# 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 bel**t? □ 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

**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

**PAIN YOU HAVE CURRENTLY FROM THE ACCIDENT (CIRCLE: RIGHT OR LEFT)** _____ **INTENSITY**

□**Headaches** _____ **1 2 3 4 5 6 7 8 9 10**
□**Lightheadedness** _____ **1 2 3 4 5 6 7 8 9 10**
□**Episodes of Dizziness** _____ **1 2 3 4 5 6 7 8 9 10**
□**Loss of Balance** _____ **1 2 3 4 5 6 7 8 9 10**
□**Difficulty Sleeping/Insomnia** _____ **1 2 3 4 5 6 7 8 9 10**
□**Nervousness** _____ **1 2 3 4 5 6 7 8 9 10**
□**Anxiety/Tension** _____ **1 2 3 4 5 6 7 8 9 10**
□**Jaw Pain/Clicking** _____ **1 2 3 4 5 6 7 8 9 10**
□**Neck Pain** _____ **1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Arm Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Left Arm** _____ **1 2 3 4 5 6 7 8 9 10**
□**Shoulder Pain Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Elbow Pain Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Wrist Pain Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Dorsal Pain, between shoulder blades** _____ **1 2 3 4 5 6 7 8 9 10**
□**Weakness in Arms** _____ **1 2 3 4 5 6 7 8 9 10**
□**Chest Pain** _____ **1 2 3 4 5 6 7 8 9 10**
□**Difficulty Breathing** _____ **1 2 3 4 5 6 7 8 9 10**
□**Abdominal Pain** _____ **1 2 3 4 5 6 7 8 9 10**
□**Low Back Pain** _____ **1 2 3 4 5 6 7 8 9 10**
□**Pelvic Pain** _____ **1 2 3 4 5 6 7 8 9 10**
□**Difficulty Bending** _____ **1 2 3 4 5 6 7 8 9 10**
□**Difficulty Standing** _____ **1 2 3 4 5 6 7 8 9 10**
□**Difficulty Sitting** _____ **1 2 3 4 5 6 7 8 9 10**
□**Difficulty Walking** _____ **1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Leg Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Weakness in Lower Extremity** _____ **1 2 3 4 5 6 7 8 9 10**
□**Knee Pain Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Ankle Pain Right/Left** _____ **1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Thighs** _____ **1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Gluteus** _____ **1 2 3 4 5 6 7 8 9 10**

**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

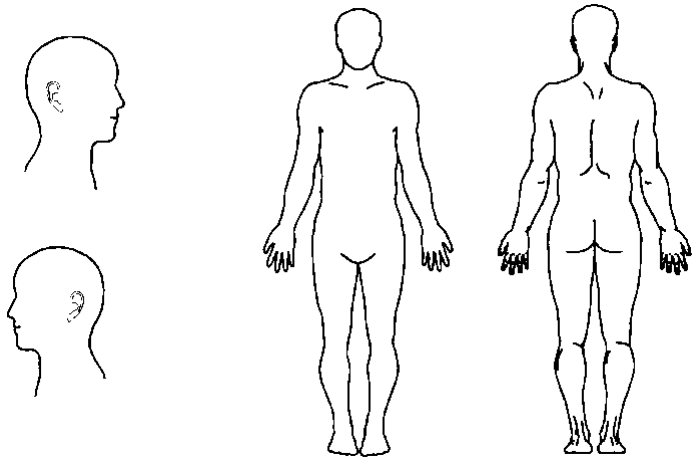
**Do you have any other pertinent personal history, including but not limited to any of the following?**

□ Neurological
□ Heart
□ TB
□ Smoke
□ Arthritis
□ No History
□ Circulation
□ High Blood Pressure
□ Thyroid
□ Asthma
□ Epilepsy
□ Kidney
□ Alcohol
□ Migraines
□ Lungs
□ Digestive System
□ Other_____

**Previous History of:**

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

◄----------►

No pain 0 1 2 3 4 5 6 7 8 9 10 Severe

**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**

THE SPINE & HEALTH CENTER OF NEW JERSEY

# Attorney's Lien Form

I, _____, hereby authorize the above facility to furnish you
(Last Name, First Name)

_____, Esq., my attorney with a Full Report, Copies of Bills, Examinations, Diagnosis,
(Attorney Name)

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/her 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 & Health Center of New Jersey 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: _____

Witness's Signature: _____

Any Person who knowingly files a statement of claim contacting 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, 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**

# 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: _____-_____-_____

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.

_____ _____
(Facility Name) (Facility 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

**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:** _____