AUTO/INJURY/W.C. QUESTIONNAIRE

Name_____Date___/___/_____File#_____
Home Address_____
City_____ State _____Zip Code_____
Social Security #_____/_____/_____ Date of Birth_____/_____/_____
Home Phone: _____Work Phone: _____

Email Address: _____

Referred By: _____

Attorney Information:
Name: _____Phone # _____
Address _____City _____State _____Zip _____

Age____ Race: ( ) Caucasian ( ) Black ( ) Spanish ( ) Other_____ Sex ( ) Male ( ) Female
1. Was the injury due to: ( ) Auto Accident ( ) Personal Injury ( ) Workman's Compensation
Date of Accident ____/____/_____Time ____: ____am / pm
Place: _____
Where you the: ( ) Driver ( ) Passenger ( ) Pedestrian
If passenger where you sitting:
( ) Front Passenger ( ) Driver-Side Rear ( ) Passenger-Side Rear ( ) Other:_____

2. In your own words, please describe the accident in detail:

_____
_____
_____
_____

3. Where were you taken after he accident?

_____

a) Were you wearing your seatbelt? ( ) Yes ( ) No

4. Did you have any physical complaints before the accident? ( )Yes ( )No
If yes, please describe in detail:

_____
_____

5. List dates of all prior Motor Vehicle Accident, Slip/Fall, Workers Comp injuries:

_____
_____

a) List all diagnostic tests & the facility performed at Ex: (MRI, SJ Radiology):

_____
_____
_____

6. Since this Injury, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
Check Symptoms you have noticed:

___ Headaches	___ Irritability	___ Numbness in Toes	___ Face Flushed
___ Feet Cold	___ Neck Pain	___ Chest Pain	___ Short Breath
___ Buzzing Ears	___ Hands Cold	___ Neck Stiff	___ Dizziness
___ Fatigue	___ Balance Loss	___ Stomach Upset	___ Depression
___ Fainting	___ Constipation	___ Back Pain	___ Loss of Smell
___ Cold Sweats	___ Nervousness	___ Loss of Memory	___ Loss of Taste
___ Fever	___ Tension	___ Ears Ring	___ Diarrhea
___ Pins & Needles in Arms		___ Pins & Needles in Legs	___ Head Seems Too Heavy
___ Sleeping Problems		___ Light Bothers Eyes	___ Other: _____

6. Have you been seen by another Dr. for this Accident? ( ) Yes ( ) No
   a) Are you: ( ) Improved ( )Unchanged ( ) Worse
   b) Are you taking any medications for this condition?

_____

_____

   c) Do these medications help? ( ) Yes ( ) No

7. Have you lost time from work as a result of the accident? ( ) Yes ( ) No
   If yes, please complete the questions below
   A. Last Day Worked ____/____/____
   B. Type of Employment?_____
   C. Present Salary? _____
   D. Are you being compensated for the lost time from work? ( ) Yes ( ) No
      If yes, what type of compensation are you receiving? _____
   E. Have you ever had a previous worker's compensation claim? ( ) Yes ( ) No
      If yes, please explain: _____

8. How would you grade your pain on a scale of (1-10) 1 lowest – 10 Highest? _____

9. How would you describe the pain?

___ Sharp	___ Soreness	___Throbbing	___ Dull	____Stiffness
___ Spasm	___ Burning	___ Weakness	___ Numbness	____ Shooting

10. How often is the pain present? ____Constant (80-100%) ____ Frequent (50-80%)
    ____ Occasional (26-50%) ____ Intermittent (25% or less)

11. What makes your problem better?

_____

_____

12. What makes your problem worse?

_____

_____

13. What is your physical activity at work?
____ Mostly Sitting _____ Light Manual Labor ____ Moderate Manual Labor _____ Heavy Manual Labor

Employer: _____ How Long?_____
Employer's Address: _____

_____

Occupation:_____

We invite you to discuss with us any questions regarding out services. The best health services are based on a friendly, mutual understanding between provider and patient.
I authorize the staff to perform any necessary service needed during diagnosis and treatment. I also authorize the provider to release any information required to process claims.
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize assignment of my insurance right and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not pain for by my insurance company. In the event that my insurance carrier forwards payment to me, I am solely responsible to forward that payment to your office within 30 days of receiving payment for treatment rendered.

Signature _____ Date _____/_____/_____

Calzaretto Chiropractic Center

401 Cooper Landing Rd.
C-17 Playa Del Sol
Cherry Hill, NJ 08002
Telephone: (856) 667-0505
Fax: (856) 667-8083

Anthony F. Calzaretto D.C.
Brian D. Ryan D.C.

Record Release

Date: _____

Print Name: _____

Records Released: _____

Important Notice

As, requested, we are lending you records/films as a courtesy for the benefits of this patient.

Patient signature provided to give permission to this office to obtain any patient information, diagnostic evaluations, and/or follow up reports.

Patient Signature: _____

Staff Initials: _____

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Brian D. Ryan D.C.

Date:_____

Ins. Co. Address:

_____
_____
_____
_____

Patient Name: _____ **File#**:_____
(Please Print)

Patient Signature: _____

D.O.A.: _____ **Claim#**:_____

Policy #: _____

Attention: _____

This notice has been certified to the above Insurance carrier within the **21-day rule**, from the start of treatment, to confirm that _____ had initiated care at our facility on _____ due to injuries which occurred in a auto related accident. If there are any questions or concerns relating to this matter please feel free to contact me personally at the above phone number.

Sincerely,

Tabitha Robinson
Office Manager

This form allows our office to notify your insurance company within 21 days that you began treatment at our facility.

DR. ANTHONY F. CALZARETTO
401 COOPERLANDING ROAD SUITE C-17
CHERRY HILL, NJ 08002
PHONE: (856) 667-0505 FAX: (856) 667-8083

ACKNOWLEDGMENT OF DOCTOR'S LIEN AND PATIENT'S RESPONSIBILITY

I do hereby request chiropractic care and treatment from Dr. Anthony Calzaretto for conditions relating to my accident. I fully understand that it is my personal obligation to promptly pay Dr. Anthony F. Calzaretto as said treatment and care is rendered. Dr. Anthony F. Calzaretto has agreed to process my bills with any insurance company that may be deemed responsible for said bills. As such, in consideration of his rendering said treatment and care to me, and in consideration of his submission of bills directly to any responsible insurance carrier I hereby authorize and direct any insurance carrier, attorney, law firm or any other party responsible for the payment of said bills to pay directly to Dr. Calzaretto such sums as may be due and owing him for medical services rendered to both by reason of this accident and by any other reason and to hold such sums from settlement, judgment or verdict as may be necessary to adequately protect said doctor. And, I hereby further give lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict or benefits which may be paid to any third party as a result of injuries for which I have been treated in connection therewith, and/or as a result of benefits due to me through any applicable insurance policy.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me and this agreement is made in consideration for said doctor's additional protection and in consideration of his awaiting payment.

I hereby acknowledge and understand that payment is not contingent on a settlement, judgment or verdict associated with any litigation arising in connection with bills generated as a result of services rendered.

I hereby acknowledge and understand that inasmuch as treatment rendered maybe in connection with physical maintenance and/a wellness program, as well as my personal comfort and desires and as much may not be entitled to coverage or otherwise compensable under any insurance policy, I will remain personally liable to Dr. Anthony Calzaretto for any balances not covered or otherwise payable under any insurance policy. As such I acknowledge and understand that my responsibility to pay said balances is not subject to, altered or conditioned by any Arbitrator's decision or Judge's decision regarding any insurer's liability to pay said bills or expenses. And, I acknowledge that decisions by an Arbitrator or Judge regarding medical necessity are not binding upon me nor affect my direct liability to the doctor. As such, this lien shall survive and not be altered by any decision from an Arbitrator or Court.

I hereby assign my right to initiate litigation or otherwise pursue any other means of collections for any outstanding balances to Dr. Anthony F. Calzaretto and I hereby agree to fully cooperate with him or his selected attorneys in the prosecution of claims for payment of his services, agreeing to execute the necessary documents including but not limited to Assignments, Powers of Attorney, appear at Depositions, Examinations and Trials.

I have read the above and confirm the same to be a true and correct representation of my wishes and desires.

I hereby sign this document freely and voluntarily without force or coercion of any type.

X_____ Date: _____
(Patient's Signature)

X_____ Date: _____
(Attorney's Signature)

This form is to inform your attorney know that you have began treatment with our facility.

DR. ANTHONY F. CALZARETTO
401 COOPERLANDING ROAD SUITE C-17
CHERRY HILL, NJ 08002
PHONE: (856) 667-0505 FAX: (856) 667-8083

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I have read the above and confirm the same to be a true and correct representation of my wishes and desires.

I hereby sign this document freely and voluntarily without force or coercion of any type.

X_____ Date: _____
(Patient's Signature)

X_____ Date: _____
(Attorney's Signature)

This form is to inform your attorney know that you have began treatment with our facility.

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ASSIGNMENT OF BENEFITS
LIMITED POWER OF ATTORNEY
RELEASE OF RECORDS

ASSIGNMENT:

I irrevocable assign to you, my medical provider, all rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocable authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I **consent** to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

As medical provider I agree to comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if I fail to comply with same, in consideration for the for the carrier's consent to this agreement.

LIMITED/SPECIAL POWER OF ATTORNEY

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited /special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit.. I specifically authorize that attorney to file directly against that carrier in my name and/or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due for services rendered to me in this matter, and hereby instruct the insurance carrier to pay directly any monies due you for medical services you rendered to me.

RELEASE OF RECORDS:

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals. Diagnostic centers, etc., and I specifically authorize such health care provider(s) to release information to you about me, including medical records, X-ray reports, .narrative reports, and any other report or information regarding my physical condition.

DATED:

_____

Patient's signature

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INSURANCE INFORMATION SHEET

AUTO

Auto Insurance Carrier_____

Policy Number_____

Date of Accident_____

Claim Number_____

HEALTH

Do you have Health Insurance? Y/N

Name Of Health Insurance Carrier_____

Subscriber's Name_____

Identification Number_____

Group Number_____

Insurance Company Phone Number_____

Please provide your Auto and Health Insurance information.

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AFFIDAVIT OF
NO INSURANCE

1 I, being duly sworn according to law, upon my oath deposes and say that:

1. On or about, I lived at

2. I was injured in an accident involving a private passenger automobile,

3. Neither I nor any member of my household was the owner of an automobile.

4. I am not otherwise entitled to New Jersey Automobile No-Fault benefits for this accident.

5. I am therefore executing this Affidavit in order to receive New Jersey Automobile No-Fault benefits under the policy issued to_____

6. My date of birth is: _____
   Social Security No._____
   Drivers license Number: _____
7. List the member in household .If no one lives with you, indicate "None."

NAME	Date of Birth

_____

Sworn to and subscribed
Before me this_____
Day_____, _____
Signature: _____ *Only Sign if you have no health insurance*

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Office Policy

We believe that a clear definition of our policies will allow both you the patient and us the doctor to concentrate on the big issue - **REGAINING AND MAINTAINING YOUR HEALTH!** It is the goal of this office to provide you with the finest quality Chiropractic care available.

APPOINTMENT POLICY

Multiple appointments have been given for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. When entering the office on any given visit, please go directly to the front desk and **"Sign-In"**. We attempt to honor all appointments at the scheduled time.

FINANCIAL POLICY

Pay at the time of service (PTS):

1. Patients with limited or no Chiropractic Coverage:
   Our office accommodates PTS, which we offer a 50% discount on services rendered.
   i.e.: Spinal Adjustment $60.00 PTS = $30.00 for visit.
2. Patients with Insurance:
   Deductibles and all co-payments are expected at the time of service.
3. HMO Subscribers: you must have a referral from your PCP, If no referral is received your are responsible for your visit

Patient balances may not exceed $50 while professional care is being rendered.

Limited list of services and fees, most covered by Major Medical Health Insurance:

FEES		
	Initial Visit:	
	History & Physical Examination	145.00
	Office Visit:	
	Chiropractic Adjustment	60.00
	Other Services:	
	Electrical Muscle Stimulation	30.00
	Heat/Ice	30.00
	Massage Therapy 20 min session	50.00
	Hydro Massage Table	30.00
	Myofascial Trigger Point Therapy	35.00

I have read the above, understand it fully and undertake chiropractic care on this basis.

PATIENT'S SIGNATURE: _____

As a courtesy to our patient's our office will perform the following tasks:

- Confirm Massage Appointments
- Send mailings
- Submit patient information to Insurance Company for authorization to treat
- Dictates initial reports for primary physicians

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle. _____

_____ _____
(signature) (date)