CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

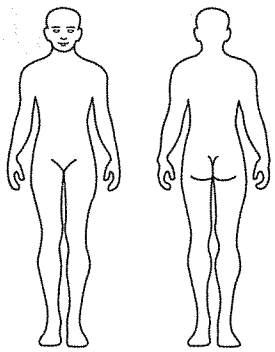
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

PLEASE CHECK OFF THE FOLLOWING AREAS OF COMPLAINTS: DATE:

- ☐ Headaches
- ☐ Neck pain and stiffness
- ☐ Restriction in neck motion
- ☐ Insomnia (unable to sleep)
- ☐ Tension and /or irritability
- ☐ Loss of taste and or smell
- ☐ Loss of memory
- ☐ Diarrhea
- ☐ Anxiety
- ☐ Fainting
- ☐ Chest pain
- ☐ Dizziness
- ☐ Constipation
- ☐ Depression
- ☐ Eye Strain
- ☐ Swelling (Where _____)
- ☐ Feet and/ or hands Cold
- ☐ Upper back pain
- ☐ Middle back pain
- ☐ Lower back pain
- ☐ Neck and/or low back pain upon rising
- ☐ Difficulty rising to walk from a seated position
- ☐ Pins and needles in arms, legs, or both (circle which apply)
- ☐ Numbness in fingers, arms, legs or all (circle which apply)
- ☐ Pain radiating into neck, shoulders, arms, hips and or legs (circle which apply)

- ☐ Eyes sensitive to light
- ☐ Buzzing in the ears
- ☐ Nausea, Vomiting
- ☐ Palpitations
- ☐ Tremors
- ☐ Sinus Trouble
- ☐ Mental Dullness
- ☐ Extreme Nervousness
- ☐ Extreme Fatigue
- ☐ Pain behind the eyes
- ☐ Double Vision
- ☐ Digestive Disorder
- ☐ Head seems heavy
- ☐ Head and/or shoulders feel tired/heavy
- ☐ Shortness of breath

Daily Activities:	Effects of current condition on performance			
Care-Family Member	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Carrying Groceries	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Change Positions-	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sit to Stand	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Climbing Stairs	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Extended Computer use	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Household Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Lifting Children	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Pet Care	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Reading/ Concentration	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self care-Bathing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care-Shaving	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Self Care-Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sexual Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Sleep	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Static Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform
Yard work	☐ No Effect	☐ Painful (can do)	☐ Painful (limits)	☐ Unable to Perform

Patient Signature _____ **Print Name** _____

ATLAS CHIROPRACTIC AND REHABILITATION CENTER

Auto Accident Questionnaire

- Name: _____
- Date of the accident _____
- Time of the accident _____ AM/PM _____
- How many vehicles were involved? _____
- Was you vehicle damaged? If so list: _____
- Is it fixed or being fixed? _____
- Anyone else in your vehicle? _____
- What city and state did the accident occur in? _____
- Did your vehicle hit anything after the accident? If yes, please describe.

  _____
- Were you the driver or passenger/ backseat: left or right? (circle)
- Explain how the accident occurred. _____

  _____

  _____
- Did you lose consciousness during the accident? _____
- Have you been experiencing anxiety after the accident? _____
- Did you have your seatbelt on that the time of the accident? _____
- Did you go to the hospital? _____
  - Ambulance NO Hospital Name: _____
  - Did you have x-rays or MRI taken? _____
  - What areas were taken? _____
  - Have you seen any other doctor?
  - Chiropractor NO Orthopedist NO Pain Management NO
  - Were you prescribed any medications? NO Please list: _____
    - _____
    - _____

ATLAS CHIROPRACTIC AND REHABILITATION CENTER

Accident or Fall Questionnaire

- Name: _____
- Date of the accident _____
- Explain how the accident occurred. _____

  _____

  _____

- Did you lose consciousness during the accident? _____
- Did you see any doctor since the accident/fall? NO

  If so, who? _____
- Did you go to the hospital? YES
  - How did you get to the hospital? _____
  - Did you have x-rays or MRI taken? _____
  - What areas were taken? _____
  - What was the name of the hospital? _____
  - Have you seen any other doctor? _____
  - Were you prescribed any medications? NO Please list: _____
    - _____
    - _____

Atlas Chiropractic & Rehabilitation Center

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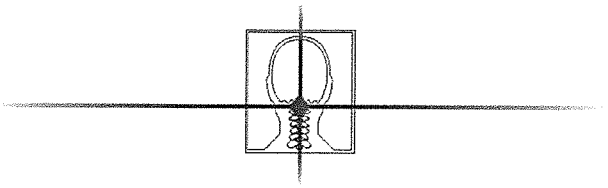

ASSIGNMENT OF BENEFITS

Patient Name: _____

Insurance Company:_____

Date of Loss:_____

I assign to **Atlas Chiropractic and Rehabilitation Center** all of my rights and benefits under any insurance contracts for payment for services rendered to me by **Atlas Chiropractic and Rehabilitation Center** I authorize all information regarding my benefits under any insurance policy relating to any claim by **Atlas Chiropractic and Rehabilitation Center** to be released to **Atlas Chiropractic and Rehabilitation Center**. I authorize **Atlas Chiropractic and Rehabilitation Center** to file insurance claim on my behalf for services rendered to me. I direct that all such payments go directly to **Atlas Chiropractic and Rehabilitation Center**. I authorize **Atlas Chiropractic and Rehabilitation Center** to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I authorize **Atlas Chiropractic and Rehabilitation Center** to obtain counsel and enter legal or other action on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due it should sums not be paid within the legally prescribed time frame. In the event that **Atlas Chiropractic and Rehabilitation Center** elect to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I assign my rights title, and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of **Atlas Chiropractic and Rehabilitation Center** choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, especially failure to appeal, I hereby authorize **Atlas Chiropractic and Rehabilitation Center** to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of **Atlas Chiropractic and Rehabilitation Center** directly in my name.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to **Atlas Chiropractic and Rehabilitation Center** upon receipt of the same. A photocopy of this assignment shall be valid as the original. This assignment of benefits has been explained to my full satisfaction, and I understand it nature and effect.

_____ _____

Patient Signature Date

100 Market Street, Clifton, NJ 07012 Tel: 973.894.3300 Fax: 973.894.3299

ASSIGNMENT OF BENEFITS

Practice Billing Address: Atlas Chiropractic & Rehabilitation Center
100 Market Street
Clifton, NJ 07012

Patient Name:_____

Employer:_____

Group#:_____

SS#/ID#:_____

I hereby instruct and direct _____ Insurance Company to Pay by check, made out and mailed to the above mentioned Atlas Chiropractic & Rehab Center Practice Billing Address.

AND/OR

If my current policy prohibits directs payment to my doctor, I hereby also instruct and direct you to make out the check to me and mail it to the following address:

Patient Name:_____
Atlas Chiropractic & Rehabilitation Center
100 Market Street
Clifton, NJ 07012

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The payment will not exceed my indebtedness to the above-mentioned assigned, and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment of Benefits Agreement shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case, which includes but is not limited to appeals and requests.

I further authorize Atlas Chiropractic & Rehabilitation Center to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____
Signature of Policyholder/Date Witness/Date

_____
Signature of Claimant, if other than Policyholder/Date

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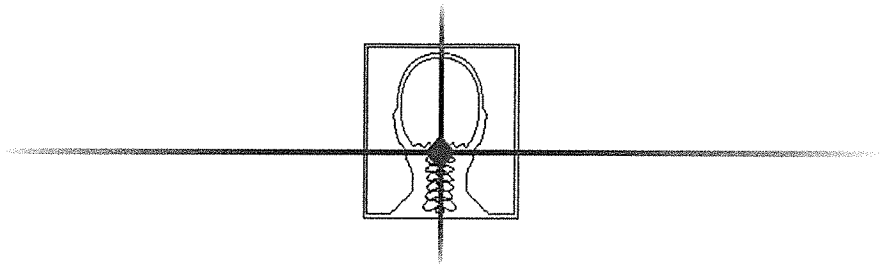

Your insurance company may not pay out of network providers directly. The payment may be sent to you instead. In order for us not to charge you up front for your visit, we expect you to bring the checks into the office within 7 days of receipt. Please bring the explanation of benefits in with the check.

At this time we are only charging you the copay or coinsurance and the insurance check will be the balance of what is due from your visit.

Print Name: _____

Patient Signature: _____

Date: _____

100 Market Street- Clifton, NJ 07012 - Tel: 973.894.3300 – Fax: 973.894.3299

Atlas Chiropractic & Rehab Center

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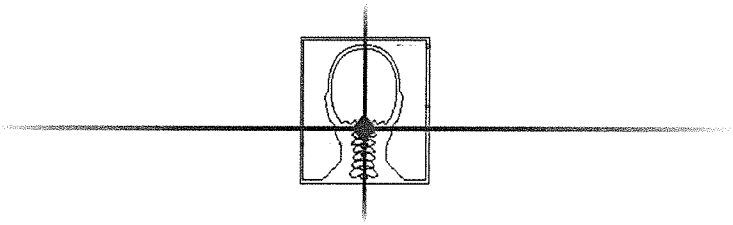

To Attorney: _____
RE: Patient: _____
Date of Accident: _____

Medical Reports and Doctor's Lien

I do hereby authorize the above clinic to furnish to you, my attorney, a full report of examination, diagnosis, prognosis, etc. Pertaining to me in regards to my personal injury cause of action.
I hereby authorize and direct you, my attorney; to pay direct to **Atlas Chiropractic & Rehab Center** such sums as may be due to **Atlas Chiropractic & Rehab Center** for medical services rendered to me for reason of this personal injury cause of action and for any other bills to **Atlas Chiropractic & Rehab Center.**

I hereby further irrevocably create a lien on my judgment or verdict which may be paid to you, my attorney, or me as a result of the injuries for which treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to **Atlas Chiropractic & Rehab Center** for all medical bills submitted by the clinic for services rendered to me and that this agreement is made solely for **Atlas Chiropractic & Rehab Center** additionally protect consideration **of Atlas Chiropractic & Rehab Center** awaiting payment and in event this case is assigned by me to another not a signatory hereto. I understand that all monies due to **Atlas Chiropractic & Rehab Center** will be due and payable by me.

I UNDERSTAND THAT THIS IS AN IRREVOCABLE LIEN AGREEMENT

Patients/Guardian Signature (SIGN): **X** _____ Date: _____
Patients Name and Address (PRINT): _____

The undersigned being attorney of record for the patient does hereby agree to observe all the terms and agrees to withhold any pay over such sums from any Settlement, judgment or verdict as may be adequately protect Atlas Chiropractic & Rehab Center.

In addition, I agree to notify said clinic within ten (10) days in event the patient (my client) is assigned to other counsel.

Attorney Signature (SIGN): **X**_____ Date: _____
Attorney Name and Address: _____
_____
_____

TO THE ATTORNEY: Please sign, date and return one copy to **Atlas Chiropractic & Rehab Center** at once, treatment can continue on the herein contain lien basis.

100 Market Street, Clifton, NJ 07013 Tel: 973.894.3300 Fax: 973.894.3299

AFFIDAVIT OF NO INSURANCE

I, _____ BEING OF FULL AGE AND BEING DULY SWORN ACCORDING TO LAW, UPON BY OATH DEPOSE AND SAY THAT;

1) I WAS INJURED IN A MOTOR VEHICLE ACCIDENT WHICH TOOK PLACE ON _____
2) ON THAT DATE, I RESIDED AT: _____
3) MY DATE OF BIRTH IS: _____
4) MY SOCIAL SECURITY # IS: _____
5) MY DRIVER LICENSE # IS: _____
6) MY HOME TELEPHONE # IS: _____
7) MY WORK TELEPHONE # IS: _____

THE MEMBERS OF MY HOUSEHOLD ON THE DATE OF THE ACCIDENT WHICH ARE OF DRIVING AGE ARE AS FOLLOWS: (If none, state as NONE).

NAME	DATE OF BIRTH	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I AM OTHERWISE ENTITLED TO NEW JERSEY AUTOMOBILE NO FAULT INSURANCE BENEFITS FOR THE DATE OF THE ACCIDENT.

I AM THEREFORE EXECUTING THIS AFFIDAVIT IN ORDER TO OBTAIN NEW JERSEY AUTOMOBILE NO FAULT INSURANCE BENEFITS UNDER THE INSURANCE POLICY AS FOLLOWS:

POLICY NAME: _____
RELATIONSHIP TO THE POLICYHOLDER: _____
NAME OF INSURANCE COMPANY: _____
POLICY NUMBER: _____
PATIENTS SIGNATURE X _____
Affiant

SWORN AND SUBSCRIBED BEFORE ME ON THIS _____ DAY OF _____.

_____
A NOTARY PUBLIC OF NEW JERSEY

*Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your 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 from us upon request.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Atlas Chiropractic & Rehab Center

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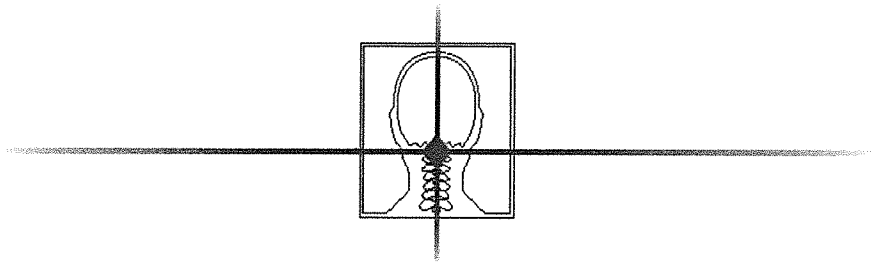

PATIENT REQUEST FOR RECORDS

To: _____
(Doctor or Hospital)

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize and consent to the release of my medical records including radiographic films or copies of such and request they be transferred to:

Dr. Ronald P. D'Amato D.C., BCAO
Dr. Christa M. D'Amato D.C., BCAO
Atlas Chiropractic & Rehab Center
100 Market Street
Clifton, NJ 07012

Patient Name (Print): _____

Address: _____

_____

DOB: _____

SS#: _____

Date of Records: _____

_____
Patient Signature Date