Auto Original Pack

ACCIDENT INFORMATION CHECKLIST

Patient Name: _____

Date of Accident: _____ 1st Office Visit Date: _____

- ❑ Auto Insurance ID Card Copy
- ❑ Health Insurance ID Card Copy(s): O Primary O Secondary
- ❑ Drivers License Copy
- ❑ Auto Insurance Declaration Page
- ❑ Auto Accident Report Copy

Auto Insurance Co. Name: _____

Billing Address: _____

_____

- ❑ Claim Number: _____
- ❑ Adjuster's Name: _____

Phone: _____

FAX: _____

Pre Certification through: _____

Phone No.: _____ Fax No.: _____

- ❑ Attorney: Yes No Attorney Name: _____

Attorney Phone: _____ Fax: _____

Attorney Address: _____

_____

Will Attorney file PIP Arb? Yes No Will they pay filing fee? Yes No

Additional notes: _____

Bloomfield Total Health Center

1129 Broad St, Bloomfield NJ 07003-2918

Patient Forms

Basic Information

Full Name _____

First Middle Last Suffix

Sex __ Male __Female __Unknown Date of Birth____/____/____

Primary Phone __Home __Mobile __Work Phone Number_____

Email_____ Social Security____-____-____

Address Line 1_____ Address Line 2_____

City_____ State_____ Zip_____

Marital Status_____ Maiden Last_____

Driver's License State_____ Driver's License #_____

Demographics

Sexual Orientation_____ Gender Identity_____

Hispanic or Latino? __Yes __No __Decline to Specify Ethnicity_____

Race_____ Language_____

Emergency Contact

Relationship to Contact_____

Full Name_____

First Middle Last

Primary Phone __Home __Mobile __Work Phone Number_____

Email_____

Address Line 1_____ Address Line 2_____

City_____ State_____ Zip_____

Financial Information

Responsible Party

Who will be financially responsible for you? __Myself __Someone Else

If you choose "Someone Else", please fill out the following:

Relationship to Contact_____

Full Name_____

First Middle Last

Primary Phone __Home __Mobile __Work Phone Number_____

Method of Payment

What will be your method of payment? __Insurance __Self-Pay

If you chose "Insurance", please fill out the following:

Primary Insurance Policy

Insurance Company_____ Policy Number_____

Insurance Plan_____ Insurance Phone Number_____

Group Number_____

Insurance Company Address_____ Address Line 2_____

City_____ State_____ Zip_____

Relationship to Primary Policy Holder_____

If you are not the primary policy holder, please fill out the following:

Full Name_____

First Middle Last

Sex __ Male __Female __Unknown Date of Birth____/____/____

Policy ID Number_____ Social Security____-____-____

Policy Holder Address_____ Address Line 2_____

City_____ State_____ Zip_____

If you are unable to provide your insurance information, please provide a reason before continuing: _____

_____

Secondary Insurance Policy

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company_____ Policy Number_____

Insurance Plan_____ Insurance Phone Number_____

Group Number_____

Insurance Company Address_____ Address Line 2_____

City_____ State_____ Zip_____

Relationship to Primary Policy Holder_____

If you are not the secondary policy holder, please fill out the following:

Full Name_____

First Middle Last

Sex __Male __Female __Unknown Date of Birth____/____/____

Policy ID Number_____ Social Security____-____-____

Policy Holder Address_____ Address Line 2_____

City_____ State_____ Zip_____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	Pharmacy Address

How did you hear about us? ___Bloomfield Total Health Center Website ___Internet Search

___Patient: _____ ___Other: _____

Patient Name_____ DOB_____ Date_____

Current Medications

Please list all medications you are taking including non-prescriptions (vitamin, herb and supplement):

Name of Drug	Dose
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9	
10.	

Others medications (please list):

Allergies

Allergen	Type of Reactions	Medications
1		
2.		
3.		
4.		
5.		

Other allergies (please list):

SURGICAL PROCEDURES OR HOSPITALIZATIONS

Surgeries/Hospital	Type of surgery	Date
1.		
2.		
3.		
4.		
5.		

Other surgeries/hospitalizations (please list):

Patient Name_____ DOB_____ Date_____

Past Medical History
(Please fill out all that apply)

Head
- ☐ Trauma
- ☐ N/A

Eyes
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wears glasses/contacts
- ☐ N/A

Ears
- ☐ Hearing aids
- ☐ N/A

Nose/Sinus
- ☐ Allergic rhinitis
- ☐ Sinus Infections
- ☐ N/A

Mouth/Throat/Teeth
- ☐ Dentures
- ☐ N/A

Cardiovascular
- ☐ Aneurysm
- ☐ Angina
- ☐ DVT
- ☐ Dysrhythmia
- ☐ HTN
- ☐ Murmur
- ☐ Myocardial infarction
- ☐ Other heart disease
- ☐ N/A

Endocrine
- ☐ Goiter
- ☐ Hyperlipidemia
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Type I DM
- ☐ Type II DM
- ☐ High Cholesterol
- ☐ N/A

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD-Bronchitis/Emphysema
- ☐ Pleuritis
- ☐ Pneumonia
- ☐ N/A

Gastrointestinal
- ☐ Cirrhosis
- ☐ Gerd
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Ulcer
- ☐ N/A

Genitourinary
- ☐ Hernia
- ☐ Incontinence
- ☐ Nephrolithiasis
- ☐ Other kidney disease
- ☐ STDs
- ☐ UTI (s)
- ☐ N/A

Heme/Oncology
- ☐ Anemia
- ☐ Cancer
- ☐ N/A

Musculoskeletal
- ☐ Arthritis
- ☐ Gout
- ☐ M/S injury
- ☐ N/A

Skin
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Other skin condition(s)
- ☐ Psoriasis
- ☐ N/A

Neurological
- ☐ Epilepsy
- ☐ Seizures
- ☐ Severe headaches, migraines
- ☐ Stroke
- ☐ TIA
- ☐ N/A

Psychiatric
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Hallucinations, delusions
- ☐ Suicidal ideation
- ☐ Suicide attempts
- ☐ N/A

Infectious
- ☐ HIV
- ☐ STD(s)
- ☐ Tuberculosis (dz)
- ☐ Tuberculosis (exposure)
- ☐ N/A

Other medical conditions (please list):

Patient Name_____ DOB_____ Date_____

Family History (Please check all that apply)				
	Mother	Father	Sister(s)	Brother(s)
Age				
General				
No Health Concern				
Arthritis				
Asthma				
Bleeding disorder				
CAD <age 55				
COPD				
Diabetes				
Heart Attack				
Heart Disease				
High Cholesterol				
Hypertension				
Mental Illness				
Osteoporosis				
Stroke				
Cancer				
Breast CA				
Colon CA				
Ovarian CA				
Uterine CA				
Other CA				
Status				
Alive				
Deceased				

Social History (Please check all that apply)				
Marital Status:	❑ Single	❑ Married	❑ Divorced	❑ Separated
Alcohol	Do you drink alcohol? If yes, what kind? How many drinks per day _____	❑ Daily ❑ Beer	❑ Never ❑ Liquor	❑ Occasional ❑ Wine
Tobacco	Do you currently use tobacco? If yes how many years_____	❑ Yes Quit date_____	❑ No	❑ N/A
Cardiovascular	❑ Eat healthy meals	❑ Regular exercise	❑ Take daily Aspirin	❑ N/A
Other social history (Please list):				

Automobile Accident Questionnaire

Please answer all questions Completely

Dear patient: In order for us to understand your condition, please be as accurate/informative as possible about the following information. Thank you.

Accident Information: Date of Accident: _____ City of Accident: _____
Police Report: □ Yes □ No (If yes, please provide us with a copy of the police report)
Anyone else in the vehicle: □ Yes □ No (If yes, please elaborate _____)

Accident Description:

1. Vehicle
□ Car □ Bus
□ SUV □ Train/Subway
□ Truck □ Other

2. Position in Vehicle
□ Driver □ Front Passenger
□ Other □ Left Rear
□ Right Rear

3. What was the vehicle doing?
□ **Stopped** □ Intersection □ In traffic □ At Light
□ Turning □ Right □ Left □ Parking
□ Proceeding along □ Slowing down □ Accelerating

4. Time/Speed/Damage
Time:
Vehicle's Speed _____ MPH
Other Vehicle's Speed _____ MPH
Damage to your vehicle
□ Mild □ Moderate
□ Totaled

5. Details of Accident
Visibility at time of accident
□ Poor □ Fair □ Good

Who hit who/what?
□ You hit other vehicle
□ Other vehicle hit you
You hit…(object):

6. Road Conditions
Road conditions at time of accident
□ Icy □ Wet □ Sandy □ Dark □ Clean and dry

Point of impact
□ Head-on □ Left Front □ Right Front
□ Rear-end □ left Rear □ Right Rear
□ Right Side (Passenger) □ Left Side (Driver)

7, Body Position
Did you see the accident coming? □ Yes □ No
Were you braced for the impact? □ Yes □ No
Did you have a seat belt on? □ Yes □ No
Did you have a shoulder harness on? □ Yes □ No
Did your airbag deploy □ Yes □ No

8. Did the vehicle have a headrest? □ Yes □ No
What was the position of your headrest?
□ Even with top of head □ Even with bottom of head
□ Middle of neck
What was the direction of your head?
□ Facing straight forward □ Turned to the right
□ Turned to the Left

9. During and after the Accident:
Did your body strike the inside of the vehicle □ Yes □ No
If yes, describe: _____
Did you lose consciousness? □ Yes □ No
If yes, how long? _____
Was ambulance on scene: _____

Emergency Room:
Where did you go after the accident?
□ Home □ Work □ Hospital ER □ Private Doctor
How did you get there?
□ Drove Self □ Somebody else □ Ambulance □ Police

10. Symptoms during and after the accident:
□ Headache □ Dizziness □ Mid back pain
□ Neck Pain □ Nausea □ Low back pain
□ Stiff/Soreness □ Confusion □ Nervousness
□ Fainting □ Fatigue □ Loss of taste
□ Ring in ears □ Tension □ Constipation
□ Loss of smell □ Irritability □ Abn. Breathing
□ Eye/Vision Issues □ Anxious □ Chest pain
□ Numbness: □ Arms □ Hands □ Legs □ Feet □ Other
□ Problems Sleeping □ Shortness of Breath
Others:

11. Treatment History:
Hospital: Date of Visit: _____
Xrays: □ Neck □ Head □ Mid Back □ Low Back □ Chest
Lab Work:
Medications:
Treatments: □ Medication □ Brace □ Injection
Other:

Doctor: _____ Date of Visit: _____
Xrays: □ Neck □ Head □ Mid Back □ Low Back □ Chest
Lab Work:
Medications:
Treatments: □ Chiropractic □ MD □ PT □ Pain Man
Explain:

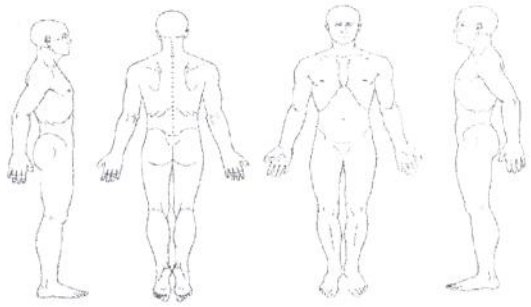
Continue on Back If Necessary ⇒

Additional Accident Information: _____

Please, describe to the best of you knowledge, what happened during this accident: _____

Current Locations of Pain (Mark all that apply):
□ Head □ Neck □ Arms □ Upper Back □ Mid Back □ Chest □ Ribs □ Low Back □ Buttock □ Legs □ Feet
Other: _____

Type of Current Symptoms:
□ Dull pain □ Sharp pain □ Burning pain □ Throbbing pain □ Shooting pain □ Cramping □ Spasm □ Stiffness
□ Numbness Arms/hands □ Numbness Legs/Feet □ Dizziness □ Spinning sensation □ Lightheaded □ Nausea
Other: _____



Mark Your Pain on the Above Diagram

On the scale below, rate your pain intensity by circling the appropriate number: 0= no pain, 10 = unbearable pain.

1	2	3	4	5	6	7	8	9	10

How often do you experience your symptoms?

□ Constantly (76-100% of the day)
□ Frequently (51-75% of the day)
□ Occasionally (26-50% of the day)
□ Intermittently (0-25% of the day)

To what degree do your symptoms interfere with your daily activities?

0	1	2	3	4	5	6	7	8	9	10
No Symptoms		Mild Forgotten with activity		Moderate interferes with activity		Limiting Prevents Full activity		Intense preoccupied with pain		Severe no activity possible

My symptoms interfere with my: □ Sleep □ Work □ Personal Care □ Social life □ Recreation □ None of these

Currently your pain is aggravated by:

□ Coughing
□ Sneezing
□ Straining at Stool
□ Neck Movements
□ Reaching
□ Sitting
□ Bending
□ Lifting
□ Standing
□ Walking
□ Other:_____
□ None of these

Have you ever had complaints in the involved areas before? □ Yes □ No
Have you ever had prior treatment for any same or similar condition? □ Yes □ No
Before the accident were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work or daily activities restricted as a result of this accident? □ Yes □ No
Since the injury are your symptoms? □ Improving □ Getting worse □ Same
Since the injury are you working? □ Yes □ No □ Limited □ Other

I understand and agree that health and accident policies are in arrangement between an insurance carrier/attorney and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist in making collection from the insurance company/attorney and that any amount authorized to be paid, will be paid paid directly to this office. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____

Guardian or Spouse's Signature: _____ Date: _____

Assignment of Benefits

Patient Name: _____

Date of loss: _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to Bloomfield Total Health Center, hereafter referred to as "the healthcare provider" to pursue and obtain payment on my behalf. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.
2. I, the patient, assign to the healthcare provider, all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my healthcare bills, then I hereby authorize and give the healthcare provider power of attorney to sign any documents on my behalf to pursue a claim for personal injury protection benefits. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my healthcare bills may be denied and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney to pay directly to the healthcare provider any monies due on my account, or have same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment of my behalf directly to the healthcare provider. The check should be made payable to the healthcare provider. Further, in the event that the health insurance carrier and/or other insurance carrier fail to forward the check to the healthcare provider, I will endorse and sign the check to the healthcare provider within five (5) days of receipt of same.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's healthcare bills unless I am requested to do so by the healthcare provider. I understand that the above referenced healthcare provider has an attorney and will collect payment on my behalf from the insurance carrier.

_____

Patient Signature

_____

Patient's Name

_____

Date

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments (also known as spinal manipulations) and other chiropractic procedures, including various modes of physical therapeutic modalities and diagnostic x-rays on me (or on the patient named below, for whom I am legally responsible) by Michael M. Credico, DC, Eric R. Franchino, DC, and/or other licensed doctors of chiropractic, physical therapy and acupuncture who now or in the future work at Bloomfield Total Health Center.

I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinical personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed. I understand that the type of treatment used in this office is a low force treatment that helps reduce the possibility of the below risks, but the information is provided so that I may make an informed decision.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some possible risks to treatment, including but not limited to fractures, disc injuries, strokes dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 Name (Print) Patient/Parent/Guardian's Signature Date

DO NOT WRITE IN THIS BOX

Accepted? YES NO Doctor's Signature _____

Total Health Center LLC

Date: _____

Motor Vehicle Accident: _____
Date of Loss

I am financially responsible for paying the following out of pocket fees, due upon processing by insurance or upon settlement of your case if represented by an attorney.

PIP / Major Medical Deductible
Co-Insurance per NJ PIP Fee Schedule Guidelines

If my account balance is referred to our attorney or collection agency for collection due to non-payment, I will be responsible for all attorney or collection fees incurred, late charges and interest in addition to my balance due.

_____ _____
Patient Name (Print) Patient Signature Date

_____ _____
Witness Name (Print) Witness Signature Date

1129 Broad Street • Bloomfield, NJ 07003 • 973 338-3620 • Fax 973 338-4849

BLOOMFIELD TOTAL HEALTH CENTER OFFICE POLICY

Office visits are scheduled according to the severity of your condition and the plan of care that our professional staff feels is best for you. Because your condition may require numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This program minimizes your time in the office and facilitates your appointments into your daily routine.

The frequency of your treatment schedule is of paramount importance to your results so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results. If for any reason you are unable to keep an appointment we require that you telephone immediately to reschedule that visit. It is your obligation to make up a missed appointment within 7 days of cancellation. Also, this office reserves the right to charge for missed appointments and those appointments canceled without 24 hours notice.

FINANCIAL POLICY

Bloomfield Total Health Center has developed a Financial Agreement in an effort to help you, our patient, understand our fees and your financial obligations. We want you to know what to expect at the onset of care so that we may move comfortably forward and focus on what is most important – YOUR health. A member of our staff will explain your benefits and coverage as well as your financial obligation for continuing care. We will be happy to answer any questions you may have in an effort to ensure that you fully understand your policy. *Please note that Bloomfield Total Health Center does not assume ANY responsibility for the accuracy of information furnished by your insurance carrier or you.* This information is only used as a guide to estimate your out-of-pocket expense and may be subject to change pending notification from your insurance carrier.

- **Assign benefits to Bloomfield Total Health Center.** The privilege of insurance assignment begins when it is determined that your insurance covers Chiropractic and/or Physical Therapy. We will submit all necessary claim forms and documentation to your insurance company as a courtesy to you, with the understanding that you will forward to us, all Explanation Of Benefits (EOB) and payments made to you by your insurance carrier for the care received at our office. This reduces your out-of-pocket expense, enabling your entire family to receive care. If payment due to us is sent to you by your insurance company and you do not forward it to us immediately, the insurance assignment will be discontinued and the total amount billed to insurance will become due and payable.
- **Establish a payment plan with our office.** Together, we can calculate a fair weekly out-of-pocket payment amount that is within your budget. (*Out-of-pocket* is the portion of our services that is not paid by your insurance, such as Deductible and Co-insurance.) Again, if you have insurance, all necessary documentation will either be submitted to your insurance company or provided to you.
- **Pay by cash, check or credit card at the time of service.** An account balance may not exceed $150. A handling fee of $25.00 will be charged on any returned check.

MEDICARE PATIENTS

Bloomfield Total Health Center has selected to be a participating provider with Medicare. As such, our office charges the Medicare fee set by law and submits claims to Medicare for you. Medicare should reimburse us directly, however, in the event that Medicare sends *our* payment to you, kindly forward the check and the Explanation Of Benefits (EOB) to our office immediately. The EOB is the statement that Medicare sends to you to explain what portion of your claim was paid or denied. Please note that examinations, x-rays and structural supports are not covered. If not covered by a secondary insurance, your Copay and if applicable, Deductible payments are due at the time that services are rendered.

WORKERS' COMPENSATION

New Jersey State law requires that in Workers' Compensation cases, a written authorization from your employer must be obtained authorizing Bloomfield Total Health Center to provide treatment for injuries sustained while working.

MOTOR VEHICLE ACCIDENT PATIENTS

Prior to the commencement of your care (if possible,) please provide us with your attorney's contact information and/or the following items that are required for us to request pre-certification of your treatment (per New Jersey State law) and to bill your Automobile Insurance company.

- PIP Application
- PIP Claim Number
- PIP Claim Adjuster's name & telephone number
- PIP Policy Declaration Page
- Auto Insurance I.D. Card(s)
- Auto Accident Police Report
- Health Insurance I.D. Card(s)

If we do not receive this information you will be responsible for payment in full at the time that services are rendered at our facility.

PERSONAL INJURY / SLIP & FALL CASES

We must be notified immediately if you are pursuing a lawsuit due to injuries sustained in an accidental slip and fall caused by another party's negligence. Please complete the additional questionnaire regarding your accident and provide us with a letter of protection from your attorney. If we do not receive this information you will be responsible for payment in full at the time that services are rendered at our facility

ALL PATIENTS

It is the goal of this office to provide you with the finest quality health care as affordably as possible. We will make every attempt to offer you a feasible payment plan. We know you understand that in the event that Bloomfield Total Health Center is forced to turn your account over to a collection agency or attorney for non-payment, you will be responsible for any fees incurred for the collection of the outstanding balance.

If you have any questions with regard to your health care or any of our policies, please let us know. We will do our best to answer you as quickly and clearly as possible. We welcome your referrals and look forward to building a doctor-patient relationship that helps us to reach our mutual goal of restoring you to glowing health.

We ask that you sign this form as acknowledgement that you understand it and that you accept full financial responsibility.

Patient or Legal Guardian Signature:_____

Print Patient Name:_____

Date:_____