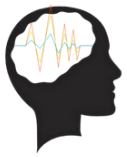


Sinha Clinic

2560 Foxfield Road, Suite 240, St. Charles, IL 60174
Office: (630) 762-9606 | Fax: (630) 762-9605
www.SinhaClinic.com | info@sinhaclinic.com

Date: _____ Home Phone: (____)-_____ Cell Phone: (____)-_____

Preferred number we use to contact you? _____ Can we leave a message [ ] Yes [ ] No

How did you hear about the Sinha Clinic? _____

Patient Information:

Name: _____ Birth date (MM/DD/YY): ___/____/_____
(Last Name, First Name and Middle Initial

Social Security Number: _____-_____-_____ Driver's License Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: Male [ ] Female [ ] Age: _____ Handedness: Right [ ] Left [ ]

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

Occupation: _____ Work Status: Full Time [ ] Part Time [ ]

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

Student Status: Full Time [ ] Part Time [ ] School Name: _____ Grade:_____

School Phone Number (if applicable) (____)-_____

Emergency Contact: _____ Relationship: _____ Phone: (___)-_____

Reason for Visit: _____

_____

_____

Patient Name: _____

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

Name: _____ Birth date: _____
(Last Name, First Name Middle Initial)

Social Security Number: ____-_____-_____ Driver's License Number: _____

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

Employer Name: _____ Employer Phone: (___)-_____

Employer Address:_____ Occupation: _____

PRIMARY INSURANCE:

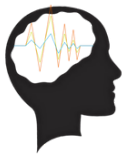
Primary Insured: _____ Birth Date (MM/DD/YY): ___/___/_____ Relationship to Patient: _____

Name of Insurance Company: _____

Identification Number: _____ Group Number: _____

Insurance Company Address: _____ Phone: (___)- _____

Patient Name: _____



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FINANCIAL POLICY: The Sinha Clinic believes that part of good healthcare is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. 1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will not include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. I authorize payment to be made directly to Sinha Clinic for insurance benefits paid on my behalf. If you do not carry insurance or your insurance is under a pre-existing clause, payment in full is expected at the time or your visit. I understand that if my account balance becomes overdue my account will be referred to a collection agency; I will be responsible for the costs of the collection including reasonable attorneys' fees.

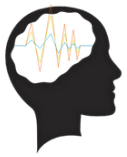
INSURANCE: We are participating providers with several insurance plans. We will file of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. Due to the many different insurance products out there, our staff cannot guarantee your coverage and eligibility. Be sure to call your insurer's member benefits department about covered services before your appointment. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment will be due upon receipt of a statement or notice from our office.

ACKNOWLEDGEMENT: I acknowledge that I have received and read a copy of the Sinha Clinic financial policy.

_____ _____

Patient Signature/Authorized Person Signature Date

Patient Name: _____



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PATIENT AGREEMENTS AND AUTHORIZATIONS CONSENT FOR TREATMENT. I hereby consent to the treatment provided by the 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 changes 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 $50.00 dollar cancelation policy that I will be charged $50.00 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 agents, 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 the 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, am explained in the Policy. I understand that I may revise in writing my consent for release of my health care information, except to the extent the Practice has already made disclosures with my prior consents. I have read and fully understand the above consent for treatment, financial responsibility, and release of medication information.

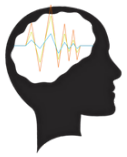
_____ _____ _____

Patient or Authorized Person | Signature Relationship | Date

_____ _____

Witness Signature | Date

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 $50.00 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 appointments. Patients who do not provide the expected 48 hours cancellation 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.

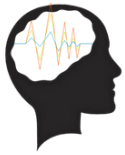
_____ _____

Patient Signature or Responsible Party Date

_____ _____

Witness Date

Patient Name: _____



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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU 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.

Patient Name: _____

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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 for treatment, payment or healthcare operations; you may give use 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, or 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 judgment 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 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. 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.

Patient Name: _____