PLEASE BRING THESE ITEMS TO YOUR VISIT

AUTO INSURANCE

- Insurance Company (Auto or Workman's Comp)
  – Name, Address, Phone Number
- Auto Insurance Policy Card
- PIP Policy Declaration Page
- Adjuster's Name and Phone Number
- Insurance Claim Number

HEALTH INSURANCE

- Health Insurance Card(s)

ATTORNEY

- Attorney's Name, address, & phone number (if applicable)
- Letter of Protection

OTHER ITEMS

- Driver's License
- Police Report
- PIP Application of Benefits form (PLEASE OBTAIN FROM ADJUSTER)

Sandoz Chiropractic Center
2057 Briggs Road Suite 204
Mount Laurel, NJ 08054
PH: 856-206-9560 Fax: 856-206-9701
www.sandozchiropractic.com
frontdesk@sandozchiropractic.com

Welcome To Sandoz Chiropractic Center
CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

First Name: _____ Middle: _____ Last: _____

Preferred Name: _____ Maiden Name: _____

Race (choose one): [Asian] [African American] [Caucasian] [Hispanic] [Native American] [Other]

Ethnicity (choose one): [Non-Hispanic] [Hispanic] [Withheld]

Address: _____ Postal Code: _____

City _____ State: _____ E-mail address: _____

Appointment reminder preference: [Cell Phone Call] [Home Phone Call] [Text Message] [E-mail]

(Circle more than one above if you would prefer that)

Home Phone _____ Work Phone _____ Cell Phone _____

Cell phone carrier (for text messages) [AT&T] [Verizon] [Sprint] [Virgin] Other _____

Date of Birth ___ / ___ / _____ Social Security Number ___ - ___ - _____

Gender: [Male] [Female] Height: ___ ft ___ in Weight: _____ lbs.

Married Single Divorced Widow(er) Number of Children Pregnant: Due Date:

Employer _____ Occupation _____

Emergency Contact: _____ Contact Phone # _____

Whom may we thank for referring you? _____

Primary Care Doctor: _____ Phone: _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____

List all accidents or injuries:

Type _____ When _____ Hospitalized? ___

List all surgeries:

Type _____ When _____

List medications and/or vitamins and supplements you are taking

Name _____ For _____ How long _____

Name _____ For _____ How long _____

Use back of sheet for any additional space needed.

PAIN DRAWING

Name:_____ Date:_____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the area of radiating pain, and include all affected areas. You may draw on the face as well.

Pain Symbols:

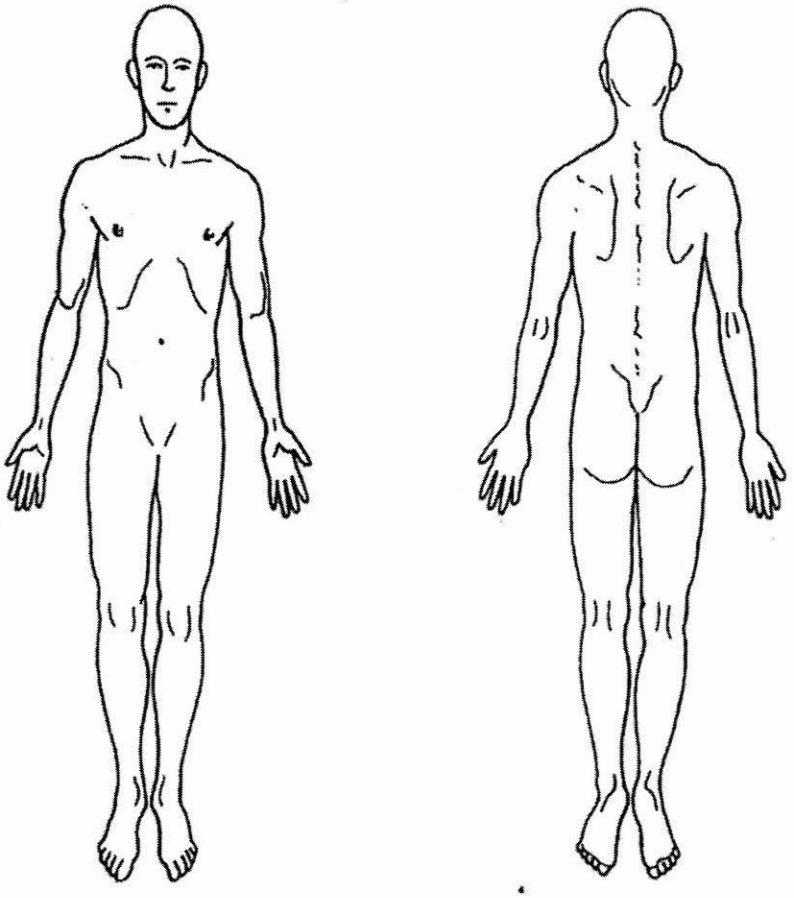
Numbness

Pins & Needles
o o o o o o o

Burning Pain
x x x x x x x x

Stabbing Pain
/ / / / / / / / / / /

Aching Pain
(((((((((



Chief Complaint:_____

Patient Explanation of Incident:_____

Date of Onset:_____ Did symptoms appear gradually or suddenly?_____
On the Job:____Yes____No Days off work:_____
Auto Accident:____Yes____No Days off work:_____

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Patient Name: _____ Date: _____

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

Past	**Musculoskeletal**	Present
[ ]	Neck pain	[ ]
[ ]	Shoulder pain	[ ]
[ ]	Pain in upper arm or elbow	[ ]
[ ]	Hand pain	[ ]
[ ]	Upper back pain	[ ]
[ ]	Low back pain	[ ]
[ ]	Pain in upper leg or hip	[ ]
[ ]	Pain in lower leg or knee	[ ]
[ ]	Pain in ankle or foot	[ ]
[ ]	Jaw pain	[ ]
[ ]	Swelling in joints (list joints)	[ ]
	_____	
[ ]	Stiffness of joints (list joints)	[ ]
	_____	

Past	**Nervous System**	Present
[ ]	Depression	[ ]
[ ]	Insomnia	[ ]
[ ]	Bed wetting	[ ]
[ ]	Fainting	[ ]
[ ]	Convulsions	[ ]
[ ]	Dizziness	[ ]
[ ]	Headache	[ ]
[ ]	Muscular incoordination	[ ]
[ ]	Hearing loss	[ ]
[ ]	Tinnitus (ear noises)	[ ]
[ ]	Ear pain	[ ]
[ ]	Impaired vision	[ ]
[ ]	Eye pain	[ ]
[ ]	Paralysis	[ ]

Past	**Cardiovascular**	Present
[ ]	Rapid heartbeat	[ ]
[ ]	Chest pains	[ ]

Past	**Endocrine**	Present
[ ]	Loss of appetite	[ ]
[ ]	Abnormal weight gain	[ ]
[ ]	Abnormal weight loss	[ ]

Past	Respiratory	Present
[ ]	Shortness of breath	[ ]
[ ]	Chronic pain	[ ]
[ ]	Chronic cough	[ ]
[ ]	Chronic sinusitis	[ ]

Past	**Gynecologic**	Present
[ ]	Pain during menstruation	[ ]
[ ]	Irregular menstrual flow	[ ]
[ ]	Spotting	[ ]
[ ]	Menopausal symptoms	[ ]

Past	**Genito-Urinary**	Present
[ ]	Painful urination	[ ]
[ ]	Loss of bladder control	[ ]
[ ]	Frequent urination	[ ]
[ ]	Urethral discharge	[ ]

Past	**GI Tract**	Present
[ ]	Abdominal pain	[ ]
[ ]	Difficult swallowing	[ ]
[ ]	Heartburn/indigestion	[ ]
[ ]	Constipation	[ ]
[ ]	Diarrhea	[ ]

Past	**Skin**	Present
[ ]	Rash	[ ]
[ ]	Dermatitis or eczema	[ ]
[ ]	Persistent itching	[ ]

Please check any of the following that apply to you.

[ ] Tobacco
[ ] Alcohol, Qty/Frequency _____
[ ] Tranquilizers/Sedatives
[ ] Laxatives
[ ] Coffee, cups/day _____
[ ] Regular soda, cans/day _____
[ ] Diet soda, cans/day _____
[ ] Water _____

Family History: Listed below are common diseases and disorders. Please indicate whether you have a Parent, Sibling, and/or Grandparent who have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	**Condition**	Present
[ ]		[ ]
[ ]	Heart disease	[ ]
[ ]	High blood pressure	[ ]
[ ]	Angina	[ ]
[ ]	Heart attack	[ ]
[ ]	Stroke	[ ]
[ ]	Asthma	[ ]
[ ]	Gallbladder	[ ]
[ ]	Cancer	[ ]
[ ]		[ ]

Past	**Condition**	Present
[ ]	Emphysema	[ ]
[ ]	Arthritis	[ ]
[ ]	Drug or alcohol dependency	[ ]
[ ]	Diabetes	[ ]
[ ]	Ulcer	[ ]
[ ]	Kidney stones	[ ]
[ ]		[ ]
[ ]	Other _____	[ ]
[ ]	Other _____	[ ]
[ ]	Other _____	[ ]

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Patient's Name_____Number_____Date_____

LOW BACK DISABILITY QUESTIONNAIRE (OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

D I can tolerate the pain without having to use painkillers.
D The pain is bad but I can manage without taking painkillers.
D Painkillers give complete relief from pain.
D Painkillers give moderate relief from pain.
D Painkillers give very little relief from pain.
D Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

D I can look after myself normally without causing extra pain.
D I can look after myself normally but it causes extra pain.
D It is painful to look after myself and I am slow and careful.
D I need some help but manage most of my personal care.
D I need help every day in most aspects of self care.
D I do not get dressed, I wash with difficulty and stay in bed.

Section 3 -- Lifting

D I can lift heavy weights without extra pain.
D I can lift heavy weights but it gives extra pain.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
D I can lift very light weights.
D I cannot lift or carry anything at all.

Section 4 -- Walking

D Pain does not prevent me from walking any distance.
D Pain prevents me from walking more than one mile.
D Pain prevents me from walking more than one-half mile.
D Pain prevents me from walking more than one-quarter mile
D I can only walk using a stick or crutches.
D I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

D I can sit in any chair as long as I like
D I can only sit in my favorite chair as long as I like
D Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 30 minutes.
D Pain prevents me from sitting more than 10 minutes.
D Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___x 2) / (____Sections x 10) = _____ %ADL

Section 6 -- Standing

D I can stand as long as I want without extra pain.
D I can stand as long as I want but it gives extra pain.
D Pain prevents me from standing more than 1 hour.
D Pain prevents me from standing more than 30 minutes.
D Pain prevents me from standing more than 10 minutes.
D Pain prevents me from standing at all.

Section 7 -- Sleeping

D Pain does not prevent me from sleeping well.
D I can sleep well only by using tablets.
D Even when I take tablets I have less than 6 hours sleep.
D Even when I take tablets I have less than 4 hours sleep.
D Even when I take tablets I have less than 2 hours sleep.
D Pain prevents me from sleeping at all.

Section 8 -- Social Life

D My social life is normal and gives me no extra pain.
D My social life is normal but increases the degree of pain.
D Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
D Pain has restricted my social life and I do not go out as often.
D Pain has restricted my social life to my home.
D I have no social life because of pain.

Section 9 -- Traveling

D I can travel anywhere without extra pain.
D I can travel anywhere but it gives me extra pain.
D Pain is bad but I manage journeys over 2 hours.
D Pain is bad but I manage journeys less than 1 hour.
D Pain restricts me to short necessary journeys under 30 minutes.
D Pain prevents me from traveling except to the doctor or hospital.

Section 10 -- Changing Degree of Pain

D My pain is rapidly getting better.
D My pain fluctuates but overall is definitely getting better.
D My pain seems to be getting better but improvement is slow at the present.
D My pain is neither getting better nor worse.
D My pain is gradually worsening.
D My pain is rapidly worsening.

Comments_____

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NECK DISABILITY QUESTIONNAIRE (OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

D I can tolerate the pain without having to use painkillers.
D The pain is bad but I can manage without taking painkillers.
D Painkillers give complete relief from pain.
D Painkillers give moderate relief from pain.
D Painkillers give very little relief from pain.
D Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

D I can look after myself normally without causing extra pain.
D I can look after myself normally but it causes extra pain.
D It is painful to look after myself and I am slow and careful.
D I need some help but manage most of my personal care.
D I need help every day in most aspects of self care.
D I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

D I can lift heavy weights without extra pain.
D I can lift heavy weights but it gives extra pain.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
D I can lift very light weights.
D I cannot lift or carry anything at all.

Section 4 – Walking

D Pain does not prevent me from walking any distance.
D Pain prevents me from walking more than one mile.
D Pain prevents me from walking more than one-half mile.
D Pain prevents me from walking more than one-quarter mile
D I can only walk using a stick or crutches.
D I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

D I can sit in any chair as long as I like
D I can only sit in my favorite chair as long as I like
D Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 30 minutes.
D Pain prevents me from sitting more than 10 minutes.
D Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___x 2) / (_____Sections x 10) = _____ %ADL

Section 6 – Standing

D I can stand as long as I want without extra pain.
D I can stand as long as I want but it gives extra pain.
D Pain prevents me from standing more than 1 hour.
D Pain prevents me from standing more than 30 minutes.
D Pain prevents me from standing more than 10 minutes.
D Pain prevents me from standing at all.

Section 7 -- Sleeping

D Pain does not prevent me from sleeping well.
D I can sleep well only by using tablets.
D Even when I take tablets I have less than 6 hours sleep.
D Even when I take tablets I have less than 4 hours sleep.
D Even when I take tablets I have less than 2 hours sleep.
D Pain prevents me from sleeping at all.

Section 8 – Social Life

D My social life is normal and gives me no extra pain.
D My social life is normal but increases the degree of pain.
D Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
D Pain has restricted my social life and I do not go out as often.
D Pain has restricted my social life to my home.
D I have no social life because of pain.

Section 9 – Traveling

D I can travel anywhere without extra pain.
D I can travel anywhere but it gives me extra pain.
D Pain is bad but I manage journeys over 2 hours.
D Pain is bad but I manage journeys less than 1 hour.
D Pain restricts me to short necessary journeys under 30 minutes.
D Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

D My pain is rapidly getting better.
D My pain fluctuates but overall is definitely getting better.
D My pain seems to be getting better but improvement is slow at the present.
D My pain is neither getting better nor worse.
D My pain is gradually worsening
D My pain is rapidly worsening

Comments_____

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SANDOZ CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC SPINAL MANIPULATION, DIAGNOSTIC X-RAYS AND TREATMENT, AUTHORIZATION AND RELEASE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy modalities (including but not limited to ultrasound, muscle stimulation, interferential, ice, heat, traction, spinal decompression) and diagnostic x-rays, on myself (or on the patient named below for whim I am legally responsible) by or under the orders of the licensed doctors of chiropractic of the Sandoz Chiropractic Center or any doctor, who now or in the future, works as a relief doctor.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, stokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications and realize that alternatives to care might include medical treatment, surgery or doing nothing. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

I authorize payment of insurance benefits directly to the Sandoz Chiropractic Center. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize the Sandoz Chiropractic Center to communicate with my medical physician(s) about my conditions and treatment. I understand and agree that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also agree that if my account goes into a 'collection state' for non-payment a charge of 35% will be incurred on the total amount owed. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I have also read, or have had read to me the above informed consent, authorization and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend for this consent form to cover the entire course of treatment for my present condition and for future conditions(s) for which I seek treatment.

Patient's Signature: _____ Date: _____

Printed Name: _____

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby authorize the doctors of Sandoz Chiropractic Center, and/or whomever they may designate as assistants to administer treatment as deemed necessary to _____.

Signature of Parent or legal guardian: _____ Relationship: _____

Date: _____ Witness Signature: _____

X-RAY PREGNANCY RELEASE FORM

___ To the best of my knowledge, I am NOT pregnant and I consent to protected Rediograph exposure at Sandoz Chiropractic Center.

___ I am or may be pregnant; however, I consent to limited protected Diagnostic Radiographs of my Cervical Spine (Neck).

Patient's Signature: _____ Date: _____

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frontdesk@sandozchiropractic.com – www.sandozchiropractic.com

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZATION FORM

Financial Responsibility

I have requested professional services from **Sandoz Chiropractic / Dr. Sandoz** 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 **Sandoz Chiropractic / Dr. Sandoz** I certify that the health insurance information that I provided to **Sandoz Chiropractic / Dr. Sandoz** is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize **Sandoz Chiropractic / Dr. Sandoz / Lynette Bernier** 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 **Sandoz Chiropractic** in good faith. I also hereby instruct my benefit plan (or its administrator) to pay **Sandoz Chiropractic / Dr. Sandoz** directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to **Sandoz Chiropractic / Dr. Sandoz**, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and **Sandoz Chiropractic / Dr. Sandoz** upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to **Sandoz Chiropractic / Dr. Sandoz**.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from **Sandoz Chiropractic / Dr. Sandoz** 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 **Sandoz Chiropractic / Dr. Sandoz / Lynette Bernier** 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.

ERISA Authorization

I hereby designate, authorize, and convey to **Sandoz Chiropractic / Dr. Sandoz / Lynette Bernier** 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, appeal 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, appeal, 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 **Sandoz Chiropractic / Dr. Sandoz** 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.

Printed patient name	Authorized signature	Date

Policyholder/Insured

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [ ], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

SANDOZ
CHIROPRACTIC
& PHYSICAL THERAPY CENTER

2057 Briggs Road, Suite 204
Mount Laurel, NJ 08054
856-206-9560
Fax 856-206-9701

www.sandozchirpractic.com

Dr. John E. Sandoz
Dr Joshua J. Sandoz

PIP Overview Sheet

Dear Patients,

You are seeking care with Sandoz Chiropractic & Physical Therapy Center for injuries you sustained in a motor vehicle accident. Please be aware that we will do everything necessary to ensure that you receive quality treatment and care.

We request that you provide all the information necessary to ensure that we can properly bill your insurance carrier. New Jersey PIP deductibles can range from $250-$2500, with a 20% co-insurance. Based on determination of responsibility, you may be IMMEDIATELY responsible for these fees. We will call your car insurance carrier to verify this information.

If you have secondary insurance (health insurance) that you would want your patient responsibility fees billed to, please provide copies of your card(s) so that we can call to verify chiropractic benefits and coverage. We will submit any remaining balance from your car insurance to see if any of the remaining cost is picked up.

If you have retained an attorney to represent you for your motor vehicle accident, please know that we will send your medical bills to your attorney, so that they may keep track of services you have incurred in our office. We will inform them of the **final balance** once care is cut off or finalized by your car insurance for any further treatment.

Your personal injury insurance carrier requires that your care be "Pre-Certified" to be deemed medically necessary. Please be advised that this "Pre-Certification" cannot be completed until you are a patient in our office.

As you progress with care or treatment for your injuries, if your "Pre-Certification" be returned to us denied, you will **immediately be responsible** for the bill. We can attempt to use your major medical insurance to submit the balance for your care.

Patient Name:_____ Signature:_____

Date:_____

LETTER OF PROTECTION
INSTRUCTIONS TO COUNSEL

I, _____,clearly understand that all past, present and future bills incurred at Sandoz Chiropractic & Physical Therapy Center are my responsibility for payment.

I hereby ratify my agreement to pay all bills incurred during my health care at this office.

I also, hereby irrevocably agree to have the doctor's entire bill paid from any proceeds of any nature by way of settlement, judgement or otherwise I or you might receive. I do hereby irrevocably authorize the Law Office of, _____, to pay Dr. Sandoz in full from any such proceeds of settlement, judgement, enforcement of judgement actions, or recovery obtained on behalf of myself. **You are to pay the doctor prior to disbursing any proceeds to me.**

I also understand that if the settlement does not cover the doctor's entire bill, I am still responsible for the remainder.

I do hereby waive any applicable statute of limitations on the collection of my account with Sandoz Chiropractic & Physical Therapy Center.

I instruct you, as my attorney, not to attempt to negotiate my doctor's bill, which has provided all services billed for, and I agree to pay in full.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Lawyer's Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Assignment of Benefits & Ltd. Power of Attorney

Patient's Name _____ Date of Accident: _____

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing any appeal in your name on my behalf against the insurance carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills and possible PIP arbitration proceedings against your insurance carrier (if needed). I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to you acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing any appeal, demand, PIP arbitration or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

I authorize you and or your assigned to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc. and I specifically authorize such health care providers to release all such information to you about me, including medical reports, X-Ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated: _____ Patient Signature: _____

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:

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		
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 THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐	
DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐		

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐

IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP #/CERTIFICATE #: _____

2. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP#/CERTIFICATE #: _____

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

IF YES, AMOUNT $ _____ ☐ 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

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

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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.

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.

SIGNATURE: _____ DATE: _____

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

(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE 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 CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE: _____