THE SPINE & HEALTH CENTER OF NEW JERSEY

Please complete all of the following information as accurately as possible. Thank you.
All information is kept *STRICTLY CONFIDENTIAL*
How did you hear about our office? ☐Internet_____ ☐Sign ☐Friend ☐Patient ☐Promotion_____
If referred by a friend/patient, whom? _____
☐Other (Please specify): _____

PATIENT INFORMATION

Name: _____ Date: _____
Home Phone: ( ) _____ Cell Phone:( ) _____ Work Phone:_( )_____
Email:_____@_____ Marital Status:_____
Address:_____ City:_____ State:____ Zip:_____
Employer:_____ Occupation:_____
Employer Address:_____ City:_____ State:____ Zip:_____
SSN:___-___-____ Date of Birth:__/__/___ Age:__ Driver's License #_____ State:___

HEALTH INSURANCE

Company Name:_____ ID Number:_____ Group #: _____
Insured's Name:_____ Telephone #: (___)_____
Date of Birth:__/__/___ Insured's SSN:____-___-____
Relationship to Patient_____Insured's Employer_____

PERSONAL INJURY HISTORY

Date of Accident: _____ Time: _____ ☐AM ☐PM State:_____
Where were you seated? _____
In your own words, please describe the accident: _____
_____
_____
_____
Type of Accident: ☐Head-on collision ☐Broad-side collision ☐ Front impact
☐ Rear-end car in front ☐ Rear impact ☐ Non-collision
At the time of the accident, recall what parts of your head or body hit what parts on the inside of your car: _____
Did you see the accident coming? ☐Yes ☐No
Did you brace for impact? ☐Yes ☐No
Were seatbelts worn? ☐Yes ☐No
Was your car braking? ☐Yes ☐No
Was your car moving at the time of the accident? ☐Yes ☐No
If yes, how fast would estimate you were going? _____mph
Head/Body position at the time of impact:
☐Head turned left/right ☐Body straight in sitting position
☐Head looking back ☐Body rotated right/left
☐Head straight forward ☐other: _____

As a result of the accident you were: Rendered unconscious ☐In shock ☐Dazed, circumstances vague ☐other: _____
Could you move all parts of your body? ☐Yes ☐No
If no, what parts couldn't you move and why? _____
_____
Were you able to get out of the car and walk unaided? ☐Yes ☐No
If no, why not? _____
Did you get any bleeding cuts? ☐Yes ☐No
Did you get any bruises? ☐Yes ☐No If yes, where? _____
Please describe how you felt:
Immediately after the accident: _____
Later in the day: _____
The next day: _____
Check symptoms apparent since the accident:

☐Headache	☐Neck pain/stiffness	☐Mid back pain
☐Eyes light sensitive	☐Pain behind eyes	☐Dizziness
☐Fainting	☐Sleeping problems	☐Numbness in fingers
☐Numbness in toes	☐Loss of smell	☐Loss of taste
☐Loss of memory	☐Fatigue	☐Breath shortness
☐Irritability	☐Depression	☐Ringing/Buzzing
☐Loss of balance	☐Tension	☐Cold hands
☐Cold feet	☐Diarrhea	☐Constipation
☐Chest pain	☐Nervousness	☐Cold sweats
☐Anxious	☐Facial pain	☐Clicking or popping jaw
☐Low back pain	☐Other: _____	

_____
Have you missed time from work? ☐Yes ☐No
If yes, full time off work: _____ to _____
If yes, part time off work: _____ to _____
Did you seek medical help immediately after the accident? ☐Yes ☐No
If yes, how did you get there?

☐Ambulance	☐Police	☐Someone else drove me
☐Drove own car		☐

Other: _____
Doctor #1: Name: _____
Date of first visit: _____
Were you examined? ☐Yes ☐No
Were x-rays taken? ☐Yes ☐No
Did you receive treatment? ☐Yes ☐No ☐Medications ☐Braces ☐Collars
If yes, what kind of treatment did you receive? _____

What benefits did you receive from the treatment? _____
Date of last treatment? _____
Do you have an attorney on this claim? ☐Yes ☐No
If yes, who? _____
Address: _____
City_____State_____Zip_____Phone_____
Are you pregnant? ☐Yes ☐No ☐Not sure
Medications, list: _____
_____
_____
Disease, describe: _____
_____
_____
Other, describe_____
_____

ACTIVITIES OF DAILY LIVING ASSESSMENT

Directions: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please check one item in each section that most closely applies to you.

SECTION 1 – PAIN INTENSITY

☐I can tolerate the pain I have without using painkillers.
☐The pain is bad but I manage without taking painkillers.
☐Painkillers give complete relief from pain.
☐Painkillers give moderate relief from pain.
☐Painkillers give very little relief from pain.
☐Painkillers give no relief from pain and I do not use them.

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, 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 causes extra pain.
☐Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (on a table).

☐ Pain prevents me from lifting heavy weights off the floor but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only light weights.
☐ I can not lift or carry anything at all.

SECTION 4 – WALKING

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than ½ mile.
☐ Pain prevents me from walking more than ¼ mile.
☐ I can only walk using a cane or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – SITTING

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting at all.

SECTION 6 – STANDING

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it causes extra pain.
☐ Pain prevents me from standing more than one hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

SECTION 7 – SLEEPING

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

SECTION 8 – SEX LIFE

☐ My sex life is normal and causes me no extra pain.
☐ My sex life is normal and causes me some extra pain.
☐ My sex life is nearly normal but is very painful.
☐ My sex life is severely restricted by pain.
☐ My sex life is nearly absent because of pain.

☐ Pain prevents me from sex life at all.

SECTION 9 – SOCIAL LIFE

☐ My social life is normal and gives me no extra 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 (dancing, etc.).
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

SECTION 10 – TRAVELING

☐ I can travel anywhere without pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain restricts me to journeys of less than one hour.
☐ Pain restricts me to short necessary trips under a ½ hour.
☐ Plan restricts me from traveling except to the doctor or hospital.

CURRENT CHIEF COMPLAINT(S)

Directions: Place an (X) in the appropriate complaint areas.

SPINE

☐ Low back ☐ Mid back ☐ Neck
☐ Pelvis

UPPER EXTREMITY

☐ Shoulder R/L ☐ Arm R/L ☐ Elbow R/L
☐ Wrist R/L ☐ Forearm R/L ☐ Hand R/L

LOWER EXTREMITY

☐ Hip R/L ☐ Thigh R/L ☐ Knee R/L
☐ Leg R/L ☐ Ankle R/L ☐ Foot R/L

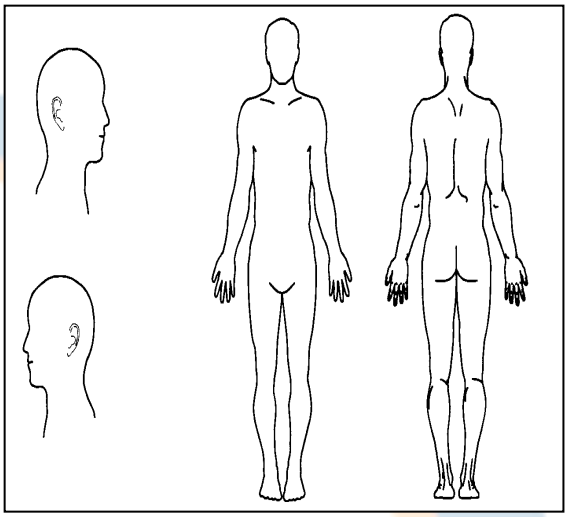
OTHER (describe)

_____
_____
_____
_____

SUBJECTIVE PAIN LEVEL

On a scale of 1 – 10 place an (X) in your current pain level

NORMAL	☐0		
LOW PAIN	☐1	☐2	☐3
MODERATE PAIN	☐4	☐5	☐6
INTENSE PAIN	☐7	☐8	☐9
EMERGENCY	☐10		



Directions:
Mark the areas of the body where you feel the described sensations. Mark stress points of radiation. Include all affected areas. Use the appropriate symbol:

X NUMBNESS
O PIN & NEEDLES
+ BURNING
= STABBING

THE SPINE & HEALTH CENTER OF NEW JERSEY

RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____ _____
Please Print (Last Name) (First Name)

DATE OF BIRTH: _____ SOCIAL SECURITY: _____-_____-_____

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:
3. The Type of information to be used or disclosed is as follows: (included dates where appropriate)

☐ **Emergency Records** **Date:** _____

☐ **Operative Reports** **Date:** _____

☐ **Admission** **Date:** _____

☐ **X-ray & Imaging Reports** **Date:** _____

☐ **Consultation Reports** **(Doctor's name):** _____

☐ **Most Recent Discharge Summary**

☐ **Laboratory Results**

☐ **Entire Records**

☐ **Other** _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may 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 or organization.

THE SPINE AND HEALTH CENTER OF MONTVALE **2 S. KINDERKAMACK ROAD MONTVALE, NJ 07645**
(Name) (Address)

For the purpose of: Investigating and pursuing a bodily injury case on my behalf.

1. 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 information that has already been released in response to this authorization. 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: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524, I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

Signature of Patient X_____ _____
(Please sign here) (Date)

Signature of Witness X _____ _____
(Please sign here) (Date)

Any person who knowingly files a statement of claim containing any False or Misleading Information is subject to criminal and civil penalties

THE SPINE & HEALTH CENTER OF NEW JERSEY

Attorney's Lien Form

I, _____ _____, hereby authorize the above Chiropractic to furnish
(Pleae Print) Last Name First Name

you, _____, Esq., my attorney with a Full Report, Copiesof Bills, Examinations,
Attorney Name

Diagnosis,Treatment, Prognosis, etc. of myself regarding the accident in which I was involved on _____/____/_____, and pay such reasonable charges as may be required.

I hereby authorize and direct you, _____ Esq., to pay directly to said party sums as may be owing, whether due to his accident or for settlement, judgment or verdict as may be necessary to adequately protect said party on my case against any and all proceeds, settlements or verdict which may be paid to you, my attorney or myself as a result of the injuries in connection therewith.

I hereby authorize my attorney to issue a letter of protection and pay the Spine and Health Center of Montvale for all the sums owed from my above accident date and/or deductible and/or co-payment.

I fully understand that I am directly responsible to said party for all bills submitted for service and or supplies furnished me and that this agreement is solely for this party's additional protection and in consideration of his awaiting payment, and further understand than such payment is not contingent on any settlement, judgment or verdict by which I may eventually receive and fee.

Date: ___/___/_____

Patient's Signature: _____

Witness Name: _____ _____
(Please Print) Last Name First Name

Witness's Signature: _____

Any Person who knowingly files a statement of claim containing any False or Misleading information is subject to criminal and civil penalties.

THE SPINE & HEALTH CENTER OF NEW JERSEY

PAYMENT POLICIES/ASSIGNMENT OF BENEFITS

We are committed to providing you with the best possible care. Please read carefully and sign at the bottom of the page indicating your acceptance of our policies and procedures.

1. PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.
   a. Your insurance is a contract between you, your employer and the insurance company. We are not included in your contract.
   b. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover
   c. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
   d. If your account becomes past due and goes to our collections agency, you are responsible for all fees incurred.
2. OUR OFFICE PRIDES ITSELF ON OUR ABILITY TO SEE PATIENTS IN A TIMELY MANNER.

THEREFORE, WE REQUIRE 24 HOURS NOTICE FOR ALL CANCELLATIONS. THERE WILL BE A $25.00 NO-SHOW OR SAME DAY CANCELLATION FEE. REPEATED SAME DAY CANCELLATIONS OR NO-SHOWS WILL REQUIRE US TO TAKE A $49 HOLD FEE VIA CREDIT CARD WHICH WILL BE CHARGED AT THE TIME THE APPOINTMENT IS MADE IN ORDER TO BOOK ANY FUTURE APPOINTMENTS. THIS $49 WILL BE CREDITED TO YOUR ACCOUNT (CO-PAY, DEDUCTIBLE, NON-COVERED SERVICE) AFTER YOU COME IN FOR THE APPOINTMENT.

1ST CANCELLATION: $25.00 CANCELLATION OR NO-SHOW FEE.
2ND CANCELLATION: $25.00 CANCELLATION OR NO-SHOW FEE
3RD + CANCELLATION: $49 HOLD FEE TO BOOK FUTURE APPOINTMENTS (CREDITED TO PATIENT ACCOUNT AFTER VISIT)

3. I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO THE SPINE AND HEALTH CENTER OF MONTVALE.
   a. This is a direct assignment of my rights and benefits under my health insurance policy. I agree to pay any balance of professional services charged over and above this insurance payment.
   b. If my current policy prohibits payments directly to the doctor, I agree to mail the check (original or personal) as payment for services rendered.

4. I HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

_____ _____

Patient/Policy holder signature **Date**

THE SPINE & HEALTH CENTER OF NEW JERSEY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Spine and Health Center of Montvale is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment—We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment—We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers Compensation— We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies—We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes. We may call you at home to remind you of appointments and may leave a message if there is no answer or you are not available. No health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.

Change of Ownership

In the event that The Spine and Health Center of Montvale, PC is sold or merges, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. The Spine and Health Center is not required to agree to the restriction.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.

Treatment

This office uses both open and closed room adjusting and therapy. Per request, we will accommodate you to a closed room for adjusting and therapy.

Changes to this Notice of Privacy Practices

The Spine and Health Center of Montvale, PC reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact Dr. Wohl at 201-746-6577. If Dr. Wohl is not available, you may make an appointment to meet with him in person or via telephone within two working days.

Complaints

Complaints about how The Spine and Health Center of Montvale has handled your health information should be directed towards Dr. Wohl at 201-746-6577. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights; 200 Independence Ave, S.W.; Room 509F HHH Building; Washington, D.C. 20201.

This notice is effective as of April 07, 2008