



THE SPINE & HEALTH CENTER OF NEW JERSEY

PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION AS ACCURATELY AS POSSIBLE. THANK YOU.

How did you hear about our office? Internet Sign Friend Patient Promotion _____ Other _____

If referred by a patient, WHOM? _____

ABOUT YOU

Full Name _____ Prefer to be called _____ Home Phone _____

Cell Phone _____ Work Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

SSN _____ - _____ - _____ Date of Birth _____ / _____ / _____ Age _____ Sex: M F Marital Status _____

MOTOR VEHICLE INSURANCE

Company Name _____ Policy Number _____ Claim # _____

Policy Holder's Name _____ Relationship to Patient _____ Policy Holder's SS# _____ - _____ - _____

Policy Holder's DOB _____ / _____ / _____ Adjustors Name _____ Phone _____ Fax _____

EMERGENCY CONTACT

Name _____ Relationship _____ Telephone (_____) _____

PRIMARY CARE PHYSICIAN (MEDICAL DOCTOR)

Name _____ Office Address _____ Telephone (_____) _____

ATTORNEY INFO

Name: _____ Telephone (_____) _____

Address: _____ City: _____ State: _____ Zip _____

AUTO ACCIDENT INFORMATION

Date of Accident: _____ **Were you the:** Driver Passenger Pedestrian Bus Bicycle Other _____

Damage to your car: Front Rear Driver Side Passenger Side Other _____

Weather Conditions: Sunny Rainy Cloudy Snowing Foggy **Street Surface:** Dry Wet Icy

Wearing Seat belt? Yes No **Were there airbags?** Yes No **Did they deploy?** Yes No **Did you see impact coming?** Yes No

Did you brace for impact? Yes No **Were you looking?** Ahead Behind Up Down To the Right To the Left

On impact were you: Thrown forward Thrown backwards Thrown sideways Other _____

Did your body hit anything inside the car? Yes No **Body Part:** _____ **What did it hit?** _____

Head trauma? Yes No **Loss of Consciousness?** Yes No **For how long** _____

Hospital? Yes No **Name of hospital?** _____ **How long there?** _____

Taken by ambulance? Yes No **X-rays taken?** Yes No **X-ray areas?** Neck Mid-back Low-back
 Other X-rays _____ **Medication Given?** Yes No RX: _____

Have you missed work or school due to your injuries? Yes No



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Have you ever had the same or similar condition or symptoms previous to this most recent occurrence? Yes No

When? ___/___/___ Describe: _____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Doctor	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Have you ever been in our office before? Yes No

<u>PAIN YOU HAVE CURRENTLY FROM THE ACCIDENT (CIRCLE: RIGHT OR LEFT)</u>	<u>INTENSITY</u>
<input type="checkbox"/> Headaches _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Lightheadedness _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Episodes of Dizziness _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Loss of Balance _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Difficulty Sleeping/Insomnia _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Nervousness _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Anxiety/Tension _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Jaw Pain/Clicking _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Neck Pain _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Radiation of Pain to Arm Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Radiation of Pain to Left Arm _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Shoulder Pain Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Elbow Pain Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Wrist Pain Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Dorsal Pain, between shoulder blades _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Weakness in Arms _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Chest Pain _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Difficulty Breathing _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Abdominal Pain _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Low Back Pain _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Pelvic Pain _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Difficulty Bending _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Difficulty Standing _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Difficulty Sitting _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Difficulty Walking _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Radiation of Pain to Leg Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Weakness in Lower Extremity _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Knee Pain Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Ankle Pain Right/Left _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Radiation of Pain to Thighs _____	1 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Radiation of Pain to Gluteus _____	1 2 3 4 5 6 7 8 9 10



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Women: Are you pregnant? Yes No Possible? Yes No

Personal and/or family history of Cancer/malignancy? Yes No Personal and/or family history of Diabetes? Yes No

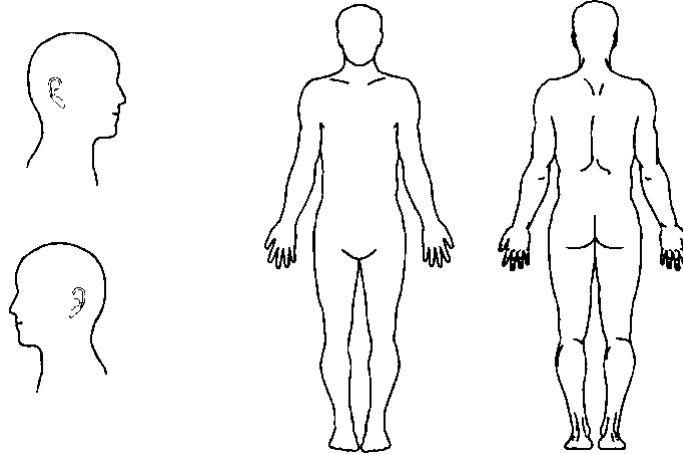
Do you have any other pertinent personal history, including but not limited to any of the following?

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Circulation | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Heart | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> TB | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Smoke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Digestive System |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> No History | <input type="checkbox"/> Kidney | |

Previous History of:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Mid-back Pain | <input type="checkbox"/> Arm/Shoulder Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma/Difficulty Breathing | <input type="checkbox"/> Gallbladder Symptoms | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Pain down legs | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Pinched Nerves |
| <input type="checkbox"/> Hepatitis/liver symptoms | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Chest Pain/Heart Trouble |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Cold, Tingling Extremities | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Insomnia/Sleeping Problems | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tight Muscles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of energy | <input type="checkbox"/> Disc Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Other _____ |

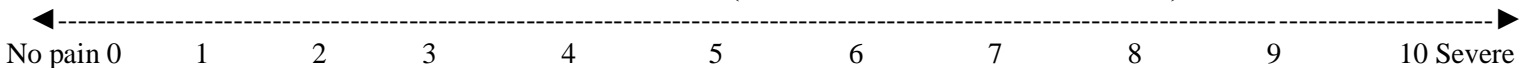
PLEASE OUTLINE ON THE DIAGRAMS BELOW THE AREAS OF YOUR DISCOMFORT



Use the following symbols, as applicable, to diagram areas of discomfort

A = Aching	N = Numbness
B = Burning	R = Throbbing
C = Cold	S = Stabbing
H = Hypersensitivity	T = Tingling

PLEASE RATE YOUR PAIN (PLACE AN "X" ON THE SCALE)





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PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- The quality of my work/my productivity at work has been affected
- I am unable to perform routine household chores
- My social life has suffered because of my symptoms
- I am unable to participate in recreational activities because of my symptoms

Current Medications (and dosages, if known): None _____

Previous Surgeries: None _____

Previous Hospitalizations: None _____

Previous Significant Illnesses: None _____

Previous Injuries and Traumas: None _____

Previous History of Similar Condition(s): None _____

ACCOUNT INFORMATION AND TERMS OF ACCEPTANCE

I hereby give my authorization to treat me, or my minor child, as named herein on this form. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable at the regular rates, irrespective of any concessions made, discounts applied and/or other such arrangements I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. We do not offer to treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of an examination, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information.

Patient Signature or Parent/Guardian if patient is a minor

Date Signed



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, a 25% fee will be charged.

- 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 CLOSTER.**
 - 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 Signed



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 New Jersey 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 New Jersey 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 of New Jersey 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 New Jersey 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 New Jersey 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



THE SPINE & HEALTH

CENTER OF NEW JERSEY

RELEASE OF MEDICAL RECORDS

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

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

- I authorize the use or disclosure of the above named individual's health information as described below:
- The following individual or organization is authorized to make the disclosure:
- 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 _____

- 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.
- This information may be disclosed to and used by the following individual or organization.

THE SPINE & HEALTH CENTER OF NEW JERSEY

(Name)

(Address)

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

- 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.
- 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

TO OUR VALUED PATIENTS:

Due to changing Governmental Regulations, we are required to gather additional information for all patients. Please answer the following questions. **ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.**

Thank you for your cooperation.

Name: _____

Date of Birth: _____

Race (select one):

Hispanic or Latino: _____

Not Hispanic or Latino: _____

Decline to answer: _____

Ethnicity: (select one)

American Indian or Alaska Native: _____

Asian: _____

Black or African American: _____

Native Hawaiian or other Pacific Island: _____

Other Race: _____

White: _____

Height: _____

Weight: _____

Allergies: _____

Alcohol Consumption (select one):

None: _____

Yes: _____ # of drinks per day: _____

Occasional/Social: _____

Do You Smoke Cigarettes?

Yes: _____ # packs per day: _____ #of cigarettes per day: _____

No: _____

Did You Ever Smoke Cigarettes?

If Yes: _____ from when: _____ to when: _____

No: _____

PATIENT SIGNATURE: _____ **DATE:** _____



INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, Physical Therapy, Acupuncture and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic, Physical Therapists or Acupuncturists who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, physical therapy, acupuncture and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to; Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. Dizziness, nausea, and flushing: these symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____

Date: _____