PERSONAL INJURY INTAKE FORMS

WE NEED THE FOLLOWING FROM YOU:

1. AUTO INSURANCE CARD
2. HEALTH INSURANCE CARD (IF APPLICABLE)
3. POLICE REPORT
4. DRIVER'S LICENSE

PLEASE WRITE LEGIBLY AND FILL OUT ALL INFORMATION

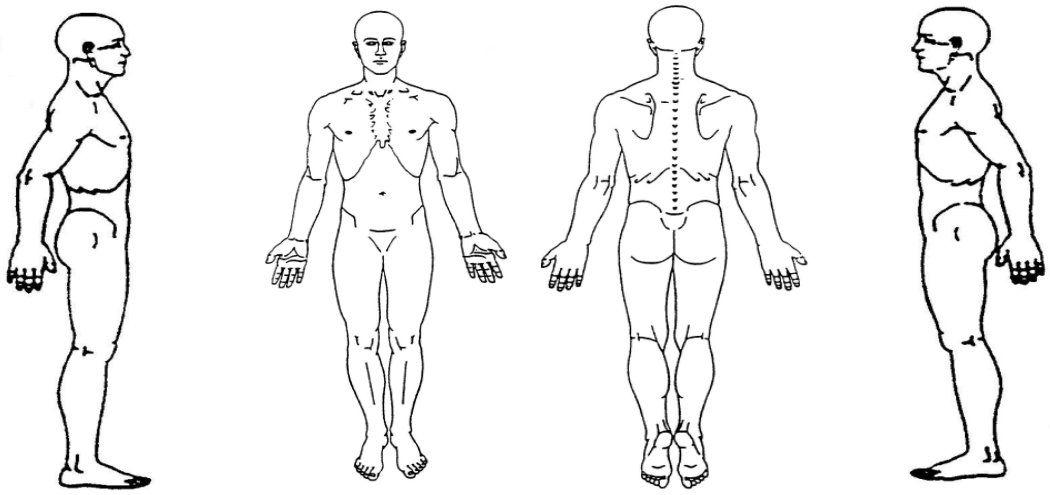
PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ E-Mail: _____
_____ Phone #: _____
_____ Alt Phone #:_____
Birth Date: _____ AT&T Verizon Other:_____
Marital Status: _____ Allow appointment reminders via text? YES or NO
S.S #: _____ Emergency Contact: _____
Preferred method of contact: _____ Phone #: _____

1. Is today's problem caused by:
□ Auto accident □ Work Related Injury □ Other _____

2. Indicate on the drawings below where you have pain/symptoms and how severe EACH problem is (using a scale of 0 – 10 where 10 is the worst):



3. Using a scale from 0 – 10 (10 being the worst), how would you rate each of your problems?
0 1 2 3 4 5 6 7 8 9 10

4. How often do you experience your problems?
□ Constantly (76-100% of the time) □ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time) □ Intermittently (1-25% of the time)

5. How would you describe the type of pain for each problem?

□ Sharp	□ Shooting	□ Sharp with motion
□ Dull	□ Stiff	□ Shooting with motion
□ Diffuse	□ Numb	□ Stabbing with motion
□ Achy	□ Tingly	□ Stabbing with motion
□ Burning	□ Electric like with motion	□ Other _____

6. How are your symptoms changing with time? Please indicate for EACH symptom:
□ Getting worse □ Staying the same □ Getting better

7. How much has each problem interfered with your work?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Very much

8. How much has each problem interfered with your social activities?
□ Not at all □ A little bit □ Moderately □ Quite a bit □ Very much

9. Who else have you seen for your problem(s)?
□ Chiropractor □ Neurologist □ Primary care physician
□ ER Physician □ Orthopedist □ No one
□ Physical Therapist □ Massage Therapist □ Other _____

10. By whom were you referred?
_____

11. Who is your primary care doctor?
_____

12. Do we have your permission to send your primary care doctor reports? □ Yes □ No

13. Do you consider your problem(s) to be severe?
□ Yes □ Yes, at times □ No
If yes, which ones?
_____

14. How long have you had each problem?
_____

15. How do you think each problem began?
_____

16. What aggravates each of you problems?
_____

17. What alleviates (helps) each of you problems?
_____

18. What concerns you the most about each of your problems? What does it prevent you from doing?
_____

19. What is your: Height:_____ Weight: _____
Occupation: _____ Employer: _____

20. How would you rate your overall health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

21. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

22. Indicate if you have immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Cancer □ Heart Problems □ ALS

23. For each of the conditions listed below, place a check or "x" in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check or "x" in the present column.

Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure
□	□	Neck Pain	□	□	Heart Attack
□	□	Upper Back Pain	□	□	Chest Pains / Angina
□	□	Mid Back Pain	□	□	Stroke
□	□	Lower Back Pain	□	□	Kidney Stones
□	□	Shoulder Pain	□	□	Bladder Infection
□	□	Elbow/Upper Arm Pain	□	□	Painful Urination
□	□	Wrist Pain	□	□	Loss of Bladder Control
□	□	Hand Pain	□	□	Prostate Problems
□	□	Upper Leg Pain	□	□	Abnormal Weight Gain/Loss
□	□	Knee Pain	□	□	Loss of Appetite
□	□	Ankle/Foot Pain	□	□	Abdominal Pain
□	□	Jaw Pain	□	□	Ulcer
□	□	Joint Pain/Stiffness	□	□	Hepatitis
□	□	Arthritis	□	□	Liver/Gall Bladder Disorder
□	□	Rheumatoid Arthritis	□	□	General Fatigue
□	□	Cancer	□	□	Muscular Incoordination
□	□	Tumor	□	□	Visual Disturbances
□	□	Asthma	□	□	Dizziness
□	□	Chronic Sinusitis	□	□	Diabetes
□	□	Depression	□	□	Excessive Thirst
□	□	Systemic Lupus	□	□	Frequent Urination
□	□	Epilepsy	□	□	Smoking/Tobacco Use
□	□	Dermatitis/Eczema/Rash	□	□	Drug/Alcohol Dependence
□	□	HIV-AIDS	□	□	Allergies
□	□	Other_____			

For Women Only:

Past	Present		Past	Present	
□	□	Birth Control Pills	□	□	Hormonal Replacement
□	□	Pregnancy			

24. List all prescription medications you are currently taking: _____
_____

25. List all over the counter medications you are currently taking: _____
_____

26. List all surgical procedures you have had: _____
_____

27. What activities do you perform at work?

□ Sit	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Stand	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Computer Work	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Talk on the Phone	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Drive	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Manual Labor	□ Most of the day	□ Half of the Day	□ A Little of the Day
□ Read a Lot	□ Most of the day	□ Half of the Day	□ A Little of the Day

28. What activities do you do outside of work? _____

29. Have you ever been hospitalized? □ No □ Yes
If so, why? _____

30. Have you seen a chiropractor before? □ No □ Yes
If so, who and when? _____

What were the results of your treatment?
□ Great □ Good □ Fair □ Mixed □ Poor □ Other _____

31. Have you had significant past trauma? □ No □ Yes
If yes, describe _____

32. Have you had a non-fasting cholesterol test in the last 5 years? □ No □ Yes
If yes, when? _____

33. Have you had an influenza vaccination this year? □ No □ Yes
If yes, when? _____

34. Have you been screened for colon cancer? □ No □ Yes
If yes, when? _____

FEMALES
35. Are you up to date on your PAP SMEARS? □ No □ Yes
If yes, when was the last? _____

MALES
36. Have you been screened for prostate problems? □ No □ Yes
If yes, when? _____

37. Is there any other information pertinent to your visit today? _____
_____
_____

Patient Signature: _____ Date: _____

NECK DISABILITY INDEX

This questionnaire helps us to understand how much your **neck pain** has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem right now.

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 (Washing, Dressing, etc.)

- ☐ 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 extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want with no pain in my neck
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all due to pain.

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 when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 - Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can not do any work at all.

SECTION 8 - Driving

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

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

REVISED OSWESTRY INDEX

This questionnaire helps us to understand how much your low back has affected your ability to perform everyday activities. Please check the one box in each section that most clearly describes your problem now.

SECTION 1 - Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderately increasing
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 - Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one mile without increasing pain.
- ☐ I cannot walk more than ½ mile without increasing pain.
- ☐ I cannot walk more than ¼ mile without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 - Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain immediately.

SECTION 6 - Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain standing, but it does not increase with time.
- ☐ I cannot stand for longer than 1 hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

SECTION 7 - Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain, my normal night's sleep is reduced by less than ½.
- ☐ Because of pain, my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing . . .
- ☐ Pain has restricted my social life and I do not go much.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

SECTION 9 - Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain prevents all forms of travel except done lying down.
- ☐ Pain restricts all forms of travel.

SECTION 10 - Changing Degrees of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but slowly improves.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

MVA Information Form

1. What was the date of the accident? _____

2. What time did the accident occur? _____

3. How many vehicles were involved in the accident? _____

4. What was the estimated damage to the vehicle you were in? _____

5. What street or intersection were you on/at when the accident occurred? _____

_____

6. In what direction were you traveling? _____

7. In what city did the accident occur? _____

8. In what state did the accident occur? _____

9. What type of impact was the auto accident? _____

10. Did your vehicle hit anything after the accident? _____

If yes, please describe: _____

11. Where were you sitting in the vehicle during the accident? _____

12. Did you know the accident was going to happen? _____

13. What type of vehicle were you in? _____

14. What type of vehicle(s) impacted yours? _____

15. At the time of impact, how fast was your vehicle moving? _____

16. At the time of impact, how fast was the other vehicle moving? _____

17. During and after the crash, what happened to your vehicle? Check all that apply

□ Kept going straight □ Spun around □ Hit a stationary object □ Stopped

□ Kept going straight, hitting a car in front □ Was hit by another vehicle □ Rolled over

□ Was hit by another vehicle □ Other _____

18. Did you lose consciousness during the accident? □ Yes □ No

19. Did your head hit anything during the accident? □ Yes □ No

If yes, please describe: _____

20. Did your face hit anything during the accident? □ Yes □ No

If yes, please describe: _____

21. Did your shoulders hit anything during the accident? □ Yes □ No

If yes, please describe: _____

22. Did your chest hit anything during the accident? □ Yes □ No

If yes, please describe: _____

23. Did your knees hit anything during the accident? □ Yes □ No

If yes, please describe: _____

24. Did you have your seatbelt on during the accident? □ Yes □ No

25. Did you slide out of your seatbelt during the accident? □ Yes □ No

26. What was damaged in/on your vehicle? Circle all that apply

□ Windshield □ Steering Wheel □ Dashboard □ Seat Frame

□ Side Window □ Rear Window □ Rear Bumper □ Front Bumper

□ Trunk □ Front Left Door □ Front Right Door □ Side Mirror(s)

□ Back Left Door □ Knee Bolster □ Completely Totaled □ Hood

□ Other: _____

27. Choose the door(s) (if any) that would not open as a result of the accident:

□ Front Left □ Front Right □ Rear Left □ Rear Right

28. Did you go to the hospital? If yes, answer questions 38-43. If no, why? _____

_____

29. How did you get to the hospital? _____

30. What hospital did you go to? _____

31. How long were you hospitalized? _____

32. Where you prescribed either pain medications or muscle relaxers at the hospital? If yes, please indicate which.

_____

33. Did you receive any stitches for any cuts at the hospital? _____

34. Did you receive any of the following:

□ Cervical Collar □ Back Brace □ Both □ Neither

35. Were x-rays taken at the hospital? If yes, of what area(s)? _____

36. Was an MRI performed at the hospital? If yes, of what area(s)? _____

37. Where any special images performed at the hospital? If yes, what of? _____

_____

38. Have you had any similar injuries/illnesses which relate to this case? If yes, please describe: _____

_____

39. Do you give our office permission to request/receive medical records from any other offices/facilities in regards to this injury?

□ Yes □ No

40. Do you have a lawyer/attorney representing you? □ Yes □ No

If yes, please provide their name, address and phone number. If this information is NOT provided,

_____

_____

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS / LIMITED POWER OF ATTORNEY / RELEASE OF RECORDS

ASSIGNMENT:

I irrevocably assign to you, my medical provider, **Contino Chiropractic Center**, 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. 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 medical provider, I agree to comply with the PIP carrier's decision point review/precertification 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 any 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.

_____	_____
Patient Signature	Date
_____	_____
Printed Name	Claim Number
_____	_____
Auto Insurer	Date of Accident

NEW PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATION

I, _____, understand that as part of my health care, Contino Chiropractic Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plan for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and/or surgical information to my bill
- A means by which a third-party payer can verify the services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information, uses and disclosure. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Contino Chiropractic Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Contino Chiropractic Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Contino Chiropractic Center change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S Mail or, if I agree, E-mail).

I wish to have the following restrictions on the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile.

I fully understand and accept/decline the terms of this consent.

_____ _____

Patient Signature Date

Patient's Name: _____

Patient S.S #: _____ Birth Date: _____

AUTHORIZATION TO PAY PHYSICIANS FEES/VOLUNTARY PHYSICIAN LIEN

Patient's Name:
_____

Patient's S.S. #: _____ Date of Accident:_____

I understand that services which I may receive are intended to assist me with my painful condition. I agree that this is fair and proper for my doctors to receive their usual fee for the procedure(s) with which they provide me. I understand that the doctors are willing to bill my insurance carrier(s) for balances until settlement of my liability case. Even though they may have to wait several months to be paid, they are willing to wait without charging me interest or late fees for delays in payment. The purpose of this agreement is to assure that both my attorney and I agree that, if I am successful in obtaining a monetary settlement from a liability case, the doctor's fees will be paid immediately after my attorney receives his fee, under the applicable statuses and/or administrative codes of the State of New Jersey, in which I reside.

Therefore, I hereby provide an irrevocable lien to Jeffrey T. Contino, D.C of Contino Chiropractic Center referred to as "PROVIDER", against any settlement judgement and/or arbitration award arising out of this or any accident case I have or may have in the future. I further agree not to rescind this agreement. The "PROVIDER" relies upon the terms of this agreement in furnishing his services. The consideration for my executing this agreement is for the treatment rendered by the "PROVIDER".

This agreement is binding upon me, my attorney and any successor attorney. I request that you notify any successor attorney of this lien. Additionally, I authorize and direct my attorney(s) to execute his (their) signature(s) to this agreement honoring same as a lien on the proceeds for this or any accident case that I may have. I further direct my attorney(s) to pay the "PROVIDER" and their assignees, their fees first, after the attorney's fee(s) from any proceeds due to me from this or any accident case in which I am involved. All professional fees are to be paid to the "PROVIDER" directly within thirty-one (31) days after receipt of the settlement funds and without regard to any action that I may institute against my insurance carrier(s) to pay the bills. I understand that, if my attorney signs and returns this form, the "PROVIDER" is willing to provide me with an interest free loan so that I may receive treatment for my painful condition. On the other hand, if payment is not made to my "PROVIDER" with in thirty-one (31) days of receipt of my settlement proceeds, I understand that I will be assessed service charges and interest at 1 ½% per month beginning with the date of the first service and for each month the charges remain 30 days overdue.

Professional services include those made for examination or treatment rendered as well as those for medical reports, consultations, depositions and court appearances on my behalf, and charges I may incur for late or broken appointments, where adequate notice was not given by me.

I understand that I am FULLY RESPONSIBLE to the "PROVIDER" for any bills which I may incur, regardless of whether there is a full or partial monetary recovery settlement, arbitration or any legal proceeding. I understand that if my attorney does not wish to cooperate in protecting the "PROVIDER'S" fees, I will be required to pay for treatment AT THE TIME OF EACH VISIT. A copy of this form shall be considered equivalent to the original.

If any portion of this agreement is declared invalid by a court of law, those portions not declared invalid shall remain in force and effect.

I hereby authorize that this agreement, as well as all medical information, reports, etc., with reference to injuries I sustained in any accident, be sent to _____, my attorney of record.
I HAVE REVIEWED THE CONTENTS WITHIN WITH THE PATIENT AND WITNESS HIS/HER SIGNATURE

_____ _____
WITNESS SIGNATURE DATE

I HAVE READ, UNDERSTAND, AND AGREE WITH THE FOREGOING DOCUMENT

_____ _____
PATIENT SIGNATURE DATE
(Guardian Signature if Patient is a Minor)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

Patient S.S #: _____ Birth Date: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:
   CONTINO CHIROPRACTIC CENTER

3. The type and amount of information to be used or disclosed is as follows:
   a. Problem list
   b. Medication list
   c. List of allergies
   d. Laboratory results
   e. X-Ray and imaging reports
   f. Consultation reports
   g. Entire Record
   h. Other: _____

4. I understand that the information in my health records may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual(s) or organization(s):
   Jeffrey T. Contino, D.C
   Contino Chiropractic Center
   174 W. Commerce Street
   Bridgeton, NJ 08302

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, I need to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact Jeffrey T. Contino, D.C of Contino Chiropractic Center.

_____ _____
Patient/Legal Representative Signature Date

_____
If Signed by Legal Representative, State Relationship to Patient

PREFERRED METHOD OF CONTACT

I, _____, hereby consent and state my preference to have my physician, Dr. Jeffrey T. Contino, and other staff at Contino Chiropractic Center communicate with me by email, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email messaging is not a confidential method of communication and may be insecure. I further understand that, because of this, there is a risk that email messages regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number_____

Email_____

I give permission to contact me, relative to appointment reminders only, by the following methods:

Phone message at the following number_____

Email messages at the following email address_____

New Jersey Application for Benefits
Personal Injury Protection

Name
Address 1
Address 2
Address 3

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Date	Type of Claim	Date of Accident	Claim Number

Your Name	Gender M / F	Phone Nos.: Home Business

Your Address (No. & Street, City/Town, State & Zip Code	Date of Birth	Social Security No. (if none, enter "none"

Your Previous Address

Date of Accident	Time of Accident ☐ AM ☐ PM	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you or any member of your household own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____

Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury:

Were you treated by a doctor? Yes ☐ No ☐	Doctor's Name and Address
If you were treated in a hospital, were you an In-patient? ☐ Out-patient? ☐	Hospital's Name and Address

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $_____	What is your average weekly wage or salary? $_____

Your lost wages: Date disability from work began: _____ Date you returned to work: _____

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side .

Signature: _____ Date: _____

Do Not Detach
Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Do Not Detach
Authorization for Wage Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____
Social Security No.: _____

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."