COVID-19
ACTIVE SCREENING QUESTIONNAIRE

This will be updated as the CDC and WA State Health Department's information on COVID-19 continues to change.

Your health and well-being are of the upmost importance and we are taking measures to keep the facility/office a safe environment for employees as well as the individuals under our charge and the public. Therefore, anyone coming into the facility/office will be screened and part of our screening process will include taking their temperature and asking the following questions.

1. Within the last 14-days, have you experienced a new cough that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

2. Within the last 14-days, have you experienced new shortness of breath that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

3. Within the last 14-days, have you experienced a new sore throat that you cannot attribute to another health condition?
   - ☐ YES
   - ☐ NO

4. Within the last 14-days, have you experienced new muscle aches that you cannot attribute to another health condition or a specific activity such as physical exercise?
   - ☐ YES
   - ☐ NO

5. Within the last 14-days, have you had a temperature at or above 100.4° or the sense of having a fever?
   - ☐ YES
   - ☐ NO

6. Within the last 14 days, have you had close contact, without the use of appropriate PPE, with someone who is currently sick with suspected or confirmed COVID-19?* *(Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes)*
   - ☐ YES
   - ☐ NO

If the individual answers YES to any of the questions they will not be allowed into the facility/office unless determined otherwise by a designated DOC medical professional.

**Facilities identified as being at critical staffing levels in health services may have healthcare workers authorized by the HQ Emergency Operations Center to enter the facility under the following guidelines:*

- *As long as they remain asymptomatic;*
- *Self-monitor symptoms as outlined in the guidance; and*
- *Wear a surgical mask at entry and at all times while on facility grounds.*

REVISED 3/30/2020

CHIROPRACTIC

TO THE PATIENT:

A Durable Limited Power of Attorney is a document which allows this office to initiate the collection procedures. This includes litigation (if necessary) in the name of the patient directly against the insurance company when it is believed that the insurance company has wrongfully denied coverage or otherwise failed to pay a medical bill in accordance with the terms of the insurance policy, within the time frame required. In those circumstances, when an insurance company has ignored this office's request for payments, has ignored an Assignment of Benefits, has failed to pay in a timely fashion, or has simply not communicated, this Power of Attorney gives this facility the right to start collection and/or litigation procedures under the patient's name. This document does not mean that the patient will have to pay any attorney fees. The Power of Attorney is "limited", which means that the only right given to this office is the right to attempt to get paid directly from the insurance company; of which is supposed to pay the bill. No other rights are given to this office. The patient maintains all his/her rights of privacy. The patient maintains the right to bring a lawsuit on his/her own for any reason such as personal injury, etc. The signing of this document assists this office in collection procedures which would otherwise have to be initiated against the patient. However, patient cooperation is still needed when such collection efforts are required.

Cherry Hill
1807 Springdale Road
Cherry Hill, NJ 08003
856.424.2251
Fax 856.424.9225

Blackwood
1504 Blackwood Clementon Rd.
Blackwood, NJ 08012
856.401.8100

CHIROPRACTIC

ASSIGNMENT OF RIGHT OF ACTION

I, _____ do hereby assign any right of action that I may have. against _____, my PIP insurance company, to Caring Chiropractic for the non-payment of my medical bills arising from the injuries I sustained in an automobile accident that occurred on, _____.

I further authorize Caring Chiropractic to institute a suit against my insurance company in my name to recover medical fees, which shall include but not be limited to the filing of a PIP claim in the Superior Court of New Jersey, the Court of Common Pleas of the Commonwealth of Pennsylvania, or any court of arbitration in any court of arbitration in any appropriate forum, using an attorney of their choice. I acknowledge the Caring Chiropractic would be pursuing any claims on my behalf; however, this does not negate my primary responsibility to pay Caring Chiropractic the full value for services and/or equipment over, above, and recovery against the insurance company.

_____ _____

Signature Date

_____ _____

Witness Date

caring
CHIROPRACTIC

Caring Chiropractic

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Cherry Hill, NJ 08003
856.424.2251
FAX – 856.424.9225

21 DAY NOTIFICATION

Date: _____

Insurance Name and Address:

_____

_____

_____

_____

RE: Patient: _____

Date of Accident: _____

Claim #: _____

To Whom It May Concern:

Please be advised that the above-named patient has started treatment at our facility on _____ and seeks to assign they're under the applicable policy of automobile insurance to our office. We request your consent to accept this assignment of benefits. If you have any objection to this request, kindly advise, in writing within 5 business days. If our office does not receive a written response in 5 business days regarding this notice, we shall deem said inaction as your consent and proceed accordingly.

All reports and bills will be sent to you in a timely fashion.

If you have any questions, please contact our office at 856.424.2251 and ask to speak with either Kathy or Michael.

Sincerely Yours,

Dr. Frank Ciala, D.C.

CHIROPRACTIC

Caring Chiropractic

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Durable Limited Power of Attorney

KNOW ALL MEN BY THESE PRESENCE:

That I, _____ referred to herein as PRINCIPLE, designate my medical provider, Caring Chiropractic to be my Attorney In Fact and AGENTS (here and after called AGENT) for the following purposes:

1. **General grant of power under any applicable automobile Personal Injury Protection Policy**

To exercise any act, power, right or entitlement whatsoever that I now have or may hereafter relating to my automobile insurance policy, or any automobile insurance policy relating to or in any way pertaining to my right to Personal Injury Benefits (hereinafter called PIP benefits) which in any way may arise or be claimed to have arisen out of my motor vehicle accident of _____. I grant to my AGENT full power and authority to do everything necessary in exercising any of the powers herein granted as fully as I might or could do if personally present, irrevocably ratifying and confirming all that my agent shall lawfully do or cause to be done by virtue of the Power of Attorney and powers herein granted:

(a) Powers of Collection and Payment: to request, demand, do for, recovery, collect, receive, all such sums of money, debts, dues, commercial paper, checks, drafts, accounts, deposits, notes, insurance and other contractual benefits and proceeds, and demands whatsoever, liquidated or unliquidated, now or hereafter owned by me, or due, owing, payable but belonging to me in which I have or may hereafter acquire an interest as against any and all automobile insurance carriers responsible for payment of First Party PIP benefits arising out of or claimed to have arisen out of my motor vehicle accident of _____, and to have, used, and take all lawful means and equitable and legal remedies and proceedings in my name for the collection and recovery thereof, and to adjust, compromise and agree for the same, and to execute and deliver for me, on my behalf, and in my name, on endorsements, releases, receipts or other sufficient discharges for the same;

(b) Legal Representation: To obtain counsel to pursue in my name litigation and/or arbitration through the appropriate forum including

Caring Chiropractic

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CHIROPRACTIC Cherry Hill, NJ 08003
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(c) the Superior Court of New Jersey, The National Arbitration Forum or alternative dispute resolution, in any forum allowed by law, a resolution of any disputes arising out of entitlement to all First Party Benefits against those automobile insurance companies which may be deemed responsible or claimed to be responsible for First Party Benefits;

(d) Investigation: To investigate, obtain and subpoena and all necessary documents, depositions including sworn statements needed to be obtained to appropriately prosecute after said PIP claims both before and after initiation of litigation.

2. **Interpretation and Governing Law:**

This instrument is to be construed and interpreted as a General Durable Power of Attorney. In consideration of the services provided by my attorney in fact, this power of attorney is to be considered irrevocable. This instrument is executed and delivered in the State of New Jersey and laws of the State of New Jersey shall govern all questions of validity of this Power and the construction of its provisions.

3. **Third Party Reliance**:

Third parties are directed to rely upon the representation of my AGENT as to all matters to any Power granted to my AGENT. Any third party may rely on a duly executed counterpart of this instrument, or a copy certified by my AGENT to be true and correct copy and original hereof, as filled in completely as if such third party had received the original of this instrument.

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4. **Effective Date:**

The provisions of this Power of Attorney which consists of three (3) pages, shall be effective upon the date of the execution as indicated here and after, it being my intention that all Powers conferred upon my attorney in fact herein or any substitute designated by me shall become effective upon the date of said document. The provisions of N.J.S. 45:2B-8 authorize me to provide that this Power of Attorney shall not be affected by my disability as PRINCIPLE, and I do hereby certify, it being my intention that al POWERS conferred upon my attorney in fact herein or any substitution designated by me shall remain in full force and effect not withstanding my incapacity or disability, or any uncertainty with regards to it.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to the provider upon receipt of the same. It is understood and agreed that should the undersigned patient not forward any benefits to the provider, the provider does maintain the right to request said checks from the patient and initiate all collection efforts. If such action is taken by the provider, the undersigned agrees to be responsible for all benefit checks received, plus all collection costs incurred including attorney fees and Court costs.

PATIENT **DATE**

WITNESS **DATE**

caring
CHIROPRACTIC

ASSIGNMENT OF BENEFITS

I, _____, the insured and/or beneficiary of the policy of policies of

_____ Insurance Company providing medical benefits to me, do hereby authorize you to pay directly to **CARING CHIROPRACTIC, D.C./FRANK J. CIALA, DC**, medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company:

Payment is authorized upon receipt of the itemized statement for the services rendered. This policy was in full force and effect at the time services were rendered. I also authorize 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 it, should sums not 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, including attempting any type of Deposition, Arbitration, or Court proceeding. I understand that if I fail to cooperate with legal Counsel, I may be held personally responsible to the medical provider for any expenses not covered by this assignment. Payment, in whole or in 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.

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by the provider. I hereby agree to immeadiatly forward said checks to the provider upon receipt of the same. It is understood and agreed that should I not forward any benefits to the provider, the provider does maintain the right to request checks from me and initiate any and all collection efforts. If such action is taken by the provider, I agree to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and Court costs.

I irrevocably assign to above company or provider all rights and benefits under any insurance contracts for payment of services rendered to provider. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by provider to be released to provider. I irrevocably authorize provider to file insurance claims on my behalf for services rendered to me. I irrevocably authorize provider to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

POLICYHOLDER: _____

CLAIM NUMBER: _____

CLAIMANT: _____

ADDRESS: _____

LEGAL SIGNATURE: _____

PATIENT SIGNATURE: _____

DATE: _____

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

IMPORTANT:

1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE AUTHORIZATION (S) ON PAGE 2.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

INSURANCE COMPANY INFORMATION

Claim Number:	Policy Number:	Date of Accident:
Our Policyholder:	Claim Representative:	

INJURED PERSON'S INFORMATION

Name:	Date of Birth:
Street Address:	Social Security No.:
City, State, Zip:	Home Phone:
Address on Date of Accident (If different from current address)	Business Phone:
Street Address:	Driver's License No:
City, State, Zip:	

Do you or any member of your household own or lease an automobile? Yes ☐ No ☐

Please describe any automobiles in your household that are not listed on this policy (use back if additional space is needed):

Year, Make & Model: _____

VIN: _____

Owners Name: _____

Relation to injured party: _____

Insurance Company: _____

Policy Number: _____

Were you the Driver of the Vehicle? Yes ☐ No ☐

Were you a Passenger in the Vehicle? Yes ☐ No ☐

Were you a Pedestrian? Yes ☐ No ☐

Were you a Resident Relative of the Automobile Owner's Household? Yes ☐ No ☐

(If, YES - Identify that Relationship)

_____

Please list any residents of your household and include their age and relationship to you.

Are you Married? Yes ☐ No ☐	If Yes: Spouse's Name:

ACCIDENT INFORMATION

Accident Date:	Street Address:
Accident Time: AM ☐ PM ☐	City or Town, State:

Brief Description of Accident.

INJURY INFORMATION

As a result of this accident, were you injured: Yes ☐ No ☐

If you answer is YES, complete the rest 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 ☐	Were you were treated in a hospital? Yes ☐ No ☐
Treating Doctor:	If Yes, were you an in-patient? ☐ Or out-patient? ☐
Street Address:	Hospital Name:
City, State, Zip:	Date of Hospital Treatment/Admission:
Phone:	

Have you ever had a similar injury? Yes ☐ No ☐

(If Yes, please describe- Type of accident, injury, approximate date of loss and all medical providers).

EMPLOYMENT INFORMATION

At the time of the accident, were you performing a job duty? Yes ☐ No ☐	If yes, have you filed a Workers Compensation Claim? Yes ☐ No ☐
Workers Compensation Carrier :	Claim Number / Adjusters Name: Employers Name:

Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount lost to date: $

What is your average weekly wage or salary? $

If you lost wages, date disability from work began:	Date you returned to work:

Have you filed for or are you eligible for, payments under:

Employees Disability Benefits, through a private plan? Yes ☐ No ☐

State Temporary Disability Benefits? Yes ☐ No ☐

List Names and Address of your Employer.

Employer & Address	Occupation	From:	To:

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Injured Person: _____ Date: _____

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. This authorization shall remain valid for the duration of the claim.

SIGNATURE _____ **DATE** _____

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the PERSONAL INJURY PROTECTION BENEFITS LAW. This authorization shall remain valid for the duration of the claim.

SIGNATURE _____ **DATE** _____

FRAUD PREVENTION NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

CHIROPRACTIC

HEALTHCARE AUTHORIZATION FORM

Patient's Name: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES ***(Caring Chiropractic)*** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS

☐ I give permission to **(Caring Chiropractic)** to use my address, phone number and clinical records to contact me with birthday cards, holiday related cards, emails, and/or text messages as well as information about treatment alternatives or other health related information.

(OPEN ROOM AUTHORIZATION - OPTIONAL)

☐ I give **(Caring Chiropractic)** permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of my care. Should I need to speak with the Doctor at any time in private, the Doctor will provide a room for those conversations.

☐ By signing this form you are giving **(Caring Chiropractic)** permission to use and disclose your protected health information in accordance with the directives listed above.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of **[Caring Chiropractic]**. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request;
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **(Caring Chiropractic)** for its own use/disclosure of protected health information. ***(Minimum necessary standards apply.)***

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, **(Caring Chiropractic)** will NOT refuse to provide treatment.

You have the right to inspect or copy the protected health information to be used/disclosed.

_____

Name of Patient

_____ _____

Signature of Patient Date

_____ _____

Signature of Personal Representative Date

_____

Description of Representative's Authority to act for Patient

caring CHIROPRACTIC

ACCIDENT REPORT

Patient Name | Initial Consultation Date | Birth Date

Address | City | State | Zip

Insurance Company

Address | City | State | Zip

Policy # | Employer

Date of Accident | Time

Where did accident occur?

How did accident happen?

How were you hurt?

Were you unconscious?

Where were you taken after the accident?

What was done for you there?

Did you return to work? | If so, when and to what kind of work?

How long were you off work? | What treatments did you receive?

Date of Disability: From To

Name of Doctor:

What medication did you take?

Are you still taking medication? | If so, how often and how much?

Are you still receiving treatments? | If so, what kind and how often?

Have you seen any other doctors? | If so, list names and when they were seen:

What were you told was wrong with you?

What are your present complaints?

Are you doing the same kind of work you were doing at the time of injury?

If not, state when you discontinued doing your regular work, what you are doing now, and when you started:

Have you ever had surgery? | If so, give date(s) and condition(s):

What illnesses have you had?

Have you had any previous accidents?

If so, state how you were injured, how long you were off work, what treatments you received, and what problems, if any, you have as a result of the injuries:

Attorney Name | Name of Insured

Address | Address

Telephone

CARING CHIROPRACTIC, PC

PATIENT INTAKE FORM

PATIENT INFORMATION		
Name:		
Date of birth:	SSN:	
Address:		
City:	State:	ZIP Code:
Phone #:	Cell #:	Sex: M or F (circle one)
Email:		May we contact you via: TEXT EMAIL
Marital Status: S M D W	# of children:	
Is your condition related to an accident? Y or N	What type of accident? MVA W/C Slip & Fall Other	Date of accident: (if applicable)

INSURANCE INFORMATION		
Primary Insurance:		
Address:		
City:	State:	Zip:
Phone #:	Policy #:	Group #:
Claim # (if accident):		
Secondary Insurance:		
Address:		
City:	State:	Zip:
Phone #:	Policy #:	Group #:
Claim # (if accident):		
Attorney (if applicable):		Phone #:
Address:		
City:	State:	Zip:

EMERGENCY CONTACT INFO		
Name:		
Relationship to you:		Phone:
Address:		
City:	State:	ZIP Code:

HEALTH INFORMATION

Have you ever had previous chiropractic care? YES NO
What is your major complaint? _____
How long have you had this condition? _____
What aggravates your condition? _____
Is this condition getting progressively worse: YES NO Constant Comes & Goes
Is this condition interfering with your: Work Sleep Daily Routine Other
How long has it been since you really felt good: _____
Other doctors who have treated this condition: _____
List surgical procedures and dates: _____
_____
Drugs you now take: -Anti-Depressants -Pain Killers -Muscle Relaxers -Energy Drinks/Stimulants -Anxiety
Age of mattress: _____ -Comfortable -Uncomfortable
Are you wearing: -Heal Lifts -Sole Lifts -Inner Soles -Arch Supports
Have you ever been in an auto accident: - Past Year -Past 5 Years -Over 5 Years -None
Have you ever had any other personal injury or accident? - Past Year -Past 5 Years -Over 5 Years -None
Do you Diet? YES NO If so explain:_____
Do You Exercise? YES NO If so how much:_____

CARING CHIROPRACTIC, PC

PATIENT INTAKE FORM

EMPLOYER INFORMATION		
Employer Name:		
Address:		
City:	State:	ZIP Code:
Phone #:		
Occupation:		

CARING CHIROPRACTIC, PC

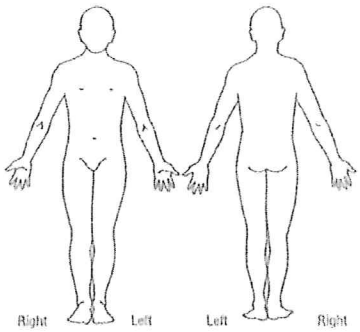
PATIENT INTAKE FORM

ACCIDENT DETAILS

Where did the accident occur?	
How did the accident happen?	Were you unconscious: YES NO
How were you hurt?	
Where were you taken after the accident?	
What was done for you there?	
Name of Doctor:	
What medication were you given?	
Are you still taking the medication? YES NO	If so, how often and how much?
Have you seen any other doctors? YES NO	If so, name and phone #:
What was told was wrong with you?	
What are your present complaints?	
Have you ever had surgery? YES NO	If so, give date(s) and condition(s):
Any ongoing/chronic illnesses?	

HEALTH QUESTIONAIRE AND PAIN LEVELS

Please mark your areas of pain:



Please rate your discomfort for each area:
(0=no pain 10= severe pain)

Neck/Shoulder Pain =
Mid Back Pain =

Low Back and Leg Pain =

Have you ever suffered from:	YES	NO
Dizziness or Fainting		
Blood in urine or stool		
Chest Pain		
Abdominal Pain		
Inability to hold urine or bowel		
Blurry Vision		
Pain at Night		
Difficulty Breathing		
Spitting up blood		
Bruise easily		
Cancer		
Digestion Problems		
High Blood Pressure		
Diabetes		

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that I suspend or terminate my care and treatment; any fees for professional services rendered me will be immediately due and payable.

We at this office are dedicated to providing you with the finest care possible. However, in order for us to best treat your condition, your cooperation is necessary. When the doctor prescribes a treatment schedule, it is for your maximum benefit and these appointments must be kept. Please understand that missed appointments yield less than ideal results and hinder your progress toward recovery. Should you miss a scheduled appointment, we ask that the appointment be made up within the same week. Persistent failure to keep scheduled appointments may result in our having to document non-compliance on the part of the patient, notification to your attorney, if represented, or possible discharge before recovery has been attained. I acknowledge that I have read the above, and will make a concerted effort to comply with any prescribed treatment schedule.

I have read and hereby state that everything written above is true and correct.

Patient Signature:	Date
Guardian/Parent Signature:	Date