

# 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: \_\_\_\_\_

If passenger, where were you sitting:

( ) Front Passenger ( ) Driver-Side Rear ( ) Passenger-Side Rear ( ) Other: \_\_\_\_\_

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

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3. Where were you taken after the 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:

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

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

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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? \_\_\_\_\_

Employers Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

We invite you to discuss with us any questions regarding our 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 rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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 may be 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 to 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 \_\_\_\_\_  
(Patient's Signature)

Date: \_\_\_\_\_

X \_\_\_\_\_  
(Attorney's Signature)

Date: \_\_\_\_\_

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X \_\_\_\_\_  
(Patient's Signature)

Date: \_\_\_\_\_

X \_\_\_\_\_  
(Attorney's Signature)

Date: \_\_\_\_\_

401 Cooper Landing Rd.  
C-17 Playa Del Sol  
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Fax: (856) 667-8083

***Calzaretto Chiropractic Center***

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

**ASSIGNMENT OF BENEFITS**  
**LIMITED POWER OF ATTORNEY**  
**RELEASE OF RECORDS**

**ASSIGNMENT:**

I **irrevocably 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 irrevocably 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 a 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 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:**

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**Patient's signature**

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Anthony F. Calzaretto D.C.  
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 an 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,

Brittany Kerper  
Office Manager

*This form allows our office to notify your insurance company within 21 days from when treatment commences at our office.*

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***Calzaretto Chiropractic Center***

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

**AFFIDAVIT OF  
NO INSURANCE**

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 members in your 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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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.

**Is your health insurance primary through your car insurance? Y / N**

**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 \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

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## ***Calzaretto Chiropractic Center***

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

### **Terms of Acceptance**

When a patient seeks chiropractic health care & 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 & 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, & social well-being, not merely the absences 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 & 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 diagnose either vertebral Subluxation or neuromusculoskeletal 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 subluxation. However, we may use other procedures to help your body hold the adjustments.

I, \_\_\_\_\_ have read & 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.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Consent to evaluate & adjust a minor child**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, I have read & fully understand the above terms of acceptance & 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 & 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: \_\_\_\_\_

# ***Calzaretto Chiropractic Center***

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*Anthony F. Calzaretto D.C.*

*Brian D. Ryan D.C.*

## **Scheduling Policy**

Our goal is to provide quality health care to all of our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well. Please be aware of our policy regarding missed appointments.

When you book your appointment, you are reserving a time slot on our calendar that is no longer available to other patients. In order to be respectful of your fellow patients, please contact our office as soon as you are aware you will not be able to keep your appointment.

We require a **24-hour notice** for all cancellations. Your advanced notice will allow another patient access to that appointment time.

A patient may reschedule an appointment by:

- Calling our office direct at 856-667-0505
- Texting our office at 856-667-0505

## **Late Cancellations/No-Shows**

A cancellation is considered late when the appointment is cancelled less than **24 hours** before the appointed time. A no-show is when a patient misses an appointment without cancelling.

## **Cancellation Fees**

- Established Patient Missed Appointment (no communication prior to missed appointment) **\$30.00 fee**
- New Patient Missed Appointment (no communication prior to missed appointment) **\$40.00 fee**

An appointment that is rescheduled to a different time slot on the same day: No Charge

An appointment which is rescheduled/cancelled at least **24 hours** in advance: No Charge

*Thank you in advance for your cooperation and we look forward to treating you!*

Patient Name (Printed): \_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_