Patient Demographic Form

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

Date of Birth: ___/___/___ Age: ____ Sex: M F (circle one) Marital Status: S M D W # Children ____

Address: _____ City: _____ State: ___ Zip: _____

Home Phone #: (____)_____ Work #: (____)_____ ext ____ Cell #: (___)_____

Occupation: _____ Employer: _____

Email: _____

Social Security #: _____ Driver's License #: _____ State: ____

Insured's Name: _____ Phone #: (____)_____ Insured's D.O.B. : ___/___/___

Insured's Address: _____ Patient's Relationship to Insured: _____

Insurance Company: _____ Telephone: (____)_____

Plan Name: _____ Policy #: _____ Group #: _____

Group Name: _____ Insurance Type: PPO POS EPO HMO Traditional

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Emergency Contact: _____

Relationship to Patient: _____ Emergency Contact #: _____

Signature of Responsible Party: _____ Date: _____

Print Name: _____

Chiropractor On Wheels, LLC
808 High Mountain Rd Suite 201-A, Franklin Lakes NJ 07417 • Phone: (551) 486-6143

Robert Press, MS, DC
NJ Lic.#: 38MC00695500

Erik Geleta, DC
NJ Lic #: 38MC00639000

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization for Patient: _____(print patient name)
I authorize the below named healthcare providers to use and disclose the protected health information described below to the above named patient's health or auto insurance company (3rd party payor), other healthcare professional for the purpose of referral or co-management of the above named patient's health condition, or other individual(s):

(individual seeking the information).____

2. Effective Period:
This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____.

OR

b. □ all past, present, and future periods.

3. Extent of Authorization:
I authorize the release of the above named patient's complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

5. This authorization shall be in force and effect from the initiation of care until:

(CIRCLE ONE)

Indefinitely, until revoked in writing OR Discharge from care OR _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that the above named patient's treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization, though I understand that if I refuse to sign this agreement and wish for care of the above named patient to proceed, that I will be financially responsible for the care received by the patient, as the healthcare provider will be unable to obtain payment from the patient's insurance company without a release of health information.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____	_____	_____
Signature of patient, parent/guardian or personal representative	Printed name of patient, parent/guardian or personal representative, and his/her relationship to patient	Date

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HIPAA Release Form

I, the undersigned, being of full age, do hereby consent pursuant to the security requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA) to allow the below named healthcare professionals to transmit my records, or the records of a minor child of whom I am the parent, guardian, or legally appointed representative by fax, email, or any other electronic means at their discretion, and as they see fit, to obtain reimbursement from my insurance carrier, from me, or to communicate with my attorney, carrier, or other party as required for the administration of my or the aforementioned minor child's affairs. Furthermore, I give the below named healthcare professionals permission to post my name in their office as a source of referrals, with my written consent.

To my carrier: You may release any information regarding my or the aforementioned minor child's records to the below named healthcare professionals and clinic, and I herewith demand a copy of any independent examination reports automatically be forwarded to them, for which I accept responsibility for any reasonable charge applicable thereto, pursuant to law.

If you understand and accept the foregoing, please sign on the line provided below:

Signed: _____ Date: _____

Print Name: _____

Name of Minor Child (if applicable): _____

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Patient Consent For Use and Disclosure of PHI

I, the undersigned, give my consent to the provider, it's agents and assigns to: (i) use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care operations; (ii) release my entire medical record to any other provider or its employees upon a representation that the provider will use the information for treatment or payment; (iii) disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number; (iv) call and leave a voice mail message at my home or other number that I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment or health care operations; (v) discuss my PHI with: (a) any person that accompanies me to a visit or procedure or is present with me when the provider is present, and (b) any person that identifies himself or herself as active in my mental, physical, emotional or spiritual care, including but not limited to family, close personal friends, clergy and patient advocates.

Assignment of Benefits: I hereby authorize any insurance benefits be paid directly to the physical and I understand that I am responsible for non-covered services. I also authorize the treating provider to release any information required in the processing of the claim. I also assign my rights to bring claims for lack of payment, to the below named healthcare provider(s).

If you understand and accept the foregoing, please sign on the line provided below:

Signed: _____ Date: _____

Print Name: _____

Name of Minor Child (if applicable): _____

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Automobile Accident Questionnaire

Accident Information

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ AM/PM

Driver of Automobile: _____ Where You Were Seated: _____

Owner of Automobile: _____ Year/Model of Automobile: _____

Visibility at time of accident: (circle one) Good / Fair / Poor / Other _____

Road conditions at time of accident: (circle one) Icy / Rainy / Wet / Clear / Dark / Other: _____

Where was the vehicle struck: (circle) Front / Rear / Side / Right / Left / Other: _____

Type of accident: (circle) Head-On / Broad-Side / Rear-End / Front Impact-Rear Ended Car In Front / Non-Collision / Other: _____

What part of the vehicle was damaged? _____

Describe what happened on impact: _____

_____

_____

Did you see that the accident was about to happen? (circle one) Yes / No

Did you brace for impact? (circle one) Yes / No

Were you wearing a seatbelt? (circle one) Yes / No

Were you wearing a shoulder harness? (circle one) Yes / No

Does the vehicle have headrests? (circle one) Yes / No

If yes, what was the position of the headrest at the time of impact? (check one)

- ☐ Top of headrest even with bottom of head
- ☐ Top of headrest even with top of head
- ☐ Top of headrest even with middle of head

Was your vehicle breaking? (circle one) Yes / No

Was the other car braking? (circle one) Yes / No

Was your vehicle moving at the time of the impact? (circle one) Yes / No

If yes, how fast do you estimate that you were moving? _____

How fast would you estimate that the other vehicle was moving? _____

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Automobile Accident Questionnaire

What was the position of your head and body at the time of impact? (check all appropriate)

- ☐ Head turned (right) / (left) - circle one
- ☐ Body straight in sitting position
- ☐ Head looking back
- ☐ Body rotated (right) / (left) - circle one
- ☐ Head straight forward
- ☐ Other: _____

At the time of the accident, recall what parts of your head or body hit the what parts of the vehicle:

_____

_____

_____

As a result of the accident, were you: (circle one)

Rendered unconscious / Dazed / Neither / Other: _____

Could you move all parts of your body? (circle one) Yes / No

If no, why not? _____

Were you able to get out of the car and walk unaided? (circle one) Yes / No

If no, why not? _____

Did you have any cuts or bruises from this accident? (circle one) Yes / No

If so, where? _____

Describe how you felt immediately after the accident: _____

_____

How did you feel later that day / night? _____

_____

How did you feel the next day (if accident wasn't today)? _____

_____

Check all symptoms experienced **since** the accident:

☐ Headache	☐ Loss of Smell	☐ Numbness in Fingers	☐ Neck pain / stiffness
☐ Loss of Taste	☐ Cold Hands	☐ Mid Back Pain	☐ Loss of Memory
☐ Cold Feet	☐ Low Back Pain	☐ Fatigue	☐ Diarrhea
☐ Tension	☐ Constipation	☐ Pain Behind Eyes	☐ Shortness of Breath
☐ Chest Pain	☐ Dizziness	☐ Irritability	☐ Nervousness
☐ Fainting	☐ Depression	☐ Cold Sweats	☐ Anxiety
☐ Sleeping Problems	☐ Loss of Balance	☐ Numbness In Toes	☐ Ringing / Buzzing In Ears
☐ Eyes Sensitive To Light		☐ Other: _____	

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Automobile Accident Questionnaire

Have you missed time from work / school? (circle one) Yes / No

If so, how much time have you missed? _____

Do you work? (circle one) Student / Work Part Time / Work Full Time / Unemployed / Other: _____

Did the accident occur during your work hours? (circle one) Yes / No

Did you seek medical help immediately / soon after the accident? (circle one) Yes / No

If yes, how did you get there? _____

Doctor / Hospital / Clinic seen: _____ Date: _____

What was done there? _____

Were X-Rays taken? (circle one) Yes (what body parts) _____ / No

What treatment / prescriptions were given? (check appropriate)

- ☐ Bed Rest - For how long? _____
- ☐ Brace - For which body parts? _____
- ☐ Adjustments - For which body areas? _____
- ☐ Medications - List Names/Dosages/Purposes _____

_____

_____

- ☐ Surgery - On which body parts? _____

_____

_____

What benefits did you receive from treatment? _____

Date of last treatment: _____

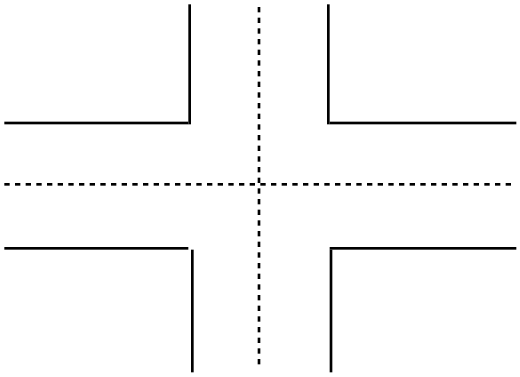
Are your activities of daily living any different now compared to before the accident? (circle one) Yes / No

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

Please indicate on the diagram below how the accident happened:



Comments: _____

_____

_____

_____

_____

_____

_____

_____

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Automobile Accident Questionnaire

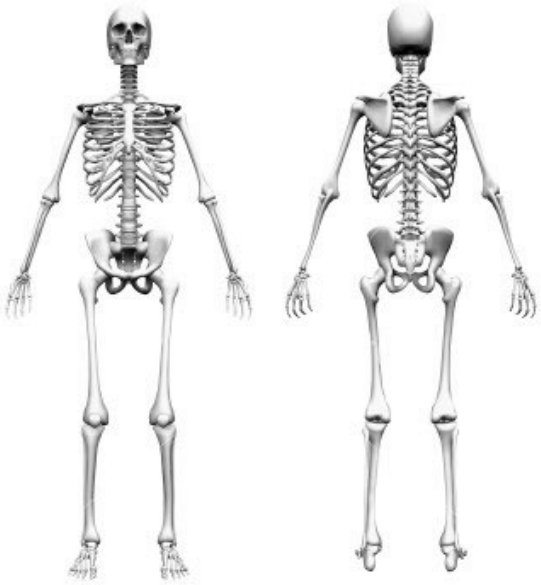
Do you have an attorney handling this case? (circle one) Yes / No

If so, whom: (name, address, telephone number) _____

_____

Pain Chart

Front **Back**



Please shade areas affected on this diagram, and label using the following abbreviations:

P=Pain
R=Radiation
N=Numbness

S=Soreness
A=Ache
St=Stiffness(ST)

Severity of symptoms: (Circle a number 0 - no pain through 10 - worst pain imaginable)

Headaches:	0	1	2	3	4	5	6	7	8	9	10
Dizziness:	0	1	2	3	4	5	6	7	8	9	10
Nausea:	0	1	2	3	4	5	6	7	8	9	10
Anxiety:	0	1	2	3	4	5	6	7	8	9	10
Neck Pain:	0	1	2	3	4	5	6	7	8	9	10
Upper Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain:	0	1	2	3	4	5	6	7	8	9	10
Pelvic Pain:	0	1	2	3	4	5	6	7	8	9	10
Tailbone Pain:	0	1	2	3	4	5	6	7	8	9	10
Chest Pain:	0	1	2	3	4	5	6	7	8	9	10
Abdominal Pain:	0	1	2	3	4	5	6	7	8	9	10
Genital Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Knee Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Ankle Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

Rt. Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Shoulder Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Arm Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Forearm Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Forearm Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Wrist Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Wrist Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Hand Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Hand Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Buttock Pain	0	1	2	3	4	5	6	7	8	9	10
Lt. Buttock Pain:	0	1	2	3	4	5	6	7	8	9	10
Rt. Thigh Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Thigh Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Knee Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Leg Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Ankle Pain:	0	1	2	3	4	5	6	7	8	9	10
Lt. Foot Pain:	0	1	2	3	4	5	6	7	8	9	10

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Automobile Accident Questionnaire

Insurance Information

Patient's automobile insurance carrier: _____

Insured's name (if other than patient): _____

Policy #: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ Zip: _____

Claim #: _____

Insurance Adjuster's Name/Phone: _____

Other party's insurance: _____

Insured's name (if other than patient): _____

Policy #: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ Zip: _____

Claim #: _____

Insurance Adjuster's Name/Phone: _____

Other insurance: _____

Insured's name (if other than patient): _____

Policy #: _____

Insurance Phone #: _____

Insurance Address: _____ City: _____ Zip: _____

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Automobile Accident Questionnaire

Claim #: _____

Insurance Adjuster's Name/Phone: _____

****** Please also fill out the Demographic Form (even if you have already been seen in the practice) *******

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Chiropractor On Wheels, LLC any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Chiropractor On Wheels, LLC the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Chiropractor On Wheels, LLC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses

Patient Signature: _____ Date: _____

Printed Name: _____

Printed Name and Signature of Parent/Guardian (if patient is a minor): _____
_____

Witness: _____

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