical records as required by my insurance company in order to process claims. I authorize this office to receive and accept payment directly from my insurance carrier in the event that I have not paid at the time of the service. I understand that my insurance will be filed by me and for my benefit only. This office does not guarantee reimbursement for any services rendered since this practice does not participate with my insurance plan.

I have read, understand and willingly consent by my signature below.

Patient Signature OR Guardian (if patient is under 18 years old) Date

Patient Name (Please print clearly) Guardian Name (Please print clearly, if patient is under 18 years old)

Patient HIPAA Awareness

With my permission, Dr. Louis Vita and/or Dr. Angelo Colavita may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Louis Vita's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Louis Vita and/or Dr. Angelo Colavita reserve the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Louis Vita/Dr. Angelo Colavita may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Louis Vita/Dr. Angelo Colavita may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Louis Vita and/or Dr. Angelo Colavita restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Louis Vita and/or Dr. Angelo Colavita to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian Date