

AUTO/INJURY/W.C. QUESTIONNAIRE

Name _____ Date ____/____/____ File# _____

Home Address _____

City _____ State _____ Zip Code _____

Social Security # _____/_____/_____ Date of Birth ____/____/____

Home Phone: _____ Work Phone: _____

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: _____	

For Office Use Only

Explain all paperwork/documents Y/N

Health Insurance Y/N

Initials _____ Comments _____

Auto, WC, PI Information Y/N

Signature on all Documents Y/N

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 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 right 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 _____/_____/_____

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

Calzaretto Chiropractic Center

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

Record Release

<i>Date Out</i>	<i>Records Released</i>	<i>Signature Out</i>	<i>Staff Initials</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

<i>Date In</i>	<i>Records Returned</i>	<i>Signature In</i>	<i>Staff Initials</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____

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Calzaretto Chiropractic Center

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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 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,

Erica Wells
Office Manager

CALZARETTO CHIROPRACTIC CENTER
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 _____
(Patient's Signature)

Date: _____

X _____
(Attorney's Signature)

Date: _____

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X _____
(Patient's Signature)

Date: _____

X _____
(Attorney's Signature)

Date: _____

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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 _____

NO HEALTH INSURANCE:

I attest that at this time I do not have Health Insurance Coverage. I request that you apply all outstanding Copay and Deductible Balances to my case.

Patient Signature _____
Date _____

Durable Limited Power of Attorney Overview

A durable limited power of attorney is a document, which allows this office to initiate collection procedures, including litigation if necessary, in the name of the patient directly against the insurance company when it is believed that the insurance company has wrongfully denied coverage or otherwise failed to pay medical bill in accordance with the terms of the insurance policy, and within the time frame required. In those circumstances, when an insurance company has ignored this offices request for payment, has ignored your assignment of benefits, has failed to pay in a timely fashion, or has otherwise simply not communicated with us, the power of attorney gives this facility the right to start collection and/or litigation procedures under the patient's name. This document does not mean that the patient will have to pay an attorney fee. The power of attorney is "limited" **which means that the only rights afforded to this office is the right to attempt to get pay directly from an insurance company, which is supposed to pay the bills. No other right is given to this office.** The patient maintains all rights of privacy. The patient maintains the right to bring a loss on his/her own for any other reason such as personal injury, etc. Signing of this document assists this office a collection procedure, which would otherwise have to be initiated against the patient. However, patient cooperation is still needed when such collection efforts are required.

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Durable Limited Power of Attorney

Insurance Company:

Patient Name: _____

Claim No: _____

D/A: ____/____/____

Adjuster: _____

KNOW ALL MEN BY THESE PRESENCE:

That I _____ of _____ referred to herein as PRINCIPLE, designate my provider Anthony Calzaretto of 401 Cooper Landing Rd, Suite C-17, Cherry Hill, NJ 08002 to be my Attorney In Fact and agents (here and after called AGENT) for the following purposes:

1. **General grant of power under any applicable automobile Personal Injury Protection Policy:**

To exercise any act, power, right or entitlement whatsoever that I now have or may hereafter relating to my policy of automobile insurance, or any policy of automobile insurance relating to or in any way pertaining to my right to Personal Injury Protection Benefits (hereinafter called PIP Benefits) which in any way may arise or be claimed to have arisen out of my motor vehicle accident of _____. I grant to my AGENT full power of attorney to do everything necessary in exercising any of the powers herein granted as fully as I might or could do if personally present, irrevocably ratifying and confirming all that my agent shall lawfully do or cause to be done by virtue of this Power of Attorney and powers herein granted:

- a) Powers of Collection and Payment; to request, demand, do for, recover, collect, receive, all such sums of money, debts, dues, commercial paper, checks, drafts accounts, deposits, notes insurance and other contractual benefits and proceeds, and demands whatsoever, liquidated or unliquidated, now or hereafter owned by me, or due, owing, payable but belonging to me in which I have or may hereafter acquire an interest as against any and all automobile insurance carriers responsible of payment of First party PIP Benefits arising out of or claimed to have arisen out of my motor vehicle accident of _____, and to have, used, and take all lawful means and equitable and legal remedies and proceedings in my name for the collection and recovery thereof, and to adjust, compromise and agree for the same, and to execute

and deliver for me, on my behalf, and in my name, or endorsements, releases, receipts or other sufficient discharges for the same;

- b) Legal Representation: to obtain counsel to pursue in my name litigation and or arbitration through the appropriate forum including the Superior Court of New Jersey, The American Arbitration Association or alternative dispute resolution, a resolution of any disputes arising out of entitlement to any and all First Party Benefits against those automobile insurance companies which may be deemed responsible or claimed to be responsible for First Party Benefits;

- c) Investigation: To investigate, obtain and subpoena any and all necessary documents, depositions including sworn statements needed to be obtained in order to appropriately prosecute after said PIP claims both before and after initiation of litigation.

2. Interpretation and Governing Law

This instrument is to be construed and interpreted as a General Durable Power of Attorney. In consideration of the services provided by my attorney in fact this Power of Attorney is to be considered irrevocable. This instrument is executed and delivered in the State of New Jersey and laws of the State of New Jersey shall govern all questions of validity of this Power and the construction of its provisions.

3. Third Party Reliance

Third parties are directed to rely upon the representation of my AGENT as to all matters to any Power granted to my AGENT. Any third party may rely on a duly executed counterpart of this instrument, or a copy certified by my AGENT to be a true and correct copy and original hereof, as filled in completely as if such the third party had received the original of this instrument.

4. Effective Date

The provisions of this Power of Attorney which consists of three (3) pages, shall be effective upon the date of the execution as indicated here and after, it being my intention that all Powers conferred upon my attorney in fact herein or any substitute designated by me shall become effective upon the date of said document. The provisions of N.J.S. 46:2B-8 authorize me to provide that this Power of Attorney shall not be affected by my disability as principle, and I do hereby certify, it being my intention that all Powers conferred upon my attorney in fact herein or any substitution designated by me shall remain in full force and effect, notwithstanding my incapacity or disability, or any uncertainty with regard to it. In witness whereof I here into set my hand and sealed this on _____.

Patient

Witness

- By executing this document our office is given the authority to:
- Fully Accept assignment of Benefits
 - File Arbitration when Carrier denies payment for service.

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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 you 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:

☒ Confirms Massage Appointments

☒ Sends mailings

☒ Submits 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 diagnose 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 satisfaction.

Therefore, I accept chiropractic care on this basis.

(signature)

(date)