Delran Chiropractic, PA
Chiropractic Physicians & Wellness Center

3001 Bridgeboro Road
Delran, New Jersey 08075
Phone: 856-461-6262
Fax: 856-461-7798
www.polinowellness.com

Vehicle Accident Questionnaire

(please print clearly)

Date:_____
Full Name: _____ Phone: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Social Security #: _____
DOB: _____ Age: _____ Sex: _____ Marital Status: _____ # of Children: _____
Employer: _____ Work Address: _____
Work Phone: _____ Occupation: _____

Insurance Information

Your Insurance Company: _____
Policy #: _____ Claim #: _____
Name of Your Vehicle's Driver: _____
Your Vehicle's Insurance Company: _____ Policy #: _____
Name of Insurance Adjuster: _____ Phone: _____

Accident Information

Give details of how the accident occurred: _____
_____
_____
_____
_____
Date and time of accident: _____ a.m. / p.m.

Please circle applicable options and/or answer the questions below:

Were police notified? Yes No
You were: Driver Passenger in the Front Seat in the Back Seat
Were you using a seat belt? Yes No
Did you lose consciousness? Yes No If yes, how long? _____
Your vehicle was struck from the: Front Back Driver's Side Passenger's Side
Exact area(s) of pain immediately after the accident? _____
_____

Where were you taken after the accident? _____
What treatment and diagnosis was given? _____
_____
Doctor's Name: _____
How often did you see this doctor? _____

If you consulted another doctor, please give name, address, and phone: _____
_____

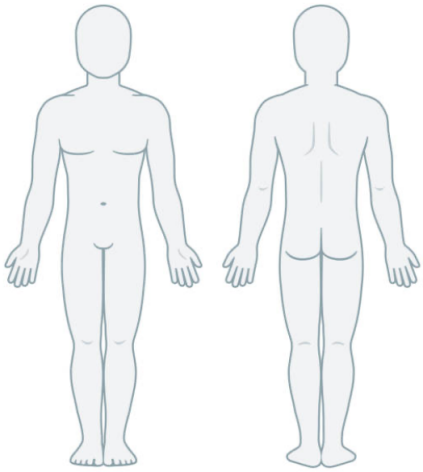
Any prior injuries or symptoms to the same area(s)? _____
If yes, please describe: _____

Have you retained an attorney? _____ If yes, give name, address, and phone: _____
_____

Has injury restricted your work? _____ If yes, in what way(s): _____
_____
Before this injury, were you able to work on an equal basis with others your age? _____
Since this injury, are your symptoms: improving the same getting worse

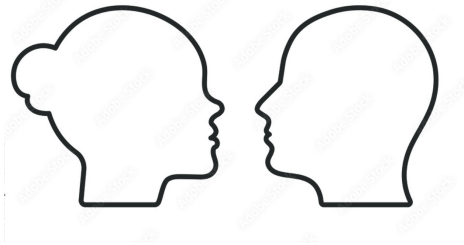
Health Survey

Please describe your injuries and symptoms resulting from this accident:
_____
_____
_____
_____
_____



Mark areas of pain resulting from this accident on the figures at right.

Please circle applicable options and/or answer the questions below:
Patient was: driver passenger other driven by _____
Year, make, and model of vehicle: _____
Was the vehicle stopped? _____
If not, what was the estimated speed? _____
Year, make, and model of *other* vehicle: _____



Time: day night dawn dusk
Road conditions: dry wet
Seatbelt: none not wearing wearing unsure
Did the airbag inflate? Yes No No airbag in vehicle
Head position: Ahead Right Left
Hand position: One on wheel Two on wheel
Brakes on: Yes No
Transmission of vehicle: Automatic Manual

Were you forewarned at all? Yes No _____
What were the movements following the collision: _____
Did any and which part(s) of your body strike the interior? _____
Immediate symptoms? _____
Delayed symptoms? _____
Any prior accidents? _____
Any prior injuries? Head Neck Jaw Low Back Other: _____
Prior Chiropractic care? _____
Any prior disability? _____

Patient Signature: _____ Date: _____

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Electronic Health Records Intake Form

In Compliance with Medicare requirements for the government EHR incentive program

First Name_____ Last Name_____ Zip Code_____

Email Address_____ Cell#_____ Cell Provider_____

Preferred method of Communication for patient reminders (Circle one): Text message / Phone Call

DOB: ____/____/_____ Gender(Circle One): Male / Female Preferred Language: _____

Smoking Status(Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race(Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity(Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

[ ] I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient signature:_____ **Date:**_____

For Office use only

Height:_____ **Weight:**_____ **Blood Pressure:**_____/_____

Patient Acct # _____
Doctor #_____
Reviewed By _____

Oswestry Disability Index for Lower Back Pain

Patient Name:_____ **File #**_____ **Date**_____

Please Read: This questionnaire has been designed to give the doctor information on how your pain has affected your ability to manage everyday life. ***PLEASE ANSWER EVERY SECTION AND MARK IN EACH SECTION ONLY ONE ANSWER*** that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please check just one which most closely describes you

SECTION 1- PAIN INTENSITY

- o I can tolerate the pain I have without pain killers.
- o The pain is bad but I manage without pain killers.
- o Pain killers give me complete relief of pain.
- o Pain killers give me moderate relief of pain.
- o Pain killers give me very little relief of pain.
- o Pain killers have no effect on pain and I do not use them.

SECTION 2- PERSONAL CARE (Washing, Dressing, etc.)

- o I can look after myself normally, without extra pain.
- o I can look after myself normally, but it causes extra pain.
- o It is painful to look after myself, but I am slow and careful.
- o I need some help but manage most of my personal care.
- o I need some help everyday in most aspects of self-care.
- o I do not get dressed: I wash with difficulty and stay in bed.

SECTION 3- LIFTING

- o I can lift heavy weights without causing pain.
- o I can lift heavy weights, but it gives extra pain.
- o Pain prevents me from lifting heavy weights off of the floor, but I manage if they are conveniently positioned.
- o Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are convenient.
- o I can lift light weights only.
- o I cannot lift or carry anything at all.

SECTION 4-WALKING

- o Pain does not prevent me from walking any distance.
- o Pain prevents me from walking more than 1 Mile.
- o Pain prevents me from walking more than ½ Mile.
- o Pain prevents me from walking more than ¼ Mile.
- o I can only walk using a stick/cane or crutches.
- o I am in bed most of the time and have to crawl to the toilet.

SECTION 5-SITTING

- o **I can still sit in a chair as long as I like.**
- o **I can only sit in my favorite chair as long as I like.**
- o **Pain prevents me from sitting more than an hour.**
- o **Pain prevents me from sitting more than a ½ hour.**
- o **Pain prevents me from sitting more than 10 minutes.**
- o **Pain prevents me from sitting at all.**

Total: _____

SECTION 6- STANDING

- o I can stand as long as I want without extra pain.
- o I can stand as long as I want but it gives extra pain.
- o Pain prevents me from standing more than an hour.
- o Pain prevents me from standing more than a ½ hr.
- o Pain prevents me from standing more than 10 min.
- o Pain prevents me from standing at all.

SECTION 7-SLEEPING

- o Pain does not prevent me from sleeping well.
- o I can sleep well only by using tablets.
- o Even when I take tablets, I have less than 6 hours.
- o Even when I take tablets, I have less than 4 hours.
- o Even when I take tablets, I have less than 2 hours.
- o Pain prevents me from sleeping at all.

SECTION 8- EMPLOYMENT/HOMEMAKING

- o Job/homemaking causes no extra pain.
- o Job/homemaking increases pain, but I can still perform.
- o Can perform most duties, pain prevents heavier activity.
- o Pain prevents me from doing anything but light duties.
- o Pain prevents me from doing even light duties.
- o Pain prevents me from doing ANY job/homemaking.

SECTION 9- SOCIAL LIFE

- o My social life is normal and causes no extra pain.
- o My social life is normal but increases the degree of pain.
- o Pain has no significant effect on my life apart from limiting my more energetic interests (dancing, etc.).
- o Pain has restricted my social life and I do not go out as often.
- o Pain has restricted my social life and I do not go out.
- o I have no social life because of pain.

SECTION 10- Traveling

- o I can travel anywhere without pain.
- o I can travel anywhere but with extra pain.
- o Pain is bad but I can manage to journey over 2 hours.
- o Pain restricts me to journeys over 1 hour.
- o Pain restricts me to short necessary journeys less than 30 min.
- o Pain prevents me from traveling except to the doctor or hospital.

Patient Signature_____ **Date** _____

Neck Disability Index

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday -life activities. Please mark in each section the **one box** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **most closely** describes your present -day situation.

Section 1 - Pain Intensity

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

Section 2 - Personal Care

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self -care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

Section 4 – Work

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

Section 5 – Headaches

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

Section 6 – Concentration

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

Section 7 – Sleeping

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

Section 8 – Driving

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

Section 9 – Reading

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

Section 10 – Recreation

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

Patient Name _____ Date _____

Score _____ [50] Benchmark -5 = _____

Delran Chiropractic, PA
Chiropractic Physicians & Wellness Center
REVIEW OF SYSTEM FORM

Name: _____ Date: _____
Tobacco Use: YES/NO How much per day? _____ How Long? _____ Date Quit_____
Alcohol Use: How much per day? _____
Caffeine (Coffee, Teas, and/or Colas): How much per day? _____

PAST ILLNESSES

	Yes	No		Yes	No		Yes	No
Alcoholism			Hepatitis			Phlebitis		
Anemia			High Blood Pressure			Rheumatic Arthritis		
Asthma			High Cholesterol			Stroke		
Cancer			HIV			Thyroid Disease		
Depression			Lung Disease			Tuberculosis (TB)		
Diabetes			Mental Illness			Ulcer in GI Tract		
Drug Abuse			Osteoarthritis			Venereal Disease		
Epilepsy/Seizures			Osteoporosis			Other:		
Glaucoma			Other Immune Disease			Other:		
Heart Disease			Phlebitis					

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)
_____
_____
_____
_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

NERVOUS SYSTEM:	Yes	No
Epilepsy		
Seizures		
Fainting Spells		
Loss of Consciousness		
ADHD		
ADD		
Cerebral Palsy		
Head Injury		
Headaches		
Migraines		
PSYCHOSOCIAL:		
Anxiety		
Depression		
Counseling Service		
Mental Illness		
HEART:		
High Blood Pressure		
Chest Pain		
Angina		
Heart Attack		
Pacemaker		
Mitral Valve Prolapse		
Heart Murmur		
Irregular Heartbeat		
Palpitations		
Skipped Beats		
Heart Surgery		
LIVER:		
Hepatitis		
Jaundice		
Liver Disease		

LUNG:	Yes	No
Asthma		
Hay Fever/Sinus		
Emphysema/COPD		
Shortness of Breath		
Croup		
Bronchitis		
Recent Cold/Cough		
TB		
Pneumonia		
Chew Tobacco		
ANESTHESIA:		
Nausea/Vomiting After		
Family History - Problems		
GI/GU		
Hiatal Hernia		
Stomach Ulcer		
Kidney Disease		
Unexplained Recent Weight Loss/Gain		
Gastric Reflux		
Indigestion		
Motion Sickness		
ENDOCRINE:		
Diabetes		
Thyroid Disease		
Insulin Dependent		
Hypoglycemia		
DENTAL:		
Bridges, Partials, Dentures		
Loose or Missing Teeth		
TMJ		

MUSCULOSKELETAL:	Yes	No
Arthritis		
Painful Stiff Joints		
Prosthesis: _____		
Back Pain		
Metal Implants: _____		
_____		
Physical Limitations: _____		
_____		
BLOOD:		
Bleeding Disorder		
Previous Blood Transfusions		
Eye Glaucoma		
Eye – Other		
AIRWAY:		
Problem Opening Mouth Wide		
Problem Turning Head in Any Direction		
Sleep Apnea		
Snoring		
ALLERGIES:		
Latex		
Medications		
Dyes/Tape		
Shellfish		
Foods		
Loss of Strength		
Numbness		
Headaches		
Tremors		
WOMEN'S HEALTH:		
Pregnant?		

SIGNATURE/REVIEWING PHYSICIAN _____

DELRAN CHIROPRACTIC PA

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN 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. This Notice takes effect 4-14-2003, 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 the 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.

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 health care provider providing treatment to you. Treatment may be administered in an open room format.

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 in connection with our healthcare operations. Healthcare Operations: include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations you may give us 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 person responsible for your care, of 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 professional judgement disclosing health information that is directly relevant to the persons involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies; x-rays, or other similar forms of health information.

Marketing Health-Related services: We will not use your health information for marketing communications without your written authorization for example. (puzzle boards, thank you board)

Required by Law: We may use or disclose your health information when we are required to do so by law.

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 or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as rescheduling rmissed appointments, phone calls, voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice; If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we of our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you received this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. QUESTIONS AND COMPLAINTS. If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your, privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if, you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr Jason Polino DC
Office Telephone: 856-461 -6262
Billing Telephone: 8564616249 contact person: Jeni Polino
Fax 856-461-7798
Address: 3001 Bridgeboro Road
Delran ,NJ 08075

Patient's Signature & Date:_____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Fax: 856-461-7798
www.polinowellness.com

Patient Name: _____
Patient Address: _____

Authorization & Assignment

I hereby authorize my insurance company to make payment directly to Delran Chiropractic, PA the expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee, and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment. If for any reason the insurance company does not pay all or part of my bill, I realize I am responsible for the balance.

Patient Signature: _____
Date: _____

Payment for Professional Service Is Due Upon Receipt of This Statement

I hereby agree to reimburse my insurance company for any amounts of overpayment in excess of amounts payable under this group policy. I hereby authorize any physician, hospital, pharmacy, insurance company, employer, or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim to my insurance company. A photocopy of this authorization shall be as valid as the original.

Patient Signature: _____
Date: _____

Delran Chiropractic, PA
Tax ID: 22-2238792

Delran Chiropractic, PA
Chiropractic Physicians & Wellness Center

3001 Bridgeboro Road
Delran, New Jersey 08075
Phone: 856-461-6262
Fax: 856-461-7798
www.polinowellness.com

Dr. Jason Polino, DC
Dr. Nancy Cillo, DC, CNT

Patient Care — Insurance Agreement

In consideration of your undertaking to care for me, I agree to the following:

1. In the event any insurance company obligated by contractual agreement to make payment to me or you for the charges made for your services refuses to make such payment upon demand by you or does not make payment within 60 days of your billing, I will become personally responsible for that amount. I will have 30 days to clear that account by calling my insurance company after being notified by your office. If the amount is not cleared by 30 days, I hereby authorize you to collect any outstanding amount on my credit card listed below.
2. Any insurance checks that may be forwarded to me for services received at the chiropractic office(s) and not previously paid for will be endorsed by me and turned over to Delran Chiropractic, PA within 5 days of receipt for payment on my account. If I do not clear this portion of my account within 5 days of receipt of said payment, I hereby authorize you to collect the full amount of my account on the credit card listed below.
3. Any balance that is on my account will be paid for and cleared within 30 days of notification of the amount. If a balance remains past 30 days, I hereby authorize you to collect the full amount of my account on the credit card listed below.
4. This clinic does not promise that an insurance company will pay, nor does the clinic promise that an insurance company will or should pay the difference.
5. The clinic will not enter into a dispute with an insurance company over reimbursement or the amount of reimbursement. This is the patient's obligation.
6. All deductible amounts must be paid prior to insurance submittal.
7. Waiting for insurance payment is a courtesy and may be withdrawn at any time.
8. If the patient discontinues care for any reason other than discharge by the doctor, then the bill is due and payable in full *immediately,* regardless of any claims submitted.
9. I also consent to the administration of chiropractic care, diagnostic, and therapeutic recommendations by Delran Chiropractic, PA and its associates. Further, if during the course of care it is determined by the doctor that an additional or different procedure or tests are medically necessary, I consent to do that as well.

Patient Name: _____
Address: _____
Credit Card (circle applicable): Mastercard AMEX Discover VISA
Card Number: _____ Expiration Date: _____ CVC: _____
Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

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Agreement

Whereas, _____, hereafter called Patient, is desirous of obtaining the serviced of Delran Chiropractic, PA, hereinafter called Doctor, for examination, diagnosis, treatment, and prognosis related to an accident or injury which occurred on or about the date of _____.

Whereas, Patient is unable to make cash payments for said services as they are provided.

Now, therefore, for an in consideration of the mutual covenants and agreements contained herein, the undersigned hereby agree as follows:

1. Doctor agrees to provide said services so long as the Patient is being cooperative in the care and treatment being provided.
2. The undersigned Patient agrees that the Doctor shall have a lien on any insurance proceeds, recovery, settlement, judgment, or verdict, which is or may become available as a result of said accident or injury, which the undersigned does hereby assign and transfer to said Doctor with full power and authority to collect said sums to the extent of the amounts of their bills for said services by whatever procedures as may be necessary or appropriate.
3. The undersigned Patient understands and agrees that they are directly and fully responsible to said Doctor for all medical bills submitted by them for services to the Patient and that this agreement is made solely for said Doctor's additional protection and to induce them to provide care and treatment while awaiting payment. It is further understood that such payment is not contingent on any settlement, judgment, verdict, or insurance proceeds by which the Patient may eventually recover said fees and expenses.
4. The undersigned further agrees that a service charge of 1.5% per month on any unpaid balance shall be added to any outstanding balance remaining unpaid after 30 days from the date of treatment. The undersigned further agrees to pay all costs of collection of collection of any such balance including reasonable attorney's fees.
5. A photocopy of this document will be deemed as valid and binding as the original.

I have read and fully understand this agreement and received a copy hereto.

In witness whereof, we have executed this agreement on the _____ day of _____.
Witness Signature: _____
Patient Signature: _____
Doctor Signature: _____

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Irrevocable Assignment of Benefits/Guarantee to Cooperate

In consideration of services rendered or to be rendered to the patient named below, I hereby authorize and assign payment directly to the office of Delran Chiropractic, PA of any and all first party no-fault automobile insurance benefits to which I am otherwise entitled for services rendered by the provider. This medical office, in turn, agrees to comply with the requirements of the no-fault insurance carrier's precertification plan/decision point review plan, and the medical office agrees not to seek to obtain payment from the insured or persons receiving treatment or undergoing medical testing whenever charges have been reduced in accordance with the no-fault carrier's precertification plan.

I authorize, assign, and direct payment of insurance benefits to Delran Chiropractic, PA for monies due on bills which relate to services rendered. I assign, to the above provider's office, the right to prosecute the claim(s) against the insurance carrier that affords benefits, and I agree to fully cooperate with this provider's office's efforts to prosecute a claim against the insurance carrier if there is not timely payment on the claim.

In the event the provider's charges are outstanding and I fail to file an application for benefits under the "State No-Fault Laws," I hereby authorize the providers to file such a claim on my behalf so that the provider may realize payments of its charges. I also authorize the above referenced provider to release any medical information necessary for the use of attorneys, doctors, insurance companies, or collection services.

As part of my assignment of benefits, I specifically request that my insurance carrier forward to the provider copies of any and all reports from independent examiners, peer review doctors, and auditing companies.

Additionally, should I recover any money by virtue of claim or legal cause of action, I hereby assign my right to payment directly to the health care provider named above, and I direct my attorney or other legal representative to honor this irrevocable assignment as a lien on my file or any funds that may be due to me. My attorney or legal representative is hereby authorized and directed to make such payment from the recovery in such claim or action up to the amount due to the above provider so as to be consistent with this assignment. This assignment will also serve as a letter or protection for the provider, which grants the provider the ability to recover outstanding balanced, which are not due to fee scheduling reductions, from any and all settlements I may recover.

I understand that the above assignment may not be revoked or amended without the expressed written consent of the above-mentioned provider. Additionally, by signing this agreement, I fully understand the terms contained within. My signature also represents that I fully understand this agreement if I needed assistance interpreting it. I have not been coerced in any way to give this assignment. If any portion of this form is found to be invalid, the remainder shall remain in effect. A photocopy of this shall be deemed as valid as an original.

Patient Signature: _____ Claim Number: _____
Patient Name: _____ Date of Accident: _____
Date: _____

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To Attorney: _____
_____
_____

Re: _____

I hereby authorize the above doctor to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc., or myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing them for professional services rendered by me both by reason of this accident and by reason of any other bills that are due to their office and to withhold such sums from any settlement, judgment, or verdict as may be necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by them for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of their waiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____
Patient Address: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all of the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary adequately to protect the said doctor named above.

Attorney Signature: _____ Date: _____

Attorney: Please date, sign, and return one copy to the doctor's office at once.
Reply envelope attached.
Keep one copy for your records.

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Authorization for the Release of Records

To: _____
(Name of Doctor or Hospital)

Address: _____

I hereby authorize and request you to release records to:

Dr. Jason Polino, DC
Dr. Nancy Cillo, DC, CNT
AND
Delran Chiropractic, PA
3001 Bridgeboro Road
Delran, New Jersey 08075

Any and all health records in your possession, including:

- Blood work
- Consultations
- CT scans
- Electrodiagnostics
- Emergency room records
- MRI reports and disks
- Police reports
- Xrays

Concerning the undersigned, you may choose either of the following options for sending all health records (please check any/all applicable selections):

- Mail the records to the above address _____
- Fax records to 856-461-5644 _____

Patient Signature: _____ Date: _____
Patient Name: _____
Witness: _____ Relationship:_____