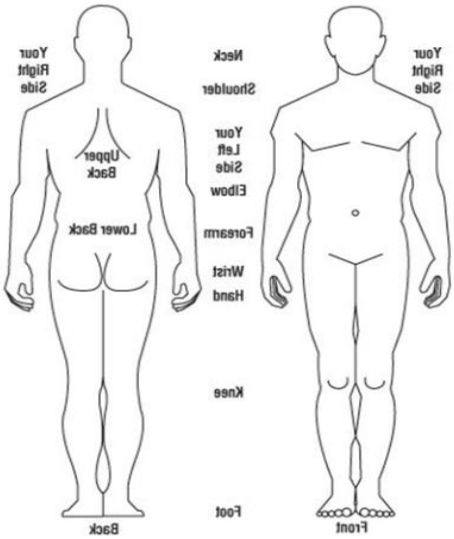
CENTER SPINE CARE

59 Main Street, Suite PL2, West Orange, NJ, 07052, P: (973)673-4400, F: (973)673-4402, CSPINE59@gmail.com

TODAYS DATE:_____/_____/_____
NAME: _____
SEX: □MALE □FEMALE D.O.B_____/_____/_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
HOME: (_____) _____-_____ CELL: (_____)_____-_____
SOCIAL_____-_____-_____
EMPLOYER: _____OCCUPATION:_____
WORKPHONE: (_____) _____-_____
EMERGENCY CONTACT: _____ PHONE: (_____) _____-_____
RELATIONSHIP_____
HEALTH INSURANCE: □YES□NO, PLAN: _____ MEMBER I.D_____

HOW CAN WE HELP YOU?

WHAT BRINGS YOU IN TODAY _____
WHEN DID YOUR SYMPTOMS APPEAR?_____



What does the pain feel like?

□*Sharp* □*Numbness* □*Throbbing*
□*Dull* □*Aching* □*Shooting*
□*Burning* □*Tingling* □*Cramps*
□*Stiffness* □*Swelling* □*Other*

Severity of Pain 1-10? _____

Does this pain interfere with Daily routine such as?

□*Walking* □*Bending* □*Standing*
□*Lying down* □*exercise* □*OTHER*

Is this conditioning worsening?

☐*YES* ☐*NO*☐*UNKOWN*

MEDICAL ASSISTANT MUST CHECK BLOOD PRESSURE
_____/_____

Please mark with an "X" the area of pain using the code diagram above:

HEALTH & WELLNESS

Please check all the that apply to you:

□ High Blood Pressure □ Pace maker □Aids/HIV □Allergies □Anxiety

□Arthritis □Asthma □Cancer □Cholesterol □Depression □Diabetes

□Epilepsy □Scoliosis □TMJ issues □Heart Disease □Hepatitis

□Osteoporosis □ High Blood Pressure □Circulation issues □Cardiovascular Issues

□Headaches/Migraines □Multiples Sclerosis □Other _____

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Motor Vehicle Questions (Personal Injury)

Date of Accident:_____/_____/_____ □DRIVER □PASSENGER □FRONT-SEAT □REAR-SEAT □PEDESTRIAN

WAS PATIENT WEARING SEATBELT? □YES□NO **DID AIRBAGS DEPLOY?** □YES□NO

AREA OF IMPACT: □FRONT □REAR □DRIVER-SIDE □PASSENGER-SIDE □OTHER_____

WAS VEHICLE TOWED? □YES □NO - **WAS IT YOUR VEHICLE?** □YES □NO;IF NOT, WHOS?_____

DID YOU GO TO HOSPITAL OR URGENT CARE? □YES □NO ;;

IF SO, WHERE?_____

DID YOU SUFFER ANY CUTS OR CONTUSSIONS? □YES□NO ;;

□ X-RAYS □CT-SCANS □MRI'S ;; □FRACTURES IF SO, WHAT SPECIFICALLY_____

WERE YOU PRESCRIBED ANY MEDICATION? □YES □NO IF SO, WHAT KIND_____

HAVE YOU EVER HAD ANY PREVIOUS MOTOR VEHICLE ACCIDENTS? □YES□NO

WHEN?_____/_____/_____ Any Injections or Diagnostic testing? _____

DO YOU HAVE AN ATTORNEY FOR THIS CURRENT ACCIDENT? □YES□NO ;

IF YES, PLEASE PROVIDE THE FOLLOWING:

NAME OF ATTORNEY:_____**PHONE:** (_____)_____-_____

ADDRESS: _____

AUTO INSURANCE NAME:_____ **CLAIM #**_____

Patient/Client Name: **Date of Loss:**

Provider: ***Center Spine Care, 59 Main Street, Suite PL2, West Orange, NJ 07052*** I, the undersigned Patient, hereby instruct my attorney to insure that Provider is paid in full for any and all treatment and services provided by them to me, or on my behalf, for the consequences of the accident that took place on or about the Date of Loss described above. Payment is to be derived from the proceeds of any settlement or funds received by me, or in my beneficial interest, from any source, as compensation for any damages I may have sustained from the consequences of the events that occurred on or about the Date of Loss described above.

Letter of Protection Terms:

- If the bills protected by this letter are for treatment of a vehicular accident, then in regard to PIP covered charges, this Letter of Protection is valid for outstanding PIP covered charges, only if PIP is appropriately billed and pursed by Provider pursuant to FS627.736 (5)(b).
- This Letter of Protection shall not be assignable or transferable to another provider.
- Upon request and periodically, Center Spine Care will forward updated bills and medical records to the Insurance Company or to the Patient's attorney and not to the Patient, unless otherwise requested in writing.
- Should Patient not agree to the sums available for payment to Provider, the Patient's attorney shall post funds, in any amount no less than the disputed charges, in the registry of the court for appropriate judicial determination.
- Provider is acting in reliance on the terms of this agreement for the provision of treatment and services contemplated herein.
- The terms contained herein are acceptable as adequate consideration for this agreement by the signatories below.

_____ _____ _____

Patient's Name Patient's Signature Date

_____ _____ _____

Provider's Name Printed Provider's Signature Date

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CONSENT TO CHIROPRACTICE SERVICES

I authorize the performance upon myself of the following procedures:

a) Examination and periodic re-examination
b) Spinal Manipulation
c) Electrical stimulation(muscle)
d) Kinetic activity(rehab)
e) Hot moist/cold therapy

To be preformed by or under the supervision of the chiropractors of the **Center Spine Care, LLC. Facility.**

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that the above-named chiropractic physicians, associates, or assistants, may consider necessary or advisable I the course of my health care.

You have been injured as the result of motor vehicle accident, work related injury, or a result of another person's actions. Therefore, I am Being treated for these injuries; it is not my intention to receive treatment for litigation purpose.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by a chiropractor of Center Spine Care facility and/or their associates and employees to my satisfaction.

Chiropractors use spinal manipulations to treat patients with neck problems. There have been rare cases of injury to a vertebral artery as a result of treatment. Such injury has been rare cases of injury to a vertebral artery as a result of treatment. Such injury has been known to cause stroke, sometimes with serious neurological injury. The chance of this happening is extremely remote, approximately 1 per 1 million treatments. Appropriate tests will be preformed on me to help identify if I may be at risk to that kind of injury. If I have any questions about this, I will not hesitate to speak with one of the chiropractors. I accept the risk described in this paragraph and consent to treatment.

I acknowledge that no guarantee or assurance as to results that may be obtained from procedures has been given by the above-named doctors, their assistants, or facility employees.

If you have been injured as the result of another's actions, it is important that you do the following:

1. Provide accident report, proof of insurance, and personal identification.
2. Sign in before receiving treatment.
3. Present for initial and periodic examinations.
4. Advise a doctor of any problems or if you are pregnant.
5. Understand the need for diagnostic testing and/or referral to the appropriate physician of your problems are persistent, severe, or not within the scope of chiropractic treatment.

Name: _____ Signature: _____ Date: _____

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. I understand that by signing the consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved)
- Obtain payment from third party payers such as my insurance company
- The day to day care operations of the practice

I am aware that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with them. I may revoke this consent at any time in writing. However, any use or disclosure that occurred prior to the date I sign this form is not affected.

_____ _____

Patient Signature Date

Authorization to Release Medical Records

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed above

The information you may release subject to this signed release form is as follows:

□Complete Records	□History & Physical	□Progress Notes
□Care Plan	□Lab Reports	□Radiology Reports
□Pathology Reports	□Treatment Record	□Operative Reports
□Hospital Reports	□Medication Record	□All/Any Records

Patient Signature: _____

Patient Name: _____

Date: _____

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Assignment of Benefits & LTD .

Patient Name: _____ Date Of Loss: _____ / _____ / _____
Patient Address: _____ City:_____ State:_____ Zip:_____
Insurance Co: _____ Name Of Policy Holder: _____
Policy Number: _____ Claim Number _____

I, the undersigned, hereafter referred to as "The Patient" do hereby assign all of my rights and interests to **Halo, PT doing business as Center Spine Care,** hereafter referred to as "The Medical Provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable request of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for the same. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same be deducted from any settlement made on my behalf.

I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the Health carrier and/or insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier. The provider will comply with the decision point review request as required by the plan. The provider shall submit disputes to personal injury protection dispute arbitration if the decision point review plan requires same.

In the event it is determined by Arbitrator and/or Court of Law that the imposition of a co-payment penalty was as result of the medical provider's failure to pre-certify treatment or comply with other decision point review requirements the provider will hold the patient harmless for such co-payment penalty.

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 you 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 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 you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and/or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

Patient's Signature: _____ Date: _____ / _____ / ____

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IRREVOCABLE HEALTHCARE POWER OF ATTORNEY

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____County, state of _____, do appoint my healthcare provider Dr._____(hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principal (or members of Principal's family) by any auto insurance, health insurance, or 3rd party liability insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

2. Demand and direct any and all auto, health, or liability insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

Dated:_____,20_____

_____(Signature of Principle)

_____(Printed Name of Principle)

On _____ ___, 20__, before me, _____, personally appeared, _____ , personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature_____

(This area for official notarial seal)

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AFFIDAVIT OF NO OTHER SOURCES OF INSURANCE

State of: _____ County of: _____

I, _____ of full age, being duly sworn according to law, on his/her oath says:

1. I currently reside at _____and have done so since _____.
2. My home phone number is _____.
3. My date of birth ("DOB") is _____.
4. My social security number ("SSN") is _____.
   (if none, enter "none")
5. My Individual Taxpayer Identification number ("ITIN") is _____.
   (if none, enter "none")
6. Gender is _____Male _____Female
7. a. _____ I **am not** a Medicare beneficiary
   b. _____ I **am** a Medicare beneficiary and my Health Insurance Claim Number ("HICN") is _____.
8. My driver's license information is : State _____ Number _____.
9. On _____, the date the accident occurred:
   a. I resided at _____.
   b. If my driver's license was different that in (7) above, it was:
   i. State _____ Number_____.

   Other residents of my household on the date the accident occurred were:

i. Name _____DOB_____SSN_____
   Driver's License # _____State_____
   Their relationship to you _____

ii. Name _____DOB_____SSN_____
   Driver's License # _____State_____
   Their relationship to you _____

Check all that apply below:

10. _____On_____, the date the accident occurred, I was not a resident of a household wherein any resident was the registered owner of a motor vehicle covered by a policy issued by an insurance company.
11. _____On_____, the date the accident occurred, I was not insured by **any** medical insurance carrier for coverage of medical services.
12. _____On_____, the date the accident occurred, I personally did not own an automobile with liability insurance coverage that would afford me Personal Injury Protection/No-Fault benefits.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statement made by me are willfully false, I am subject to punishment.

_____
Signature

Sworn to and subscribed before me this
_____day of _____, 20____.

_____
Print Name

_____

Notary Signature & Seal:_____

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IMPORTANT NOTICE

INSURANCE FRAUD

I. As you have been informed, this office has a **ZERO TOLERANCE** policy toward insurance fraud. Under no circumstances will this office represent or participate in the representative or anyone who is involved in fraudulent activity to either fabricate or improperly enhance his or her claim. In order for you to receive treatment as a patient, you must have sustained injuries caused by an automobile accident. **Center Spine Care** will not be held liable for any false information provided by you.

II. In certain cases, at the patient's request, we may recommend other medical providers, who based upon own experience and favorable information received from patients, are both capable professional and understand the requirements of proper treatment. This only as a service to our patients. Naturally, all patients are free to seek any medical provider of their choice.

If at any time, you believe that a party or witness in your case is committing a fraud, advise us immediately.

Remember, Insurance fraud hurts all of us by increasing the cost of our insurance and preventing plaintiffs with legitimate claims from receiving fair and just compensation for their claims.

Center Spine Care, LLC.

Under the penalties of perjury, I certify that I have received, read, and understand this important notice and to the best of my knowledge, I declare that all statements are true, correct, and complete.

Patient Name: _____
Patient Signature: _____
Date: _____

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HARDSHIP AGREEMENT

Date: _____

To whom it may concern:

By my signature below, I am requesting that my doctor reduce normal and customary fees charged so as to allow me to receive chiropractic care.

My financial circumstances are such that if I were to pay the customary fees charged, I would be forced (due to economic reasons) no go for chiropractic care.

I recognize that my agreement made to assist me is purely confidential and that my fee agreement would be different than which is standard in the office.

If my insurance company policy demands full payment of deductible or copayment, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship. I have made financial arrangements with my doctor.

Patient Name: _____
Patient Signature: _____
Date: _____