

Sinha Clinic

2560 Foxfield Rd. Ste 240

St. Charles IL 60174

Phone: 630-762-9606/Fax: 630-762-9605

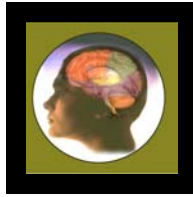
www.sinhaclinic.com

Dear Sir or Madam:

Enclosed you will find an intake packet for an upcoming intake session at the Sinha Clinic with Dr. Young. Please take the time to complete the forms in advance and bring them to the scheduled appointment.

Thank you,

The Sinha Clinic



Sinha Clinic

2560 Foxfield Rd. Ste 240
St. Charles IL 60174

Phone: 630-762-9606/Fax: 630-762-9605

www.sinhaclinic.com

Date: _____

Home Phone: (____)_____

O.K. to leave message? [] Y [] N

PATIENT INFORMATION

Name: _____ Birth date: _____

(Last Name) (First Name) (M Initial)

SS# _____ Driver's License #: _____

Address: _____ City: _____ State: ____ Zip: _____

Sex: M F Age: _____ Handedness: R L A

Marital Status: [] Single [] Married [] Widowed [] Separated [] Divorced

Occupation: _____ Work Status: FT PT Student Status: FT PT No

Employer Name and Address: _____ Employer Phone: (____)_____

School Name and Address (if applicable) _____ Grade: _____

Additional Phone Numbers to contact you? _____

Preferred Number we use to contact you? _____

GUARANTOR INFORMATION Parent or legal guardian must complete this information if patient is under 18 years of age.

Name: _____ Relationship to Patient: _____ Birthdate: _____

Social Security No: _____ Phone: (____)_____ Drivers Lic #: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Employer Phone: (____)_____

How did you hear of our practice or who referred you to our practice?

Name _____ Address _____ Phone# _____

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

Reason for Today's Visit:

Patient Name: _____

PRIMARY INSURANCE

Primary Insured: _____ Birth date: _____ Relationship to Patient: _____

Employer: _____ Employer Phone No: (____) _____

Name of Insurance Company: _____ I.D.#: _____ Group#: _____

Insurance Company Address: _____ Phone: (____) _____

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by *Sinha Clinic* and its employees or designees. I authorize the mental and physical health care services necessary or advisable by my caregivers to address my needs.

FINANCIAL POLICY

I understand charges incurred for services received by me are due and payable at the time of service unless other prior financial arrangements have been made. I have been informed that there is a \$40.00 dollar cancellation policy. That I will be charged \$40.00 dollars for any session not cancelled within 48 hours of the scheduled visit.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize *Sinha Clinic* TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESS OF APPLICATIONS FOR FINANCIAL COVERAGE OF THE SERVICES RENDERED. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by the insurance company or its designated agent, referring physicians or therapists. Release of information includes use of fax for transmittal of records.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE.

I authorize payment to be made directly to *Sinha Clinic* for insurance benefits payable on my behalf. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys' fees.

PRIVACY POLICY. I acknowledge having received *Sinha Clinic's*, "Notice of Privacy" Policies" including my rights to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consent.

I have read and fully understand the above consent for treatment, financial responsibility, and release of medical information.

Patient or Authorized Person Signature Relationship Date

Witness Signature Date

Patient Name: _____

INTAKE / HISTORY

Name of Client: _____ Age: _____ DOB: _____

Parent(s) or Guardian(s) of minor:

Name(s): _____

Physician / other health care professional (chiropractor, therapist, naturopath, bodyworker, etc):

Name: _____ Phone: _____

Referral source if referred to this office: _____ **Phone:** _____

Diagnosis: _____ **Current medications:** _____

Briefly list other approaches you have tried for this condition: (Medication, behavior therapy, counseling, alternative medicine, etc.?)

What benefits do you hope to gain from Treatment?: _____

Developmental History – Please indicate your (or your child’s) history in relation to the following:

<u>Prenatal and Birth</u>	<u>Yes</u>	<u>No</u>	<u>Details</u>
Prenatal stress or injury	_____	_____	_____
Prenatal drug/alcohol exposure	_____	_____	_____
Birth trauma (forceps, breech, etc.)	_____	_____	_____
Anesthesia, pain medications	_____	_____	_____
Anoxia (oxygen deprivation @ birth)	_____	_____	_____
Premature/late delivery	_____	_____	_____
Medical problems after birth	_____	_____	_____
Birth weight _____		Adopted at age _____	Other _____

<u>Growth and Development</u>	<u>Typical</u>	<u>More</u>	<u>Less</u>	<u>Details</u>
Activity level	_____	_____	_____	_____
Motor/coordination development	_____	_____	_____	_____
Infections/allergies	_____	_____	_____	_____
Emotional development	_____	_____	_____	_____
Behavior concerns	_____	_____	_____	_____
Handedness development	_____	_____	_____	_____
Appetite/digestion	_____	_____	_____	_____
Language/speech development	_____	_____	_____	_____

<u>Physical Traumas</u>	<u>Yes</u>	<u>No</u>	<u>Details</u>
Head injury (even minor falls, etc.)	_____	_____	_____
Coma (loss of consciousness)	_____	_____	_____
Accidents (list all)	_____	_____	_____

Patient Name: _____

High fever	_____	_____	_____
Serious illness	_____	_____	_____
Surgery	_____	_____	_____
CNS infection	_____	_____	_____
Drug overdose/poisoning	_____	_____	_____
Recreational drug use	_____	_____	_____
Anoxia	_____	_____	_____
Stroke	_____	_____	_____
<u>Psychological Stress/Life Changes</u>	<u>Yes</u>	<u>No</u>	<u>Details</u>
Death in family	_____	_____	_____
Divorce/remarriage	_____	_____	_____
Move/relocation	_____	_____	_____
School change	_____	_____	_____
Job change	_____	_____	_____
Family member chronic illness	_____	_____	_____

Symptom Checklist

Please indicate if the **client** and/or **family member(s)** (parents, grandparents, brothers, sisters, aunts, uncles, and/or children) **currently experience** or have a **history** of any of the following symptoms.

<u>Symptom</u>	<u>✓ if client</u>	<u>✓ if family</u>	<u>✓ if current</u>	<u>Symptom</u>	<u>✓ if client</u>	<u>✓ if family</u>	<u>✓ if current</u>
<u>Feeling Tense</u>	_____	_____	_____	<u>Addictions</u>	_____	_____	_____
<u>Depressed</u>	_____	_____	_____	<u>Bowel disturbances</u>	_____	_____	_____
<u>Always on the go</u>	_____	_____	_____	<u>Chronic fatigue/FMS</u>	_____	_____	_____
<u>School/work problem</u>	_____	_____	_____	<u>Inferiority feelings</u>	_____	_____	_____
<u>Impulsivity</u>	_____	_____	_____	<u>Dizziness</u>	_____	_____	_____
<u>Hyperactivity</u>	_____	_____	_____	<u>Fainting spells</u>	_____	_____	_____
<u>Attention problems</u>	_____	_____	_____	<u>Heart palpitations</u>	_____	_____	_____
<u>Behavior problems</u>	_____	_____	_____	<u>Stomach trouble</u>	_____	_____	_____
<u>Vocal or motor tics</u>	_____	_____	_____	<u>Poor appetite</u>	_____	_____	_____
<u>Sleep problems</u>	_____	_____	_____	<u>Picky eater</u>	_____	_____	_____
<u>Legal trouble</u>	_____	_____	_____	<u>Nightmares</u>	_____	_____	_____
<u>Headaches</u>	_____	_____	_____	<u>Alcohol/drug problem</u>	_____	_____	_____
<u>Feeling lonely</u>	_____	_____	_____	<u>Feeling panicky</u>	_____	_____	_____
<u>Frequent illness</u>	_____	_____	_____	<u>Tremors</u>	_____	_____	_____
<u>Repetitive thoughts</u>	_____	_____	_____	<u>Suicidal ideas</u>	_____	_____	_____
<u>Repetitive behavior</u>	_____	_____	_____	<u>PMS</u>	_____	_____	_____
<u>Shy with People</u>	_____	_____	_____	<u>Physical/sexual abuse</u>	_____	_____	_____
<u>Allergies</u>	_____	_____	_____	<u>Over ambitious</u>	_____	_____	_____
<u>Asthma</u>	_____	_____	_____	<u>Unable to relax</u>	_____	_____	_____
<u>Seizures / Epilepsy</u>	_____	_____	_____	<u>Can't make decisions</u>	_____	_____	_____
<u>Chronic pain</u>	_____	_____	_____	<u>Communication prob.</u>	_____	_____	_____
<u>Food sensitivity</u>	_____	_____	_____	<u>Problems at home</u>	_____	_____	_____
<u>Head injury</u>	_____	_____	_____	<u>Financial problems</u>	_____	_____	_____
<u>Memory problems</u>	_____	_____	_____	<u>Any chronic illness</u>	_____	_____	_____
<u>Temper tantrums</u>	_____	_____	_____				
<u>Rages</u>	_____	_____	_____				
<u>Verbal Aggression</u>	_____	_____	_____	<u>Other, specify:</u>	_____	_____	_____
<u>Physical Aggression</u>	_____	_____	_____				
<u>Stubbornness</u>	_____	_____	_____				

Please circle the **five current problems** listed above which are the **most distressing** to you or your child.

Patient Name: _____

MNI Symptom Checklist – Mark only current or recent symptoms (6 months)

Mark all boxes across from each of your symptoms. If a symptom has more than one box, check them all.

Depressed			
(unhappy, low)	<input type="checkbox"/>	<input type="checkbox"/>	
(angry and controlling)	<input type="checkbox"/>	<input type="checkbox"/>	
Impulsive / hyperactive	<input type="checkbox"/>		
Inattentive / daydreams	<input type="checkbox"/>		
Shy	<input type="checkbox"/>	<input type="checkbox"/>	
Oppositional	<input type="checkbox"/>		
Lacks empathy	<input type="checkbox"/>	<input type="checkbox"/>	
Anxious	<input type="checkbox"/>	<input type="checkbox"/>	
Poor language skills	<input type="checkbox"/>		
Unmotivated	<input type="checkbox"/>	<input type="checkbox"/>	
Misses social cues	<input type="checkbox"/>	<input type="checkbox"/>	
Fearful	<input type="checkbox"/>	<input type="checkbox"/>	
Poor sequential processing	<input type="checkbox"/>		
Impatient	<input type="checkbox"/>	<input type="checkbox"/>	
Obsessive and/or compulsive	<input type="checkbox"/>		
Emotionally sensitive	<input type="checkbox"/>	<input type="checkbox"/>	
Poor drawing and spatial skills	<input type="checkbox"/>		
Tics (can't seem to control)	<input type="checkbox"/>		
Irritable	<input type="checkbox"/>		
Easily frustrated	<input type="checkbox"/>		
Manipulative, aggressive, no remorse	<input type="checkbox"/>	<input type="checkbox"/>	
Holds a grudge	<input type="checkbox"/>	<input type="checkbox"/>	
Remorseful after tantrums	<input type="checkbox"/>		
Teased by peers	<input type="checkbox"/>	<input type="checkbox"/>	
Poor spatial skills	<input type="checkbox"/>		
Recovers quickly from tantrums	<input type="checkbox"/>		
Poor math concepts	<input type="checkbox"/>		
Socially aloof	<input type="checkbox"/>	<input type="checkbox"/>	
Stomachaches (with stress)	<input type="checkbox"/>	<input type="checkbox"/>	
Lack of body awareness	<input type="checkbox"/>	<input type="checkbox"/>	
High threshold for pain	<input type="checkbox"/>	<input type="checkbox"/>	
Speech lacks intonation	<input type="checkbox"/>		
Poor sense of appetite	<input type="checkbox"/>		
Problems staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	
Problems falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	
Enuresis (bedwetting)	<input type="checkbox"/>	<input type="checkbox"/>	
Bruxism (teeth grinding)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Encopresis (soiling)	<input type="checkbox"/>	<input type="checkbox"/>	
Rushes through work	<input type="checkbox"/>	<input type="checkbox"/>	
Restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep walking and talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Narcolepsy (can't stay awake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic pain (injury)	<input type="checkbox"/>	<input type="checkbox"/>	
Tension headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Perfectionist	<input type="checkbox"/>	<input type="checkbox"/>	
Loud unmodulated voice	<input type="checkbox"/>		
Slow processing, slow response	<input type="checkbox"/>		
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	
Poor eye contact	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	
Rages, loss of control	<input type="checkbox"/>	<input type="checkbox"/>	
Mood unrelated to life events	<input type="checkbox"/>	<input type="checkbox"/>	
Autistic symptoms	<input type="checkbox"/>		
Sugar cravings	<input type="checkbox"/>		
PMS	<input type="checkbox"/>	<input type="checkbox"/>	
Poor reading comprehension	<input type="checkbox"/>		
Poor sense of direction	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tight muscles / muscle strain	<input type="checkbox"/>		
Difficulty understanding concepts	<input type="checkbox"/>		
Allergies and asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Immune deficiency	<input type="checkbox"/>		
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>		
Poor word fluency	<input type="checkbox"/>		
Chronic burning pain	<input type="checkbox"/>		
Poor visual tracking	<input type="checkbox"/>		
Aggressive, controlling	<input type="checkbox"/>	<input type="checkbox"/>	
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical agitation	<input type="checkbox"/>	<input type="checkbox"/>	
Lack of feeling of well-being	<input type="checkbox"/>	<input type="checkbox"/>	
Compulsive overeating	<input type="checkbox"/>	<input type="checkbox"/>	
Intolerant of stimulants	<input type="checkbox"/>		
Anorexia, bulimia with:			
depression and PTSD	<input type="checkbox"/>	<input type="checkbox"/>	
anxious and controlling	<input type="checkbox"/>	<input type="checkbox"/>	
Totals:	Col. 1 BL ___	Col. 2 SR ___	Col. 3 A/T ___

Patient Name: _____

Head Injury Questionnaire

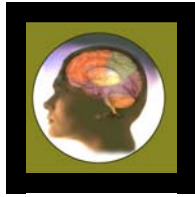
This questionnaire is designed to determine whether you have ever had a significant injury to your brain. Please read the questions carefully and think carefully about your history. It is common for people to forget head injuries, car accidents, minor falls, etc. when they are not followed by a loss of consciousness or significant impairment.

Event	Yes	No	List events and dates	Low ← <u>Severity</u> → High
Have you ever had an injury involving an impact to your head?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____
Were you ever in a motor vehicle, skate board, skiing, bike or other accident?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____
Were you told that you fell as a child (down stairs, off a table or chair, at a park?)			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____
Ever been in a fight, been beaten or attacked, passed out from alcohol?			1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____	1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10 1 2 3 4 5 6 7 8 9 10
Loss of consciousness from above? Event #s _____			Residual symptoms (circle) dizzy, spacey, headache, neck pain, other: _____ _____	Length of time unconscious: _____ _____

Patient Name: _____

Symptoms persisting after event	Yes	No	Describe <u>ONLY</u> head injury related symptoms – intensity, duration, affect on life tasks, i.e. work/school	Low ← Severity → High
Headache – tension and/or migraine				1 2 3 4 5 6 7 8 9 10
Tinnitus				1 2 3 4 5 6 7 8 9 10
Light headed				1 2 3 4 5 6 7 8 9 10
Impaired memory				1 2 3 4 5 6 7 8 9 10
Reduced attention span				1 2 3 4 5 6 7 8 9 10
Easily distractible				1 2 3 4 5 6 7 8 9 10
Impaired comprehension				1 2 3 4 5 6 7 8 9 10
Forgetful				1 2 3 4 5 6 7 8 9 10
Frustration				1 2 3 4 5 6 7 8 9 10
Problems with logical thinking				1 2 3 4 5 6 7 8 9 10
Trouble with abstract concepts				1 2 3 4 5 6 7 8 9 10
Anxiety				1 2 3 4 5 6 7 8 9 10
Depression				1 2 3 4 5 6 7 8 9 10
Insomnia				1 2 3 4 5 6 7 8 9 10
Apathy				1 2 3 4 5 6 7 8 9 10
Fatigue				1 2 3 4 5 6 7 8 9 10
Irritability				1 2 3 4 5 6 7 8 9 10
Angry outbursts				1 2 3 4 5 6 7 8 9 10
Mood swings				1 2 3 4 5 6 7 8 9 10
Hyper acute or diminished senses				1 2 3 4 5 6 7 8 9 10
Dizzy				1 2 3 4 5 6 7 8 9 10
Reduced libido				1 2 3 4 5 6 7 8 9 10
+-				1 2 3 4 5 6 7 8 9 10
Reduced motivation				1 2 3 4 5 6 7 8 9 10

Patient Name: _____



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Dear Sinha Clinic patient:

If you are unable to make your scheduled appointment kindly provide notice of cancellation of your appointment within 48 hours of the scheduled session. If the appointment is not cancelled within 48 hours of the scheduled appointment you will be charged \$40.00 dollars for the missed session. Unfortunately insurance companies typically refuse to pay for missed sessions consequently Sinha Clinic does not charge insurance companies for missed appointment. Patients who do not give the expected prior notice are billed for the missed session. Exceptions are made for emergencies and in these cases please inform the receptionist.

Thank you for your cooperation and we look forward to serving you.

Patient Signature or responsible party

Date

Witness

Date

Patient Name: _____

Sinha Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect 01/01/2006 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

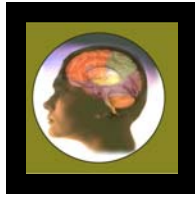
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.



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I, _____, hereby give my permission to
have Dr. _____ at the Sinha Clinic release/receive information which
pertains to:

Name: _____ Date of Birth: _____

Information From/To (Dates):

The purpose of this disclosure is:

Materials to be released:

Materials are being released from:

Materials are being released to:

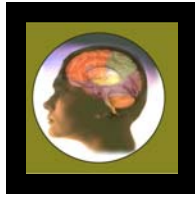
It is understood that the refusal to consent means no information will be released; that
this consent may be revoked at any time prior to the information being released. This
authorization is valid until _____(Date) .

Signature of Consenting party: _____

Signature of Parent/Guardian: _____

Date of Consent: _____ Witness: _____

Patient Name: _____



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I, _____, hereby give my permission to
have Dr. _____ at the Sinha Clinic release/receive information which
pertains to:

Name: _____ Date of Birth: _____

From/To: _____

The purpose of this disclosure is:
Coordination of treatment, school observation

Materials to be released:
IEP Records, Clinician notes, Progress notes, grades, test results, observation notes,
instructor's notes

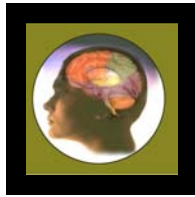
It is understood that the refusal to consent means no information will be released; that
this consent may be revoked at any time prior to the information being released. This
authorization is valid until _____(Date) .

Signature of Consenting party: _____

Signature of Parent/Guardian: _____

Date of Consent: _____ Witness: _____

Patient Name: _____



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I _____ give/do not give permission for Sinha Clinic to use visual (pictures) and auditory material (testimony) and/or written material in any Sinha Clinic printed material and for any research and/or advertisement purposes.

Thank you,

Patient or responsible party (if minor)

Date

Witness

Date