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 ( ) Slip and Fall ( ) Workman's Compensation
Date of Accident ____/____/_____Time ____:____ am / pm
Place: _____
Where were you sitting:
( ) Driver ( ) Front Passenger ( ) Driver-Side Rear ( ) Passenger-Side Rear
( ) Other: _____

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

_____
_____
_____

Please fill in the appropriate spaces:
a.) Side of Impact: ( ) Front ( ) Rear ( ) Driver's Side ( ) Passengers' Side
( ) Other _____
b.) Did you see the crash coming: ( ) Yes ( ) No
c.) Were you braced for impact: ( ) Yes ( ) No
d.) Were you wearing a seatbelt: ( ) Yes ( ) No
e.) Did you lose consciousness: ( ) Yes ( ) No
f.) Did the airbags deploy: ( ) Yes ( ) No
g.) Did police arrive at the scene: ( ) Yes ( ) No
If Yes, was a police report generated: ( ) Yes ( ) No

h.) Did you go to the hospital after the accident: ( ) Yes ( ) No
If Yes, Where: _____
Date of Arrival: ___/___/_____

i.) How were you transported after the accident: ( ) Continued to Destination ( ) Drove Home Myself
( ) Driven Home By Someone ( ) Drove to the Hospital ( ) Driven to the Hospital ( ) Taken by Ambulance

j.) Diagnostic tests performed since accident: ( ) None ( ) X-Ray ( ) CT Scan ( ) MRI ( ) EMG
( ) Ultrasound ( ) Urinalysis ( ) Complete Blood Count ( ) Other _____

k.) Seen other healthcare professionals since accident: ( ) None ( ) Primary Care Physician (medical)
( ) Orthopedic Doctor ( ) Neurologist ( ) Pain Management Doctor ( ) Physical Therapist
( ) Acupuncturist ( ) Massage Therapist ( ) Other: _____

l.) Medication prescribed since accident: ( ) None ( ) Muscle Relaxers ( ) Pain Killers
( ) Anti-inflammatories ( ) Other

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

_____
_____
_____

4.) List dates of all prior Motor Vehicle Accident, Slip/Fall, Worker's Comp injuries:

_____
_____

a.) List all diagnostic tests for these previous accidents & the facility performed

_____
_____
_____

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

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

6.) 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: _____

7. How would you grade your pain on a scale of (1-10) 1 lowest - 10 highest? _____

8. How would you describe the pain?

___ Sharp
___ Spasm
___ Soreness
___ Burning
___ Throbbing
___ Weakness
___ Dull
___ Numbness
___ Stiffness
___ Shooting

9. How often is the pain present? ___ Constant (80%-100%)
___ Frequent (50%-80%)
___ Occasional (26%-50%)
___ Intermittent (25% or less)

10. What makes your problem better?

_____
_____

11. What makes your problem worse?

_____

_____

12. 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 _____/_____/_____

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

Date: _____

Print Name: _____

Records Released: _____

Important Notice

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

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

Patient Signature: _____

Staff Initials: _____

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Brian D. Ryan D.C.

Date: _____

Ins. Co. Address:

_____
_____
_____

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

Patient Signature: _____

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

Policy #: _____

Attention: _____

This notice has been certified to the above Insurance carrier within the **21-day rule**, from the start of treatment, to confirm that _____ had initiated care at our facility on _____ due to injuries which occurred in 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 that you began treatment at our facility.

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

ACKNOWLEDGMENT OF DOCTOR'S LIEN AND PATIENT'S RESPONSIBILITY

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

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

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

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

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

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

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

X_____ Date: _____
(Patient's Signature)

X_____ Date: _____
(Attorney's Signature)

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

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

X_____ Date: _____
(Patient's Signature)

X_____ Date: _____
(Attorney's Signature)

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Calzaretto Chiropractic Center

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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:

_____

Patient's signature

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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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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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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 & 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, & 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 & interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnosis either vertebral Subluxation 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-reguarding 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.

_____ _____
(Signature) (Date

Consent to evaluate & adjust a minor child

I,_____ being the parent or legal guardian of _____ 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: _____

Effective Date: October 14th, 2019

Calzaretto Chiropractic Center

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

Thank you for choosing Calzaretto Chiropractic Center for your health care needs! Our mission is to provide and maintain an excellent physician- patient relationship. Letting you know in advance of our office policies allows for good flow of communication and enables us to achieve our goal! Please read this carefully and if you have any questions please do not hesitate to ask a member of our staff.

Insurance: If you are treating in our office under a health insurance plan (it is a contract between you and your insurance carrier), then it is your responsibility to know the terms contained under your policy regarding coverage, co-pays, co-insurance, deductibles, out of pocket maximums, and any non-covered services. Your most up to date insurance card must be presented to the office on a yearly basis, and if there is a switch in your plan you must alert our office as soon as possible.

INITIAL:_____

Referrals: If a referral is required by your plan to see a specialist be sure to give our office a minimum of 48 hours notice within your initial appointment. You are in charge of contacting your primary care physician to obtain one and our office will alert you when and if you require a renewed referral. There is a $30 fee for failure to provide a timely referral.

INITIAL: _____

Self Pays: All self- pay visits must be paid at the time of your visit. This means if you are on our cash plan or have a co-pay it must be paid the day of your visit, no exceptions. If you keep track of out of pocket expenses for tax purposes or Flexible Spending accounts, please be sure to request a receipt/proof of payment after every visit.

INITIAL: _____

Missed Appointments: Our office has a missed appointment fee of $30 per visit if you do not alert our office 24 hours before your scheduled appointment. This is required for all case types; Health, Auto, Slip & Fall, etc.

INITIAL:_____

Motor Vehicle Accidents: We will bill your motor vehicle insurance or health insurance company (if primary), if you do not have a copy of you motor vehicle insurance card, claim number, and an adjuster name and do not provide one within 48 hours of your initial visit all claims will become patient responsibility and must be satisfied through your settlement process.

INITIAL: _____

Miscellaneous Fees:
$20 short-term disability, FMLA, leave of absence form completion.
$20 minimum for medical letters, miscellaneous.
Medical Records $1 per page – up to 100 pages.
Flexible Spending/ Reimbursement Letter $10.00 minimum

Patient Name (Printed): _____

Patient/ Guardian Signature: _____ Date: _____

Effective Date: October 14th, 2019

Calzaretto Chiropractic Center

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 hours 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: _____