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, PLEASE COMPLETE AND SIGN THIS FORM. **NOTE:** THE SOCIAL SECURITY NUMBER IS A REQUIRED FIELD.
2. YOU MUST ALSO SIGN THE AUTHORIZATION (S) ON PAGE 2.
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

INSURANCE COMPANY INFORMATION		
Claim Number:	Policy Number:	Date of Loss:
Policy Holder:	Claim Adjuster:	

INJURED PERSON'S INFORMATION	
Name:	Date of Birth: Gender: ☐ Male ☐ Female
Street Address:	Social Security No: *Note: If you do not have a Social Security Number, complete the enclosed Certification.*
City, State, Zip:	Home Phone:
Address on Date of Accident *(if different from current address)*:	Business Phone:
Street Address:	Driver's License No:
City, State, Zip:	Email Address:
Do you or any member of your household own or lease an auto? ☐ Yes ☐ No Please describe any automobiles in your household that are not listed on this policy *(use back if additional space is needed):* Year, Make & Model: VIN: Owners Name: Relation to injured party: Insurance Company: Policy Number: Are you Married? ☐ Yes ☐ No *If Yes, Spouse's Name*:	Were you the Driver of the Vehicle? ☐ Yes ☐ No Were you a Passenger in the Vehicle? ☐ Yes ☐ No Were you a Pedestrian? ☐ Yes ☐ No Were you a Resident Relative of the Automobile Owner's Household? ☐ Yes ☐ No *If Yes, Identify that Relationship:* Please list any residents of your household and include their age and relationship to you.

ACCIDENT INFORMATION	
Accident Date:	Street Address:
Accident Time: ☐ AM ☐ PM	City or Town, State:
Brief Description of Accident:	

INJURY INFORMATION
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:**

INJURY INFORMATION

Were you treated by a Doctor? ☐ Yes ☐ No	Were you were treated in a hospital? ☐ Yes ☐ No
Treating Doctor:	If Yes, were you an: ☐ In-patient ☐ Out-patient
Street Address:	Hospital Name:
City, State, Zip:	Hospital Address:
Phone:	Date of Hospital Treatment/Admission:

Describe Your Injury:

Have you ever had a similar injury? ☐ Yes ☐ No

If Yes, please describe type of accident, injury, approximate date of loss and all medical providers:

EMPLOYMENT INFORMATION

At the time of the accident, were you ☐ Yes ☐ No performing a job duty?	If yes, have you filed a Workers Compensation Claim? ☐ Yes ☐ No
Workers Compensation Carrier:	Claim # / Adjusters Name: Employers Name:

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:

If you are disabled, will you be making a claim for Essential Service Benefits? ☐ Yes ☐ No

Have you filed for or are you eligible for, payments under:
Employees Disability Benefits, through a private plan? ☐ Yes ☐ No
State Temporary Disability Benefits? ☐ Yes ☐ No

List Names and Address of your Employer:

Employer & Address	Occupation	From:	To:

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALITIES.

SIGNATURE of INJURED PERSON: ______________________ **DATE:** ______________

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. This authorization shall remain valid for the duration of the claim.

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. This authorization shall remain valid for the duration of the claim.

SIGNATURE: ______________________ **DATE:** ______________

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

To assure my ability to attend the required physical examination, I hereby authorize my insurance company 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 decision point review plan of my insurance company.

SIGNATURE: ______________________ **DATE:** ______________

Chiropractic • Physical Therapy • Acupuncture • Nutrition • Wellness

AUTOMOBILE ACCIDENT INFORMATION

Please answer the following questions with the greatest amount of detail that you can accurately recall. This will help us better tailor our care and complete the necessary documentation for your case.

Date of Accident: ____/____/______ Time of Accident: ________ □ am □ pm

About the Accident:

Were you the: □ Driver □ Front Passenger □ Rear Left Passenger □ Rear Right Passenger

Make and Model of the vehicle you were occupying? ______________________________

Total number of people in the vehicle at time of impact? ______________________________

Location of accident:

City: ______________________________ Road/Intersection: ______________________

Please explain, in detail, how your accident happened:

____

____

____

In the space below, please **draw out** your representation of what the accident looked like. Please try to include names of streets, if known.

You were struck from: □ Behind □ In Front □ Left Side □ Right Side

You □ were wearing a seatbelt or other protective device
□ were not wearing a seatbelt or other protective device

Was the car you were in equipped with airbags? □ Yes □ No

As a result of the impact, did they inflate? □ Yes □ No

The approximate speed of your car upon impact was ______mph

The approximate speed of the other vehicle involved in the incident was _____ mph

The traffic conditions at the time of impact were: ______________________________

The weather conditions at the time of impact were: ______________________________

Was there are police report filed: □ Yes □ No

If so, with what police department was the report filed with: ______________________________

Did you come in contact with any objects? □ Yes □ No If yes, what objects (e.g., door, steering wheel, etc.)?

____

What part(s) of your body came in contact with the above object(s)?
____

Where did you feel pain or unusual feeling immediately after the accident?

____

____

Were you □ aware of the impending impact and braced yourself as best you could OR
□ surprised by the impact and unable to prepare yourself for it

After the Accident:

Were you unconscious as a result of the injury? □ Yes □ No If yes, how long? _________
Can you accurately recall the events of the accident? □ Yes □ No
Were you bleeding as a result of the injury? □ Yes □ No If yes, where? __________________
Were you taken to the hospital after the accident? _____ By Ambulance? ____ If so, where? _______________

Treating Doctor's name: _______________________________________ ____DC ____MD ____DO ____DDS

Describe the doctor's diagnosis: ____

What treatment did you receive?

____

____

Are you still under a doctor's care? □ Yes □ No If yes, please explain:

____

____

Past History:

Have you ever injured this area before? □ Yes □ No If yes, when? ____

Have you ever lost time from work due to injury? □ Yes □ No If yes, how long? ___________________________________

Have you been involved in previous accidents of any kind (personal injury, automobile accident, or worker's compensation)? □Yes□ No

If yes, please explain? ____

Have you been previously treated by a chiropractor? □ Yes □ No If yes, when? ____________________________________

Have you been previously treated by a physical therapist? □ Yes □ No If yes, when? ________________________________

Have you been previously treated by an acupuncturist? □ Yes □ No If yes, when? ___________________________________

Present Injury/Disability Information:

On a scale of 1-10, with ten being going to a hospital, how would you rate your pain? ______________________________
Are your symptoms present: □ Constantly □ More in the AM □ More in the PM □ During activity (walking, running) □ During rest (sitting, sleeping, laying down)
Since this injury, are your symptoms: □ Improving □ No Change □ Gradually getting worse □ Worsening
As best as you can, please describe your pain. Please be as clear as possible.

____

____

Did you lose any time from work? □ Yes □ No If yes, for how long? *(please include dates)* ______________________________

Have you returned to work? □ Yes □ No If yes, what was the date of your return? _________________________________

Please briefly describe your job: ____

Please briefly describe your physical duties at your job: ____

Are your work activities restricted as a result of the accident? □ Yes □ No

Do you have to favor any part of your body in your work? □ Yes □ No If yes, explain? _____________________________

____

NOTICE OF LIEN

Patient ________________________________

Date of Accident ________________________

I do hereby authorize Ferraro Spine and Rehabilitation to furnish ____________________________, my attorney, with a full report of the procedure(s) I underwent as a result of my accident referenced above.

I hereby authorize and direct my attorney, to pay directly to Ferraro Spine and Rehabilitation `such sums as may be due and owing them for medical service rendered me both by reason of this accident and by reason of any other bills that are due to the office, and withhold such sums from any settlement judgment or verdict as may be necessary to adequately protect and fully compensate said office, and I hereby further give lien on my case to said office against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated of injuries in connection therewith.

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

I agree to promptly notify said office of any changes or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such submitted or added attorney(s).

Please acknowledge this letter by signing below and returning to the office. I have been advised that if my attorney does not wish to cooperate in protecting the office's interest, the office will not await payment but may declare the entire balance due and payable.

Dated____________________________ Patient's Signature___________________________________

The above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect and fully compensate said office named above. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated____________________________ Attorney's Signature___________________________________

Please date, sign and return one copy to our office. Also keep one copy for your records.

1 Patient Information

Name: ___________ ________ ____________ ___________ ______________

Address: ________________ ____________ _______ _________________

_________ _______ ____________________ ___________ ___________
(City) (State) (Zip)

Birthday: ____________ ___ Age: ___ ___ ________

Height: _____________ __ Weight: _____ ___ ______ ☐ Male ☐ Female

Social Security #: ____________ / __________ / __________ _

Occupation: _______ _______ _____ _______ ___________

Employer: _______ _______ ___________ _______ ________

Employer Address: ____________________________ _______

_________ _______ ____________________ ___________ ____

Guardian's Name *(if minor)*: _______________ _______ ______

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Spouse's Name: _________ ____________ ___________ ___

Referred by:______________ _____________ ___________

2 Insurance

Who is responsible for this account?: _______ _______ ___________

Relationship to patient: ___________ ___ _______ ______________

Insurance company: ______________ ___ ___________ ___________

Insurance Employer ______________ _______ _______ ___________

Insurance ID number: ____________ _______ ___________ _______

Group / Claim Number: ______________________ _______ ________

Are you covered by additional insurance? ☐ Yes ☐ No

Insurance company: ________ ________________ _______ ________

Insurance ID number: ____________ _______ ___________ _______

Group / Claim Number: ______________________ _______ ________

Birthdate of Insured: _______ ______ ___________ _______ ________

Please present insurance card(s) so we may obtain a copy on file

3 Accident Information

Is your condition due to an accident? ☐No ☐Yes

☐Date: __________ _______ ___________ _

Type of accident? ☐ Automobile ☐Work ☐Slip-and-Fall

Who have you reported the accident to? ☐Insurance Co.

☐ Worker's Comp ☐Employer ☐Other: ___________________ _

Attorney Name *(if applicable)*: _________________ _______ ______

4 Contact Information

Home #: _______________ _____________ _______ ______________

Mobile #: ________________ _________ *Provider: _____ _________

(To generate text reminders)

Work #: __________________ ______ ______ Ext: ___ ___ _________

Email: __________________________________ @_____ ________ ___

Best way to reach you: ☐Home ☐Cell ☐Work ☐Email

EMERGENCY CONTACT

Name: ____________ ____________ Relationship: _______ ________

Home No.: __________ __________ Cell No.: _________ ___________

5 Patient Condition

What is your major symptom / problem? ____________ ____________ _______ _______________________ _______ _______________ ______

When did your symptoms begin? ________________ _________________

Have you had this problem before? ☐Yes ☐No

Is your condition getting worse? ☐Yes ☐No

Is this problem: ☐ Constant ☐ Comes and Goes

Describe your pain ***(mark all that apply)***

☐Burning ☐Sharp ☐Shooting ☐Dull ☐Aching ☐Stiffness

☐Tingling ☐Throbbing ☐Swelling ☐Other: _________ _____________

CIRCLE below the severity of your pain on a scale of 1-10

(No pain) **1 2 3 4 5 6 7 8 9 10** *(Severe pain)*

What makes your condition better?: ______________ _____________

What makes your condition worse?: _______ ___________ ______ __

How often do you experience your symptoms?
Indicate where you have pain or other 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)

Please mark with an X below where you feel pain:

When are you most in pain? ☐ Morning ☐ Afternoon ☐ Evening ☐ While sleeping ☐ Constantly

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

Activities/movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Reading ☐ Getting up

6

Health History

What other treatments have you had for this condition? And When?

☐ Chiropractic ______ ☐ Orthopedic ______ ☐ Neurologist _______ ☐ Physical Therapy ___ __ ☐ Medication ______ _

☐ Surgery _______ ☐ Acupuncture ______ ☐ Nutrition ______ ☐ Massage _____ ☐ Personal Training________

Name of other doctors who have treated you for your condition: ______________ _______ __________ _______ ___________

Females: Are you pregnant? ☐Yes ☐ No

Check any of the following conditions that you/ your family have had:

Family/Self		Family/Self		Family/Self	
☐ ☐	AIDS / HIV	☐ ☐	Ear Ringing	☐ ☐	Neck Pain
☐ ☐	Allergies	☐ ☐	Epilepsy	☐ ☐	Osteoporosis
☐ ☐	Anxiety / Depression	☐ ☐	Headaches	☐ ☐	Poor Circulation
☐ ☐	Arm / Shoulder Pain	☐ ☐	Headaches (Migraines)	☐ ☐	Prostate problems
☐ ☐	Arthritis	☐ ☐	Heart Disease	☐ ☐	Rheumatoid Arthritis
☐ ☐	Asthma	☐ ☐	Hemorrhoids	☐ ☐	Sciatica
☐ ☐	Bladder Problems	☐ ☐	Herniated Disc	☐ ☐	Shingles
☐ ☐	Cancer	☐ ☐	High Blood Pressure	☐ ☐	Sinus Infections
☐ ☐	Chronic Fatigue	☐ ☐	Insomnia	☐ ☐	Stroke
☐ ☐	Deafness	☐ ☐	Irregular Cycle	☐ ☐	Thyroid Problems
☐ ☐	Diabetes	☐ ☐	Kidney Problems	☐ ☐	TMJ
☐ ☐	Digestion Problems	☐ ☐	Leg Pain	☐ ☐	Venereal Disease
☐ ☐	Earache	☐ ☐	Low Back Pain	☐ ☐	Vertigo / Dizziness
☐ ☐	Chest Pain/ Heaviness	☐ ☐	Shortness of breath	☐ ☐	Memory Loss
☐ ☐	Difficulty concentrating	☐ ☐	Fatigue		

What tests have you had for your symptoms and when were they performed?

☐ X-Rays *Date:* ______________
☐ MRI *Date* __________________
☐ CT Scan *Date* ______________
☐ EMG/NCV *Date* _____________
☐ Other *Date* ____________

STRESSORS

☐ Smoking — Packs/Day: ___________________
☐ Alcohol — Drinks/Week: ________________
☐ Coffee/Caffeine Drinks — Cups/Day: ___________________
☐ High Stress Level — Reason: ______________________

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

TOLERANCE

☐ Same
☐ Increasing
☐ Decreasing

Have you had any:	Description	Date(s)
Automobile accidents	____________________	___________
Surgeries	____________________	___________
Broken Bones	____________________	___________
Falls / Head Injuries	____________________	___________

7

Medications and Allergies

What allergies do you have or have you had in the past? *Include all seasonal and medication related allergies.*

____________________ ________ ______________ _______ ________ ____________________ ________ ____________________ ___________________

Complete list blow to inform the office of any medications, vitamins, herbs, and/or supplements that you are currently taking.

Be sure to complete all fields within the table.

Medication/Vitamin/Herb/Supplement	Strength	Dosage/Frequency

State of New Jersey - Department of Human Services
Notice of Privacy Practices
Effective date April 14, 2003

***Please Note: YOUR BENEFITS OR ELIGIBILITY WILL NOT BE AFFECTED BY THIS NOTICE. ***

This notice applies to individuals, or legal guardians or parents of minor children receiving services from the Department of Human Services.

Protected health information excludes individually identifiable health information in Education Records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g.

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

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

OUR RESPONSIBILITIES: The Department of Human Services is required by law to:
- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.

In addition, the Department of Human Services is required to:
- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Notify you if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our privacy practices change, we will provide you with a revised notice.

GENERAL PRIVACY RULE

We will not use or disclose your health information without your written authorization, except as described in this notice.

Revoking Your Authorization: If you provide us with a written authorization to release your health information, you may revoke that authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

Separate Authorization for Psychotherapy Notes: We will not release any psychotherapy notes about you without a separate written authorization from you. You may revoke your specific written authorization at any time. A revocation must be in writing. A written revocation will not revoke your prior authorization if we have already released information pursuant to your prior authorization or if your insurance coverage requires your written authorization.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

1. **Treatment.** We may use your health information for your treatment. For example, information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and may be used to determine your diagnosis or the course of treatment that should work best for you. A doctor or other health care professional may share your information with other health care professionals who are either part of the Department of Human Services or who are outside of the Department of Human Services to determine how to diagnose or treat you.
2. **Payment.** We may use your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
3. **Health care operations**. We may use your health information for regular health operations. For example, members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it.
4. **Business Associates**. There are some services provided in our organization through contracts with business associates. Examples include our accountants, consultants and attorneys. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, however, we require that the business associates appropriately safeguard your information.
5. **Facility Directory**. If you do not object, we may include your name, location within our facility, and general condition in our facility directory while you are at the facility. This information would only be disclosed to people who ask for you by name. In addition, unless you object, we may include your religious affiliation to disclose only to clergy members and will disclose that information even if the clergy member does not ask for you by name.
6. **Family and Friends Involved in Your Care**. If you do not object, we may share your health information with a family member, a relative or close personal friend who is involved in your care or payment related to your care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us to notify those persons.

7. **Research**. We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
8. **Funeral directors**. We may disclose health information to funeral directors and coroners to carry out their duties consistent with applicable law.
9. **Organ procurement organizations**. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking of organs, or transplantation of organs for the purpose of tissue donation and transplant.
10. **Contacts**. 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.
11. **Food and Drug Administration (FDA)**. We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.
12. **Workers compensation**. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
13. **Public Health**. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
14. **Correctional institution.** Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
15. **Law enforcement**. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
16. **Abuse, Neglect or Domestic Violence.** We may disclose your health information to the extent provided by law to an authority, social service agency or protective services agency if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will notify you of this disclosure promptly unless it would place you at risk of serious harm.
17. **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law such as audits, civil administrative or criminal investigations, inspections, licensure or disciplinary actions, or other activities necessary for oversight of the health care system, government benefit programs, government regulated programs, or compliance with civil rights laws.
18. **Judicial and Administrative Proceedings.** We may disclose your health information in response to an order of a court or administrative tribunal, or in response to a valid subpoena if we receive satisfactory assurances from the party seeking the information that the party has made an attempt to notify you or to secure a protective order for your information.
19. **National Security and Intelligence Activities.** We may disclose your health information to authorized federal officials for national security activities.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the Department of Human Services, the information in your health record belongs to you. You have the following rights:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, the Department's general health care operations, and/or to a particular family member, other relative or close personal friend. We ask that such requests be made in writing to the privacy officer. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it.
- You have the right to receive confidential communications of your health information. If you are dissatisfied with the manner in which or location where you are receiving communications from us that are related to your health information, you may request that we provide you with such information by alternative means or at alternative locations. Such a request must be made in writing and submitted to the privacy officer. We will accommodate all reasonable requests.
- You may request to inspect and/or obtain copies of health information about you, which will be provided to you within 30 days. Such requests must be made in writing to the privacy officer. If you request to receive a copy, you may be charged a reasonable fee.
- If you believe that any health information in your record is incorrect or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. You must provide a reason to support your request. Such requests must be made in writing to the privacy officer.
- You may request that we provide you with a written accounting of all disclosures made by us of your health information for up to a six-year period of time; however, disclosures made prior to April 14, 2003, do not have to be accounted for by law. We ask that such requests be made in writing to the privacy officer. Please note that an accounting will not include the following types of disclosures: disclosures made for treatment, payment or health care operations; disclosures made to you or your legal representative, or any other individual involved with your care; disclosures authorized by you or your legal representative; disclosures to correctional institutions or law enforcement officials or for national security purposes; disclosures made from the directory; and disclosures that are incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by). There is no charge for the first request for an accounting made in any twelve-month period, but there may be a reasonable charge for additional requests in the same twelve-month period.
- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.
- You may revoke any authorization to use or disclose health information, except to the extent that action has already been taken. Such a request must be made in writing to the privacy officer.

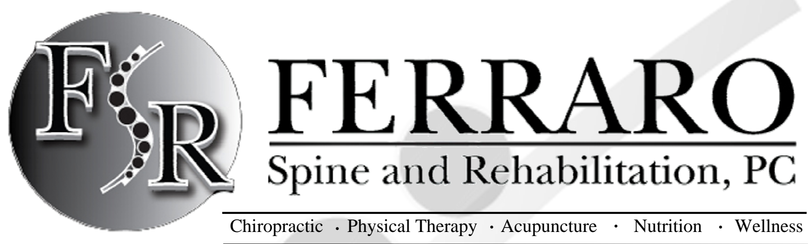
FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the appropriate privacy officer listed on the attached sheets.

If you believe that your privacy rights have been violated, you may file a complaint with us. These complaints must be filed in writing to the Department's Privacy officer. The complaint form may be obtained from the Department's Privacy Officer and when completed should be returned to State of New Jersey, Department of Human Services PO Box 700, Trenton, NJ 08625. You may also file a complaint with the Secretary of the federal Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington DC 20201. This needs to be done within 180 days of when the problem happened. You can also complain to the Office of Civil Rights by calling 866-627-7748.

If you make a complaint to the Department's Privacy Officer or to the Secretary of Health and Human Services, there will be no retaliation against you and your benefits will not be affected.

______________________________	______________________________	__________________________
Patient Name (please print)	**Patient Signature**	**Date**



Patient Informed Consent and Responsibilities

I understand that I am a patient of Ferraro Spine and Rehabilitation, PC, a multidisciplinary facility that encompasses chiropractic care, physical therapy rehabilitation and acupuncture treatments. My care is the exclusive responsibility of the practitioners of Ferraro Spine and Rehabilitation, PC, as well as any other practitioners who also may practice at this location.

Cooperation with treatment:
In order for treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my physician.

No warranty:
I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of treatment have been explained to me. The physicians at the facility provide a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

- Chiropractic Care
  - The doctor will use his/her hands or mechanical device in order to move your spinal joints. This procedure is called a spinal adjustment and it is intended to reduce spinal subluxations. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. You may feel a "click" or "pop", and you may feel movement of the joint. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. Variously ancillary procedures, such as electrical stimulation, ultrasound, mechanical traction, manual therapeutic massage of the musculature, or hot/cold packs may be used.

- Physical Therapy Care
  - Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them. Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Ferraro Spine and Rehabilitation, PC does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.
- Acupuncture
  - I understand that methods may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, soreness, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur

- IDD Therapy®
  - IDD Therapy® (Intervertebral Differential Dynamics Therapy) provides computer-directed mechanical traction to the lumbar and/or cervical intervertebral discs and facet joints. IDD Therapy® protocols allow for the controlled manipulation and distraction of targeted intervertebral discs to mobilize the joint and create a negative pressure inside the intervertebral disc. This negative pressure leads to the diffusion of fluid and nutrients into the disc to stimulate its metabolism and promote hydration and healing. The negative pressure can also lead to the retraction of a herniated nucleus pulposus. IDD Therapy® treatment further delivers a passive exercise element to release spasmodic behavior and to re-educate supporting soft tissues. Ferraro Spine and Rehabilitation, PC does not guarantee what your reaction will be to IDD Therapy®, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. There is a possibility that IDD Therapy® may result in aggravation of existing symptoms and may cause pain or injury.
- Laser therapy
  - Laser therapy is a safe, non-invasive FDA cleared modality for the treatment of pain and temporary increase in microcirculation. Increased microcirculation can provide relief for many acute and chronic conditions. Laser therapy utilizes visible and invisible laser radiation; therefore, appropriate eye protection is required at all times during treatment. Effects of the treatment will continue for up to 18 hours. Individuals respond uniquely to treatment. Results may be immediate after the first treatment or depending on the severity of the condition it may require several treatments before results are seen. Increased soreness may occur after the first laser session. This is a normal healing phenomenon known as retracing. Mild bruising may occur from the soft tissue manual therapy element of your treatment program. Failing to complete any part of the treatment program will reduce the chances of success. Ferraro Spine and Rehabilitation, PC does not guarantee what your reaction will be to laser therapy, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. There is a possibility that laser therapy may result in aggravation of existing symptoms and may cause pain or injury.

Potential risks:
I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physician. Additionally, I understand that there are some risks to treatment. While rare, these risks include but are not limited to fractures, disc injuries, strokes, and sprains. The risks of injuries or complication from treatment are substantially lower than that associated with many medical or other treatments, medication, and procedures given for the same conditions, and I 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 them known to him or her is in my best interest. The risks of complications due to treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can even be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered rare.

Potential benefits:
I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives:
If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider. I have read the above information and I consent to evaluation and treatment

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known are in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read or have had read to me the explanation above of care that is available to me within Ferraro Spine and Rehabilitation. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the health plan recommended to me and hereby give my full consent to treatment. 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.

______________________________	______________________________	______________
Patient Name (Please print)	**Patient Signature or Legal Guardian Signature**	**Date**

ASSIGNMENT OF BENEFITS/E.R.I.S.A. AUTHORIZATION FORM
FERRARO SPINE & REHABILIATION, P.C.

Patient (*print name*): ____

Employer (*of policy holder*): ____

SSN/ID#: ____

I hereby instruct and direct ____ Insurance Company to pay by check made out and mailed to:
(name of insurance company)

Ferraro Spine and Rehabilitation, PC
230 Midland Avenue
Saddle Brook, NJ 07663

If my current policy prohibits direct payment to my doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

Ferraro Spine and Rehabilitation, PC
230 Midland Avenue
Saddle Brook, NJ 07663

My health insurance benefits have been explained to me. I am aware that Ferraro Spine and Rehabilitation is a non-participating facility and is subject to my deductible and co-insurance.

Financial Responsibility

I have requested professional services from Ferraro Spine & Rehabilitation, P.C. ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

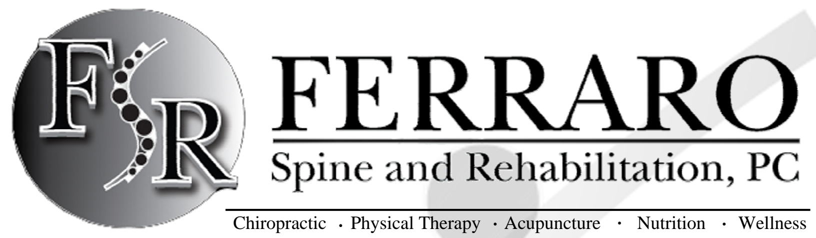
Attorney Representation and Protection of Balance

I hereby request my attorney to pay any outstanding bills out of my settlement and in effect, protect any such balance. I hereby make and declare the instructions herein contained to be irrevocable. If fully understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgement, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services
I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

______________________	______________________	______________________
Signature of Policyholder	**Signature of Patient**	**Date**



Agreement to Forward Payment

This letter is to inform you that in most cases **Blue Cross Blue Shield** does not send payments to the physician directly. As the patient, you will be receiving payments for services rendered at our offices. When this occurs, we find that it is easiest to **endorse the back of the checks, and simply mail or bring them in with you on your next visit along with the explanations of benefits.** This will allow us to refrain from asking you for payment when services are rendered. **Please do not cash the checks you receive for services provided by our office**. We are then in the uncomfortable position of asking for payment months later, after hours on the phone to the insurance company tracking where the payments have been sent.

BC/BS also posts **"PAID"** payments to our billing service that they have paid. If this occurs our billing company, **Precision Billing**, will send you a letter that you have received a check. If you have not received the check then please call **Precision Billing** at (201)501-8500, and they will in turn set up a conference call with BC/BS to resolve the situation.

For your convenience, Ferraro Spine and Rehabilitation, PC is asking that our BC/BS patients provide a credit card to keep on file. This information will only be utilized if an outstanding balance is incurred from receiving and not remitting BC/BS checks that you receive.

Thank you for your patience in this matter, as these are BC/BS policies not our own.

I, ________________________________, am aware that my insurance company may send me payments for services rendered by Ferraro
(print first & last name)
Spine and Rehabilitation, which may include a consultation, physical therapy exam / treatment, chiropractic exam / treatment, acupuncture exam / treatment, etc. These are insurance phrases that include the treatment that you receive when you are at our office. If you have any questions regarding these charges, please do not hesitate to inquire at the front desk upon your next visit.

By completing this form, you agree that when you receive any payments for those services, you will:

1. Sign the check and **not deposit or cash it**
2. Under your signature print the following:
   "Make Payable Only to Ferraro Spine and Rehabilitation"
3. Enclose the check with all accompanying letters or forms, such as the Explanation or Benefits, in an envelope, and mail immediately to Dr. Peter Ferraro at the address on this letterhead.

Additionally, by completing this form, you understand that in the event that the check is not immediately sent to Dr. Ferraro, you will be responsible to pay the full and entire fee for all of the services rendered, plus 12% interest on any additional collection fees and legal costs in connection with collecting this debt.

Ferraro Spine and Rehabilitation and/or Dr. Ferraro is hereby given Power of Attorney to endorse/sign your name on any and all checks for payment of your doctor's bill; only in connection with services provided by Ferraro Spine and Rehabilitation and/or Dr. Ferraro.

A copy of this agreement can be provided to you as a reminder of what is required when you receive the payment from your insurance company.
Yours in good health,

______________________	______________________	______________________
Patient's Name *(please print)*	**Patient's Signature**	**Date**
______________________	______________________	______________________
Credit Card Number	**Date of Expiration**	**CCV**

The provider or place of service, as described on your explanation of benefits, will be:
Ferraro Spine and Rehabilitation, PC
or your provider(s):

Peter M. Ferraro, DC **Kyle J. Robertson, DC** **Nicholas Angione, DC**

Kim Bauernfeind, DPT **Michelina Mann, M.Ac** **Kathy Ryu, L.Ac**

230 Midland Avenue – Saddle Brook, NJ 07663 – Phone: 973.478.2212 – Fax: 973.478.2123
www.ferrarospine.com

Cancellation/No Show Policy:
All treatments in chiropractic, physical therapy, acupuncture, nutrition and specialty doctors require 24 hour notice for the cancellation of a scheduled appointment. There is a $50 charge for a no-show or cancellation without proper notice. This charge *will not* be covered by your insurance. We understand that extenuating circumstances may occur which is why we have implemented a "three-strike" policy. We will allow for three cancellations before charging a fee. For every cancellation or no-show beyond three, a $50 fee will be assessed. Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no shows will hinder your care and may result in discharge from our facility.

Lateness Policy:
It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available, however; simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 15 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive more than 10 minutes early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. You, the patient — for not receiving the treatment you need
2. Your provider — as now he or she has a gap in the schedule
3. Another patient — who could have had your appointment time

Certain accident claims adjusters expect regular attendance to treatments as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioners to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or *not* having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

I consent to the above, as indicated by my signature below:

______________________	______________________	______________
Print Name	**Signature**	**Date**

230 Midland Avenue – Saddle Brook, NJ 07663 – Phone: 973.478.2212 – Fax: 973.478.2123
www.ferrarospine.com

Wellness Questionnaire

At Ferraro Functional Fitness we believe that physician approved fitness, nutrition, and stress management are key components to actively managing your health.

By answering these questions, we are better able to serve you and deliver the right programs to meet your needs.

1. What goals do you have?
   - ☐ Lose Weight
   - ☐ Improve Balance
   - ☐ Increase Flexibility
   - ☐ Gain Strength
   - ☐ Be More Active
   - ☐ Eat Healthier
   - ☐ Have More Energy
   - ☐ Lower Stress
   - ☐ Other: ____________________
2. What services would be most beneficial to help you achieve your goals?
   - ☐ Health Coaching
   - ☐ Exercise Classes
   - ☐ Nutrition Education
   - ☐ Stress Management
   - ☐ Vibration Plate Therapy
   - ☐ Yoga
   - ☐ Golf Training
   - ☐ Personal Training
   - ☐ Corrective Exercise
   - ☐ Pilates
   - ☐ Weight Loss
   - ☐ Other: ____________________
3. What is your availability to participate in a program (days, times)?

   ____
4. Is the Saddle Brook site a convenient location for you to come to on a regular basis?
   - ☐ Yes
   - ☐ No
5. What questions do you have that we can help you with regarding fitness and nutrition?

   ____

   ____

Did you know we offer many free and affordable wellness programs in this building? Please fill out your contact information and our program specialist will provide you with more information.

Name: ________________________________

E-mail: ________________________________

Phone Number: __________________________