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 out 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 responsile for any balance not pain for by my insurance company. In the event that my insurance carrier forwards payment to me, I am solely responsible to forward that payment to your office within 30 days of receiving payment for treatment rendered.

Signature ______________________________ Date ____/_____/________

Dr. Anthony F. Calzaretto

401 Cooperlanding Rd. Suite C17
Cherry Hill, NJ 08002

Telephone 856-667-0505
Fax 856-667-8083

Date:__________

Re:________________________

____

____

File #: ____________________

This is to certify that the above named individual is employed by:

____

and was injured on:____________________

the injury was documented and reported to: ________________________

Address of employer: ____

____

the employer is aware that the above named individual has chosen this office as his/her health care provider.

Employer's signature:__________________________ Date: ____________

Title:______________________________

WCAUTH.WPS

Dr. Anthony F. Calzaretto

CHIROPRACTOR

401 COOPERLANDING ROAD
C-17 PLAYA DEL SOL
CHERRY HILL, NJ 08002
TELEPHONE (856) 667-0505
FAX (856) 667-8083

PATIENT REQUEST FOR RECORDS AND/OR X-RAYS

DATE________

I, ______________________ hereby authorize the release of my records and/or x-rays.

Transfered to/Initials:	Record/X-ray/MRI	Date Released	Date Returned	Staff Initials

Patient signature: ________________________________

IMPORTANT NOTICE

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

Since these films are legally a part of our permanent office records, do not send the records/films to any other physician or hospital without our release.

Please return these records/film to this office within 30 days of the date above.

Your cooperation in this matter will be appreciated so that we may extend this courtesy to you in the future.

____
Dr. Anthony F. Calzaretto, D.C.

NOTES: ____
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Dr. Anthony J. Calzaretto

CHIROPRACTOR

DOCTOR'S LIEN

TO: ______________________

____

____

RE: MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize the above doctor to furnish you with a report of his examination, diagnosis, treatment, prognosis etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that our due his office and to withhold such sums from settlement, judgment or verdict as may be necessary to adequate 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 which may be paid to you or myself as the result of the injuries for which I have been treated of injuries in connection therewith.

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

DATED: ____________ PATIENT'S SIGNATURE: ______________________

The above undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment pr verdict as may be necessary to adequate protect said doctor above named.

DATED: ____________ ATTORNEY'S SIGNATURE: ______________________

Please date, sign and return one copy to doctor's office as once. reply enveloped attached keep one copy for records.

LIEN.WPS

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CHIROPRACTOR

ASSIGNMENT OF BENEFITS

Insurance Company:

____
____
____
____

I, ______________________________ the insured and/or beneficiary of the policy or policies of the insurance providing medical benefits to me, do hereby authorize you to pay directly to the above named company, medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by you company:

Calzaretto Chiropractic Center
401 Cooperlanding Road, C-17
Cherry Hill, NJ 08002

Tax ID: 22-3772770

Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effective at the time services were rendered. I also authorized the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due if should such sums no be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider for any expenses not covered by the responsible insurance carrier. I realize that I am financially responsible for charges not covered by this assignment. Payment, in whole or part, shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original.

Insured:

____
____
____
____

Claim#: ______________________________

Legal Signature: ____
(If minor, parent or guardian must sign)
Patient's Signature: ____

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Calzaretto Chiropractic Center

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

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 your 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:

- Confirm Massage Appointments
- Send mailings
- Submit 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 diagnosis 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 complete satisfaction.

Therefore, I accept chiropractic care on this basis.

______________________ (signature)   ______________________ (date)

Consent to evaluate and adjust a minor child

I, ______________________ being the parent or legal guardian of ______________________ have read and fully understand the above terms of acceptance and 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 and 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)