BRUNSWICK HEALTH CENTER

'LEASE PRINT CLEARLY) Date: _____

ame; _____ SS#: _____

ddress: _____ Apt#: _____

ity: _____ State: _____ Zip: _____

ome Phone #: _____ Cell Phone#: _____ Age: _____

mail: _____ Birth Date: _____/_____/_____

ccupation: _____ Employer: _____

mployer's Address: _____ Work Phone Number: _____

Male/☐ Female (If Female is possible you are pregnant? ☐Yes ☐No)
heck One: ☐Married ☐ Single If Married, spouse name: _____

n case of emergency, whom may we contact: _____ Phone#: _____

NSURANCE INFORMATION

ow did the Injury Occur: ☐Auto ☐Gradual Onset ☐Slip & Fall ☐Taxi ☐Workers Compensation
☐Pedestrian ☐Other: _____

our Major Medical Insurance Company: _____ Policy #: _____

F AN AUTO ACCIDENT:

our car insurance company: _____ Policy #: _____

ttorney's Name & Info: _____

id you report your accident to the Insurance Company? ☐Yes ☐ No Claim# _____

you are not the insured, who in your household has car insurance? Company? Policy #?:

_____

low is the insured related to you?: ☐Spouse ☐Parent ☐Child Other: _____

Was your injury related to the accident? ☐Yes ☐No Date of Accident: _____/_____/_____ Time:_____ am/pm

ocation: _____ City: _____

an auto accident were you the ☐Driver ☐Passenger ☐Front Seat ☐Back seat
Were you struck from : ☐Behind ☐Front ☐Left Side ☐Right Side
Were you wearing a Seatbelt ☐Yes ☐ No
id the Police come and take a police report? ☐Yes ☐No if so please explain:

_____

What type of damage was done to the vehicle? _____

_____

Did you go to the hospital after the accident? Yes No
By Ambulance? Yes No Hospital's name: _____
Were you (circle) X-rayed Examined. Released Admitted
If admitted, list dates: From _____ To _____

What were your major complaints immediately following the Accident? _____

_____

Were you treated by any other doctors for this accident? Yes No
Doctor's Name: _____

What type of treatment did you receive? _____

_____

PAST HISTORY

Have you ever been involved in an accident before? Yes No
If yes, please describe, including date, type of accident, as well as any injuries sustained:

_____

Did you treat with any doctors for your injuries due to the previous accident?

_____

Have you had any serious illnesses? Yes No (If yes, please explain) _____

_____

Past Surgeries: _____ Past Fractures: _____

What type of medications if any, are you taking? _____

DISIBILITY

Have you lost time from work as a result of this accident? Yes No
(If yes, please complete this question):
a. List dates missed from work: From _____ To _____
b. Are you applying for state disability? Yes No

I certify that I am _____ (Name) and I was injured in a(n) _____ accident that occurred on ____/____/____.
I am aware that is punishable under law to commit insurance fraud and that it is a breach of the doctor-patient relationship to knowingly mislead the doctor. I am also aware that filing a statement of claim containing any materially false information, or concealing for the purpose of misleading, information concerning any fact, mate thereto, is a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

I hereby that all my statements on this application for Physical Therapy care are true, accurate and complete.

Signature: _____ Date _____
For Office use only: Information taken by: _____

BRUNSWICK HEALTH CENTER, PC
71 LIVINGSTON AVE
NEW BRUNSWICK, NJ 08901
TEL: (732) 565-1701 FAX: (732) 565-1710

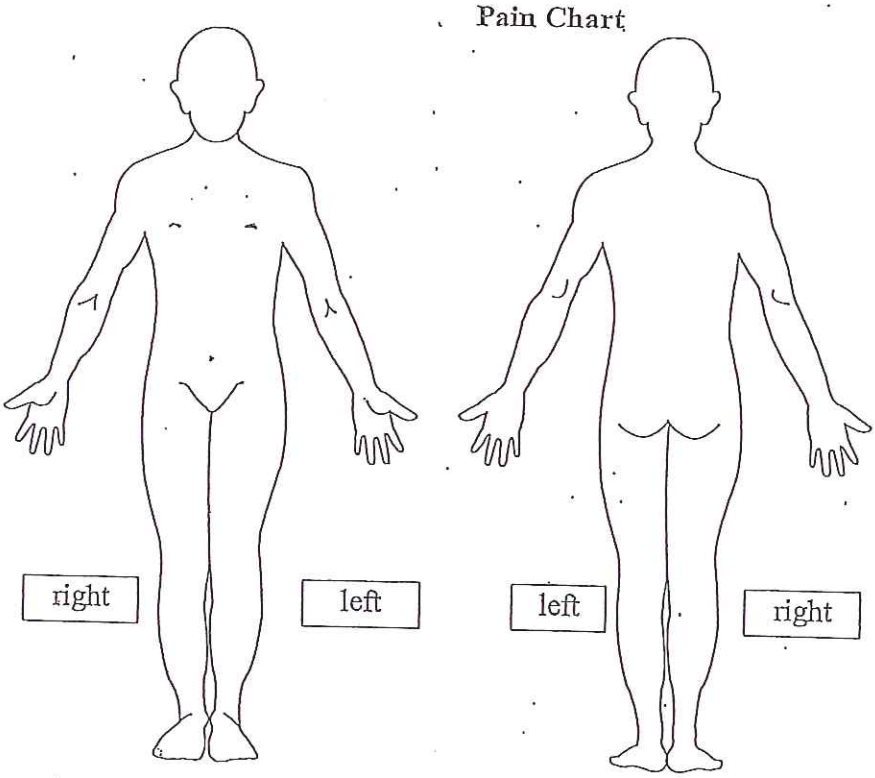
DR. BLESSEN ABRAHAM
CHIROPRACTIC PHYSICIAN

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////
- - - - -	00000	xxxxx	*****	/////

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate t
discomfort as follows:
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate t
discomfort as follows:
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate t
discomfort as follows:
0 10
no pain severe pain

Date: _____ Signature _____

BRUNSWICK HEALTH CENTER, PC
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Activities of Daily Living Assessment

Name:_____ Date:_____

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", 2 = "I can do it without much difficulty, despite some pain", 3 = "I manage to do it by myself, despite marked pain", 4 = "I manage to do it, despite the pain, but only if I have help", 5 = "I cannot do it all, because of the pain".
Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities
Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____
Showering____ Combing hair____ Making bed____ Tying shoes____ Doing laundry____ Washing hair____
Washing face____ Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____ Eating____

Difficulties with Physical Activities
Standing____ Walking____ Kneeling ____ Bending back ____ Twisting left____ Leaning back____
Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
Reclining____ Squatting____ Bending forward____ Bending right____ Leaning forward____ Leaning right____
Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities
Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities
Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____ Golfing____
Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Travelling
Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following 1 to 5 scale to describe the difficulties below:
1 = "This area is not affected by my condition", 2 = "This area is slightly affected by my condition", 3 = "My condition moderately restricts my ability in this area", 4 = " My condition seriously limits my ability in this area", 5 = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication
Concentrating____ Hearing____ Listening____ Speaking____ Reading____
Writing____ Using a keyboard____

Difficulties with the Senses
Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions
Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function
Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Date of Loss: _____

Insurance Company: _____

Name of Policyholder: _____

Policy Number: _____

Claim Number: _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to *Brunswick Health Center PC, 71 Livingston Ave, New Brunswick, NJ 08901*, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. 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, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. 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 medical 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 medical 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 on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (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 medicals bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

7. In the event that the insurance carrier and/or the vendor designated by the insurance carrier does not accept my assignment, or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the carrier in my name and/or allow the medical provider to amend the law suit and/or arbitration to include my name.

Signed: _____

Patient's Name: _____

Dated: _____

Witness: _____

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: _____
CLAIM DEPT.

FOLD HERE

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

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐
NAME OF INSURANCE COMPANY _____

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 AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? 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	IF YES, AMOUNT
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐	
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐	$_____
(3) MEDICARE?	☐	☐	☐ 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

EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO

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.

SIGNATURE _____ DATE: _____

DO NOT DETACH

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.

X _____

SIGNATURE DATE

Section 17:33A-6 of the New Jersey fraud prevention act provides that any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

DO NOT DETACH

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

SOCIAL SECURITY NO. _____

PIP 1

BRUNSWICK HEALTH & PHYSICAL THERAPY CENTER
71 LIVINGSTON AVENUE, SUITE 1
NEW BRUNSWICK, NJ 08901
Tel: (732) 565-1701
Fax: (732) 565-1710

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purpose of treatment, payment or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosure that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practices and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations be contacting our Office Manager.

The effective date of this Notice of Information Practices is 11/6/2007.

Thank you.