CHIRO WORX CHIROPRACTIC AND WELLNESS STUDIO

714 Scotland Road, Orange, NJ 07050

Todays Date:_____/_____/_____

Name: _____

Ss#: _____-_____-_____ **Sex:** □M □F **D.O.B**_____/_____/____

Address:_____

City: _____ **State:**_____ **Zip:**_____

Home: (_____) _____-_____ **Cell:** (_____)_____-_____

Employer: _____**Occupation:**_____

Workphone: (_____) _____-_____

Emergency Contact: _____

Phone: (_____) _____-_____ **Relationship:** _____

Health Insurance: □Yes□No, **Plan:** _____

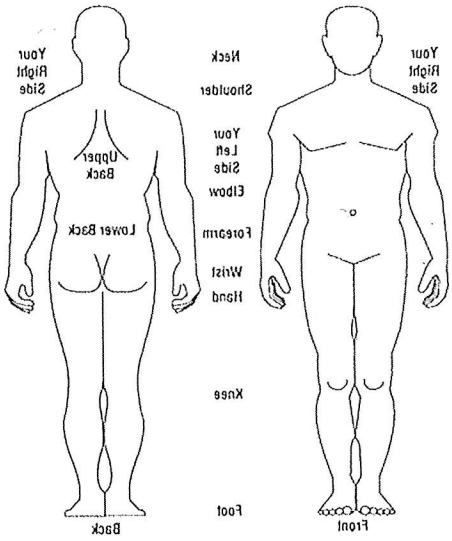
Member I.D_____ **Group#:** _____

□Headaches/Migraines □Multiples Sclerosis □Other _____

HOW CAN WE HELP YOU?

WHAT BRINGS YOU IN TODAY _____

WHEN _____



What does the pain feel like?

□*Sharp* □*Numbness* □*Throbbing*
□*Dull* □*Aching* □*Shooting*
□*Burning* □*Tingling,* □*Cramps*
□*Stiffness* □*Swelling* □*Other*

Severity of Pain 1-10? _____

Does this pain interfere with Daily routine such as?

□*Walking* □*Bending* □*Standing*
□*Lying down* □*exercise* □*OTHER*

Is this conditioning worsening?

☐*YES* ☐*NO*☐*UNKOWN*

MEDICAL ASSISTANT MUST CHECK BLOOD PRESSURE

/

Please mark with an "X" the area of pain using the code diagram above:

HEALTH & WELLNESS

Please check all the that apply to you:

□ High Blood Pressure
□Anxiety
□Cholesterol
□Scoliosis
□ High Blood Pressure
□ Pacemaker
□Arthritis
□Depression
□TMJ issues
□Circulation issues
□Aids/HIV
□Asthma
□Diabetes
□Heart Disease
□Cardiovascular Issues
□Allergies
□Cancer
□Epilepsy
□Hepatitis

Date of Accident:_____/_____/_____

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Patient was the □DRIVER □PASSENGER □FRONT-SEAT □REAR-SEAT □PEDESTRIAN

Seatbelt? □YES□NO **Did Airbags Deploy?** □YES□NO
Area Of Impact: □Front □Rear □Driver-Side □Passenger-Side □Other: _____

Was Vehicle Towed? □Yes □No **Was It Your Vehicle?** □Yes □No;

Do You Own Your Own Vehicle □Yes □No;

Live With Someone That Owns A Vehicle? □Yes □No;

Did You Go To Hospital Or Urgent Care? □Yes □No ;;
If So, Where?_____

Did You Suffer Any Cuts Or Contussions? □Yes□No ;;
□ X-Rays □Ct-Scans □Mri's ;; □Fractures If So, What Specifically_____

Were You Prescribed Any Medication? □Yes □No If So, What Kind_____

Have You Ever Had Any Previous Motor Vehicle Accidents? □Yes□No

When?____/_____/_____ Any Injections Or Diagnostic Testing? _____

Do You Have An Attorney For This Current Accident? □Yes□No ;
If Yes Please Provide The Following:
Name Of Attorney:_____**Phone:** (_____)_____-_____
Address: _____
Auto Insurance Name:_____
Claim #_____

CHIRO WORX CHIROPRACTIC AND WELLNESS STUDIO

714 Scotland Road, Orange, NJ 07050

Letter of Protection Agreement

Patient/Client Name: _____
Date of Loss: _____

Provider: ***Chiro Worx Chirpractic and Wellness Studio located at 714 Scotland Road, Orange, NJ 07050,*** I, the undersigned Patient, hereby instruct my attorney to insure that Provider is paid in full for any and all treatment and services provided by them to me, or on my behalf, for the consequences of the accident that took place on or about the Date of Loss described above. Payment is to be derived from the proceeds of any settlement or funds received by me, or in my beneficial interest, from any source, as compensation for any damages I may have sustained from the consequences of the events that occurred on or about the Date of Loss described above.

Letter of Protection Terms:

- If the bills protected by this letter are for treatment of a vehicular accident, then in regard to PIP covered charges, this Letter of Protection is valid for outstanding PIP covered charges, only if PIP is appropriately billed and pursed by Provider pursuant to FS627.736 (5)(b).
- This Letter of Protection shall not be assignable or transferable to another provider.
- Upon request and periodically, Center Spine Care will forward updated bills and medical records to the Insurance Company or to the Patient's attorney and not to the Patient, unless otherwise requested in writing.
- Should Patient not agree to the sums available for payment to Provider, the Patient's attorney shall post funds, in any amount no less than the disputed charges, in the registry of the court for appropriate judicial determination.
- Provider is acting in reliance on the terms of this agreement for the provision of treatment and services contemplated herein.
- The terms contained herein are acceptable as adequate consideration for this agreement by the signatories below.

_____	_____	_____
Patient's Name	Patient's Signature	Date
_____	_____	_____
Provicer's Name Printed	Provider's Signature	Date

CHIRO WORX CHIROPRACTIC AND WELLNESS STUDIO

714 Scotland Road, Orange, NJ 07050

Informed Consent for Physical Therapy Services

I authorize the performance upon myself of the following services:

- ✓ Examination & periodic re-exam
- ✓ Electrical stimulation (Muscle)
- ✓ Hot Moist Heat/Cold Therapy
- ✓ Massage Therapy
- ✓ Therapeutic Activities
- ✓ Therapeutic Exercises
- ✓ Infrared Therapy
- ✓ Ultrasound
- ✓ Gait Training
- ✓ Manuel Therapy

Physical Therapy: The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and intervention by use of rehabilitative procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my condition. I will notify my practitioner if I am pregnant, become pregnant, or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the recourses available to me.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. Insurance: I, the patient, am ultimately responsible for payment of my account. As a courtesy, ***Chiro Worx Chirpractic and Wellness Studio located at 714 Scotland Road, Orange, NJ 07950,*** . will bill my insurance company on my behalf. I am responsible for paying any deductible and/or co-payment due at time of service. After 60 days any balance not paid by insurance will become my responsibility.

I have read the above information and I consent to physical therapy evaluation and treatment. My signature below acknowledges that I have read, understood, and will abide by the conditions and policies noted on this consent form.

Print Name: _____

Signature: _____

Date: _____

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CONSENT TO CHIROPRACTICE SERVICES

I authorize the performance upon myself of the following procedures:

a) Examination and periodic re-examination
b) Spinal Manipulation
c) Electrical stimulation(muscle)
d) Kinetic activity(rehab)
e) Hot moist/cold therapy

To be preformed by or under the supervision of the chiropractors of the ***Chiro Worx Chirpractic and Wellness Studio located at 714 Scotland Road, Orange, NJ 07050,***

I also consent to the performance of other diagnostic and therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that the above-named chiropractic physicians, associates, or assistants, may consider necessary or advisable I the course of my health care.

You have been injured as the result of motor vehicle accident, work related injury, or a result of another person's actions. Therefore, I am Being treated for these injuries; it is not my intention to receive treatment for litigation purpose.

The nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by a chiropractor of ***Chiro Worx Chirpractic and Wellness Studio located at 714 Scotland Road, Orange, NJ 07050,*** and/or their associates and employees to my satisfaction.

Chiropractors use spinal manipulations to treat patients with neck problems. There have been rare cases of injury to a vertebral artery as a result of treatment. Such injury has been rare cases of injury to a vertebral artery as a result of treatment. Such injury has been known to cause stroke, sometimes with serious neurological injury. The chance of this happening is extremely remote, approximately 1 per 1 million treatments. Appropriate tests will be preformed on me to help identify if I may be at risk to that kind of injury. If I have any questions about this, I will not hesitate to speak with one of the chiropractors. I accept the risk described in this paragraph and consent to treatment.

I acknowledge that no guarantee or assurance as to results that may be obtained from procedures has been given by the above-named doctors, their assistants, or facility employees.

If you have been injured as the result of another's actions, it is important that you do the following:

1. Provide accident report, proof of insurance, and personal identification.
2. Sign in before receiving treatment.
3. Present for initial and periodic examinations.
4. Advise a doctor of any problems or if you are pregnant.
5. Understand the need for diagnostic testing and/or referral to the appropriate physician of your problems are persistent, severe, or not within the scope of chiropractic treatment.

Name: _____ Signature: _____ Date: _____

CHIRO WORX CHIROPRACTIC AND WELLNESS STUDIO

714 Scotland Road, Orange, NJ 07050

Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. I understand that by signing the consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved)
- Obtain payment from third party payers such as my insurance company
- The day to day care operations of the practice

I am aware that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with them. I may revoke this consent at any time in writing. However, any use or disclosure that occurred prior to the date I sign this form is not affected.

_____ _____

Patient Signature Date

Authorization to Release Medical Records

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed above

The information you may release subject to this signed release form is as follows:

□Complete Records	□History & Physical	□Progress Notes
□Care Plan	□Lab Reports	□Radiology Reports
□Pathology Reports	□Treatment Record	□Operative Reports
□Hospital Reports	□Medication Record	□All/Any Records

_____

Patient Name: _____

Patient Signature: _____

Date: _____

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Assignment of Benefits & LTD .

Patient Name: _____ Date Of Loss: _____ / _____ / _____
Patient Address: _____ City:_____ State:_____ Zip:_____
Insurance Co: _____ Name Of Policy Holder: _____
Policy Number: _____ Claim Number _____

I, the undersigned, hereafter referred to as "The Patient" do hereby assign all of my rights and interests to ***Chiro Worx Chirpractic and Wellness Studio located at 714 Scotland Road, Orange, NJ 07050***, hereafter referred to as "The Medical Provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable request of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for the same. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same be deducted from any settlement made on my behalf.

I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the Health carrier and/or insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier. The provider will comply with the decision point review request as required by the plan. The provider shall submit disputes to personal injury protection dispute arbitration if the decision point review plan requires same.

In the event it is determined by Arbitrator and/or Court of Law that the imposition of a co-payment penalty was as result of the medical provider's failure to pre-certify treatment or comply with other decision point review requirements the provider will hold the patient harmless for such co-payment penalty.

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 you 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 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 you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and/or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

Patient's Signature: _____ Date: _____ / _____ / ____

CHIRO WORX CHIROPRACTIC AND WELLNESS STUDIO

714 Scotland Road, Orange, NJ 07050

IRREVOCABLE HEALTHCARE POWER OF ATTORNEY

BY THIS POWER OF ATTORNEY:

I, _____ (hereinafter, "Principal") of _____County, state of _____, do appoint my healthcare provider Dr._____(hereinafter, "Attorney"), as my true and lawful attorney in fact. In Principal's name, and for Principal's use and benefit, said Attorney is hereby authorized to:

1. Endorse any and all checks or other forms of reimbursement made payable to Principal (or members of Principal's family) by any auto insurance, health insurance, or 3rd party liability insurance companies which relate to medical treatment provided by Attorney to Principal (or members of Principal's family) over to Attorney.

2. Demand and direct any and all auto, health, or liability insurance companies, during the course of Principal's (or members of Principal's family) medical treatment with Attorney on personal injury cases or major medical matters, to make all reimbursement checks for such treatment payable to Attorney and to send such checks directly to Attorney.

This Special Power of Attorney is created for Attorney's benefit to secure Attorney's right to payment for healthcare services provided and shall be irrevocable throughout the duration of the healthcare services provided by Attorney to Principal arising from any injury or major medical conditions sustained either by Principal or members of Principal's family.

GIVING AND GRANTING to said attorney full power and authority to do all and every act and thing whatsoever requisite and necessary to be done relative to any of the foregoing as fully to all intents and purposes as Principal might or could do if personally present.

All that said attorney shall lawfully do or cause to be done under the authority of this power of attorney is expressly approved.

Dated:_____,20_____

_____(Signature of Principle)

_____(Printed Name of Principle)

On _____ __, 20__, before me, _____, personally appeared, _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s) or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Signature_____ _____(This area for official notarial seal)