AUTO

Chiropractic Spine Center of Flemington
35 State Route 31, Flemington, NJ, 08822-
Phone: (908) 751-5706 Fax: (908) 751-5708

PATIENT INFORMATION FORM

Today's Date: _____

Patient Name: _____

Last 4 of Social Security Number _____ Birth Date: ____/____/____ Age: _____ Gender: F M Decline

Phone Number: _____ E-mail address: _____

Address: _____

City _____ State _____ Zip _____

Occupation: _____ Employer _____

Address _____ Work Phone (____) _____

Student at _____ ☐ FULL-TIME ☐ PART-TIME

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

Spouse Name: _____ Date of Birth ___/___/___

Phone (____) _____ Occupation _____

Employer _____

Who should we contact in the event of an emergency? _____ Phone (____) _____

INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☐ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth _____

Is the policy through an employer? ☐ YES ☐ NO If so, who is the employer? _____

HEALTH INFORMATION

Is your condition or injury due to a work-related accident or cause? ☐ YES ☐ NO

Did the condition or injury result from automobile accident? ☐ YES ☐ NO

Date of accident: ___/___/___ (briefly describe): _____

Date of last physical examination? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: _____

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO

How did you learn about us? _____

Patient Questionnaire – General Information Related to the Condition:

Approximately, when did the symptoms begin to occur? ____/____/____

or ☐ No particular condition or symptoms -- Just seeking good health

Describe the conditions, symptoms, and/or purpose of the appointment:

Describe your pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Aching ☐ Radiating ☐ Burning ☐ Throbbing ☐ Numbness

What causes it?

What aggravates it?

What relieves it?

Have you experienced these conditions previously to this most recent occurrence? ☐ No ☐ Yes When? _____
Describe:

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

Name	Type of Licensure	Date of Last Visit
_____	_____	_____/_____/_____
_____	_____	_____/_____/_____

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

Do you smoke cigarettes? ☐ No ☐ Occasionally ☐ Yes If yes, Number of packs: _____ ☐ DAY ☐ WEEK

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Yes If yes, Number of Drinks _____ ☐ DAY ☐ WEEK

MEDICAL HISTORY:

Have you ever been in our office before? ☐ Yes ☐ No

List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.)

1) _____ Date _____

2) _____ Date _____

Surgeries/Hospitalizations: _____

List all medications you are taking and why: _____

Allergies _____

Patient Questionnaire – Auto-Accident

Patient Name:_____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient☐ Yes ☐ No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:___ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the ☐Driver ☐Passenger ☐Pedestrian

Automobile you were in. Year _____ Make _____ Model _____

Damage to your car:☐Front☐Rear☐Pedestrian☐Driver Side☐Passenger Side☐Bumper☐Fender

Damage Amount Estimate: $_____ :☐Minor☐Major☐Totaled

Other Automobile. Year _____ Make _____ Model _____

Damage to other car: ☐Front ☐Rear ☐Pedestrian ☐Driver Side ☐Passenger Side ☐Bumper ☐Fender

☐Minor ☐Major ☐Totaled

Where did the accident happen?Street Names: _____ City/State _____

Was it? ☐Controlled Intersection☐Uncontrolled☐Not Intersection

Was there a traffic light? ☐None☐Green☐Red☐Turn Arrow☐Stop Sign

Were you.☐Slowly Moving☐Moving☐Stopped

Weather Conditions: ☐Sunny☐Rainy☐Cloudy

Street Surface:☐Dry☐Wet☐Slick ☐Icy☐Pavement☐Other _____

Type of Impact. ☐Rear end☐Front☐Side Impact☐Roll Over

Brakes on Impact: ☐Locked Tight☐Loosely Applied☐Foot not on brake

How far did your car move?☐Did not move ☐Moved 1-5 ft☐Moved 6-10 ft☐Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness. ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐Up☐ Down

Is the car equipped with airbags?☐ Yes ☐NoDid they deploy?☐ Yes ☐ No

Did you see the impact coming?☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was 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? _____

Do you remember the accident happening? ☐ Yes ☐ No

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: _____

Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: ☐Burning ☐Sharp ☐Dull ☐Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar conditionor 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 Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐Headache	☐Dizziness	☐Light Bothers Eyes	☐Diarrhea	☐Head seems too heavy	☐Neck Pain
☐Loss of Memory	☐Clumsiness	☐Feet Cold	☐Neck Stiff	☐Tingling in arms/hands	☐Ears Ring
☐Hands Cold	☐Sleeping Problems	☐Tingling in legs/feet	☐Face Flushed	☐Nausea	☐Back Pain
☐Numbness in arms/hands	☐Buzzing in Ears	☐Constipation	☐Nervousness	☐Numbness in legs/feet	☐Loss of Balance
☐Cold Sweats	☐Tension	☐Shortness of Breath	☐Fainting	☐Fever	☐Fatigue
☐Irritability	☐Loss of Smell	☐Chest pain/rib pain	☐Pain in arms/hands	☐Pain in legs/feet	☐Jaw pain
☐Loss of strength - arms	☐Burning muscle pain	☐Loss of strength - legs	☐Difficulty swallowing	☐Sharp/shooting pain	

Other _____

Have you experienced changes to:

☐Eyes (sight)	☐Ears (hearing)	☐Nose (smell)	☐Mouth (taste)	☐Bladder
☐Bowels	☐Sleep	☐Emotion	☐Appetite	

Please Explain: _____

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

REVIEW OF SYMPTOMS: Do you now have or have you ever had? Please check all that apply.

Allergic-Immunologic:

- ☐ Hives/Eczema
- ☐ Hay fever
- ☐ Catch colds easily
- ☐ Frequent sinus trouble
- ☐ Frequent influenza
- ☐ HIV
- ☐ AIDS
- ☐ Allergies
- ☐ Fever

Cardiovascular:

- ☐ Murmur
- ☐ Chest pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Swollen ankles
- ☐ Heart attack
- ☐ Irregular heartbeat
- ☐ Pressure over chest
- ☐ Pain down arm
- ☐ High triglycerides
- ☐ High cholesterol levels
- ☐ Profuse sweating
- ☐ Nausea
- ☐ Vomiting
- ☐ Low blood pressure
- ☐ Fainting spells
- ☐ High blood pressure
- ☐ Difficulty lying flat

Ear/Nose/Throat:

- ☐ Difficulty hearing
- ☐ Buzzing in ears
- ☐ Ringing in ears
- ☐ Vertigo
- ☐ Sinus trouble
- ☐ Nasal stuffiness
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Mouth sores
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Dental problem
- ☐ Frequent sore throat
- ☐ Difficulty swallowing

Endocrine:

- ☐ Loss of hair
- ☐ Heat/Cold Intolerance
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Diabetes
- ☐ Goiter

Eyes:

- ☐ Glasses/Contacts
- ☐ Eye pain
- ☐ Light bothers eyes
- ☐ Double vision
- ☐ Cataracts
- ☐ Vision problems
- ☐ Blurred vision
- ☐ Glaucoma

Gastrointestinal:

- ☐ Heartburn/Reflux
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Change in BMs
- ☐ Diarrhea
- ☐ Black or bloody BM
- ☐ Gallbladder problem
- ☐ Liver problem
- ☐ Hepatitis
- ☐ Distress from greasy food
- ☐ Ulcers
- ☐ Heartburn
- ☐ Hiatal hernia
- ☐ Colitis
- ☐ Blood in the stool
- ☐ Colon cancer
- ☐ Abdominal pain
- ☐ Burning in stomach
- ☐ Pancreatitis
- ☐ Jaundice
- ☐ Pain over stomach
- ☐ Mucus in stool

Genitourinary:

- ☐ Burning/Frequency
- ☐ Blood in urine
- ☐ Erectile dysfunction
- ☐ Abnormal discharge
- ☐ Leakage
- ☐ Incontinence
- ☐ Kidney infection
- ☐ Sexual difficulty
- ☐ Kidney stones
- ☐ Loss of libido

Hematology/Lymph:

- ☐ Easy bruising
- ☐ Gums bleed easily
- ☐ Enlarged glands
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Sickle cell anemia
- ☐ Lymphoma

Musculoskeletal:

- ☐ Joint Pain/Swelling
- ☐ Stiffness
- ☐ Muscle pain
- ☐ Neck pain
- ☐ Stiff neck
- ☐ Back pain
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Bone spurs
- ☐ Broken bones
- ☐ Compression fracture
- ☐ Head injury
- ☐ Back injury
- ☐ Spinal trauma
- ☐ Birth trauma
- ☐ Birth defects

- ☐ Cancer
- ☐ Muscle weakness
- ☐ Muscular dystrophy
- ☐ Scheuerman's disease
- ☐ Scoliosis
- ☐ Lupus
- ☐ Spina bifida
- ☐ Spondylolisthesis
- ☐ Arthritis
- ☐ Neck injury
- ☐ Osteoporosis

Neurological:

- ☐ Loss of strength
- ☐ Numbness
- ☐ Headaches
- ☐ Heavy head
- ☐ Tremors
- ☐ Memory loss
- ☐ Difficulty speaking
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Fainting
- ☐ Concussion
- ☐ Migraines
- ☐ Disorientation
- ☐ Loss of coordination
- ☐ Difficulty in walking
- ☐ Stroke
- ☐ Alzheimer's disease
- ☐ Weakness
- ☐ Disk problem
- ☐ Light Headed/Dizzy
- ☐ Epilepsy/Seizure
- ☐ Tingling

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Difficult sleeping
- ☐ Nervousness
- ☐ Tension

Respiratory:

- ☐ Cough
- ☐ Coughing blood
- ☐ Wheezing
- ☐ Chills
- ☐ Chronic cough
- ☐ Pneumonia
- ☐ Asthma
- ☐ Superficial breathing
- ☐ Chest pain
- ☐ Tuberculosis
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Difficulty breathing
- ☐ Lung cancer

Skin:

- ☐ Rash/Sores
- ☐ Lesions
- ☐ Itching/Burning
- ☐ Skin problem
- ☐ Slow healing
- ☐ Bruise easily
- ☐ Psoriasis
- ☐ Change in moles
- ☐ Change in skin color
- ☐ Skin cancer
- ☐ Scars
- ☐ Discolorations

Men's Health:

- ☐ Burning on urination
- ☐ Difficulty in starting urine
- ☐ Dripping urination
- ☐ Prostate trouble
- ☐ Prostate cancer

Women's Health:

- ☐ Hot flashes
- ☐ Vaginal discharge
- ☐ Nipple discharge
- ☐ Menstrual cramps
- ☐ PMS depression
- ☐ Lumps in breast
- ☐ Hysterectomy
- ☐ Last Mammogram is normal
- ☐ Last Mammogram is abnormal
- ☐ Last Pap is normal
- ☐ Last Pap is abnormal
- ☐ Periods are regular
- ☐ Periods are irregular
- ☐ Menopause (Age of onset _____)
- ☐ Previous pregnancies (How many _____)

General:

- ☐ Recent weight gain
- ☐ Loss of sleep
- ☐ Recent weight loss
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Cancer of any kind
- ☐ Metal Rods
- ☐ Pins
- ☐ Screws
- ☐ Staples
- ☐ Any type of Metal Beneath Skin

PLEASE NOTE SIGNIFICANT OTHER(S): _____

Chiropractic Spine Center of Flemington
35 State Route 31, Flemington, NJ, 08822
Phone: (908) 751-5706 Fax: (908) 751-5708

Dr. Gunnar Henning
Dr. Jesse Hann

New Patient Intake Form

Patient Name: _____

Date: _____

To the right, please mark to indicate the type and strength of your pain on a scale of 1-10 (10 being severe)

Key to help convey symptoms:

S = STABBING

A = ACHING

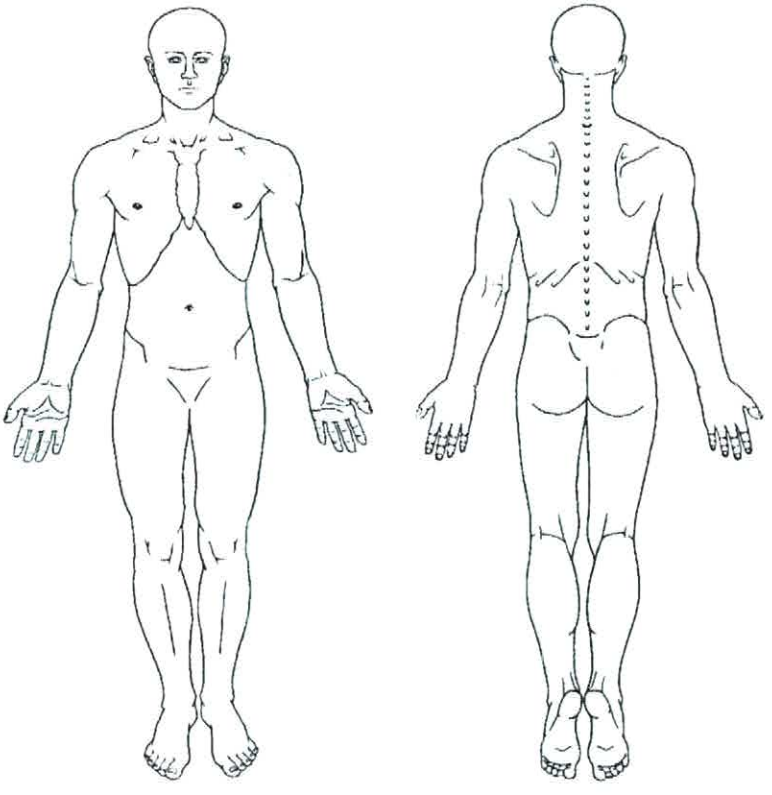
R = RADIATING

B = BURNING

T = THROBBING

N = NUMBNESS

P = PINS & NEEDLES



Posture Scan

Height: _____
Weight: _____

Shoe Size: _____

Shoe width: ☐ Regular ☐ Narrow ☐ Wide

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35 State Route 31, Flemington, NJ, 08822
Phone: (908) 751-5706 Fax: (908) 751-5708

Dr. Gunnar Henning DC PC
Dr. Jesse Hann DC

NOTICE OF PRIVACY PRACTICES - PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of this notice in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or material limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated and that no retaliatory action will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of this notice upon request.

This practice reserves the right to change the terms of its notice of privacy practices and to make new provisions effective for all protected health information tat it maintains. I understand that I can obtain this practice's current notice of privacy practices upon request.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Relationship to patient (if this notice is signed by a personal representative of patient): _____

NOTICE OF INSURANCE COMPLIANCE

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself -- not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

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, YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

YOUR NAME	PHONE NO. HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / /	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐

IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME:
ADDRESS:
PHONE:
FAX#:
E-MAIL:
POLICY/GROUP #/CERTIFICATE #:

2. NAME:
ADDRESS:
PHONE:
FAX#:
E-MAIL:
POLICY/GROUP#/CERTIFICATE #:

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? YES ☐ NO ☐ IF YOUR 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 ☐	DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
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 RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT $ _____ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

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

SIGNATURE: _____ DATE: _____

A 3965A (1-95)

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.

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.

SIGNATURE: _____ DATE:

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW
(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE:

CHIROPRACTIC SPINE CENTER OF FLEMINGTON
CHIROPRACTIC PHYSICIANS
35 ROUTE 31, FLEMINGTON, NJ 08822
PHONE: *(908) 751 – 5706* FAX: *(908) 751 – 5708*

Doctor Lien

Patient's Name: _____ D/A: _____

Attorney Name: _____ Phone: _____

Re: MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident, in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident by reason of any other bills that are due his office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor, and I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict, which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection there with.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is solely for said doctor's additional protection and in consideration of his awaiting payment, and I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor above named.

Attorney Signature: _____ Date: _____

Attn attorney: Please return one copy of this document to the doctor's office signed and dated. Keep one copy of this document for your records.