CORE SPINE & WELLNESS

180 Tices Lane
Bldg A Ste 105
East Brunswick, NJ 08816
732-253-5450
732-253-5451

Auto Accident Insurance Verification Questionnaire

Date of auto accident:_____

Patient Name:_____Date of Birth:_____
Home address_____

_____
Mailing address_____
Home phone #_____Cell #_____

Name of **your** auto insurance carrier:_____
Have you filed a claim with your auto insurance carrier:_____
Claim #_____
Policy #_____
Adjustor name:_____
Phone #:_____

Do you have your own vehicle? _____
Was your vehicle the one involved in the accident?_____
Was your personal vehicle insured at time of accident?_____

Were you the driver or passenger of the vehicle involved in the accident?_____
Are you the insured policy holder?_____
If not, what is the insured's name?_____
Are you listed as a driver on the policy?_____
Are you married?_____Do you live with your spouse?_____
Do you live with any blood relatives who may have their own auto insurance?_____
If yes, whom?_____

Have you retained an attorney?_____
What is their name?_____Phone#_____

New Jersey is a no-fault state, this means that regardless of whose fault the accident is or who's car the accident took place in the patient will automatically use **their own car insurance carrier to cover their medical expenses. If the patient does not have their own auto insurance policy then the patient would file a claim with the insurance policy of any blood relative with whom the patient lives. If nobody in the patients household has an auto insurance policy then they must sign and notarize an Affidavit of No-Insurance. Please inform the receptionist if you require a Affidavit of No-Insurance Form.*

New Jersey Application for Benefits
Personal Injury Protection

Name
Address 1
Address 2
Address 3

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 authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Date	Type of Claim	Date of Accident	Claim Number

Your Name — Gender M / F — Phone Nos.: Home / Business

Your Address (No. & Street, City/Town, State & Zip Code) — Date of Birth — Social Security No. (if none, enter "none")

Your Previous Address

Date of Accident	Time of Accident	Place of Accident (Street, City/Town & State)
	☐ AM ☐ PM	

Brief Description of Accident

Do you or any member of your household own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____

Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder 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 expenses?	At the time of your accident, were you in the course of your employment?	Did you lose wages or salary as a result of your injury?	What is your average weekly wage or salary?
$_____	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐ If yes, amount loss to date: $_____	$_____

Your 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 Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

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 & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "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.

Signature: _____ Date: _____

Do Not Detach
Authorization for Wage Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage 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.: _____

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

Patient Information and Condition Form

Date_____

Name_____

Address_____

City_____State_____Zip_____

Date of Birth_____Age_____Sex: M F

Social Security # (for insurance purposes only)_____

Emergency Contact & Phone#_____

Name of Spouse or Guardian) if minor) _____

Your Occupation_____

Home Phone_____Work Phone_____

Cell Phone_____E-Mail_____

Who is your Primary Care Physician (PCP)?_____

Where is your PCP located?_____Phone_____

How did you hear about us?_____

If you find our facility on the internet, please indicate where and how (example: Google, Facebook, searched for back pain_____

Do you have health insurance: Yes No

Insurance Company Name:_____

Name of Subscriber:_____

Relationship to Patient (self) (spouse)(parent)_____

Subscriber Date of Birth_____

Subscriber Social Security #:_____

Insured ID #_____Group #_____

List your chief complaints in order of severity:

1._____For how long_____

Cause:_____

2._____For how long_____

Cause:_____

3._____For how long_____

Cause:_____

Auto Accident? Y N Work Related? Y N

Have you had any type of diagnostic test for your chief complaint? If yes, please indicate where and date of test:

X-Ray_____ EMG_____

MRI_____ Other_____

Have you received any prior medical treatment? Please indicate when and for how long you received treatment:

Physical Therapy_____

Acupuncture_____

Chiropractic_____

Any type of injection_____

Other_____

Circle any activities that aggravate the condition:

Walking lifting coughing sitting bending sneezing sleeping standing other

Circle any activities that alleviate the condition:

Rest standing heat exercise lying down ice sitting standing massage other

Do you currently have, or have you had any of the following conditions or symptoms?

____Headaches	____Heart Condition	____Cancer
_____Knee pain	____High Blood Pressure	____HIV
_____Neck pain	____Shortness of Breath	____Dizziness
_____Low Back Pain	____Loss of smell/taste	____Depression
____Hip Pain	____Numbness/Tingling	____Anxiety
____Fatigue	____Osteoporosis	____Shoulder Pain
____Vertigo	____Stomach Problems	____Scoliosis
____Wrist or Hand pain	____Ringing in Ears	____Other
____Chest pain	____Loss of Balance	

List any hospitalizations, operations, and /or serious illnesses:

_____

_____

_____

_____

_____

_____

_____

_____

_____

List all medications you are currently taking:

_____

_____

_____

_____

Please list any allergies:

_____

_____

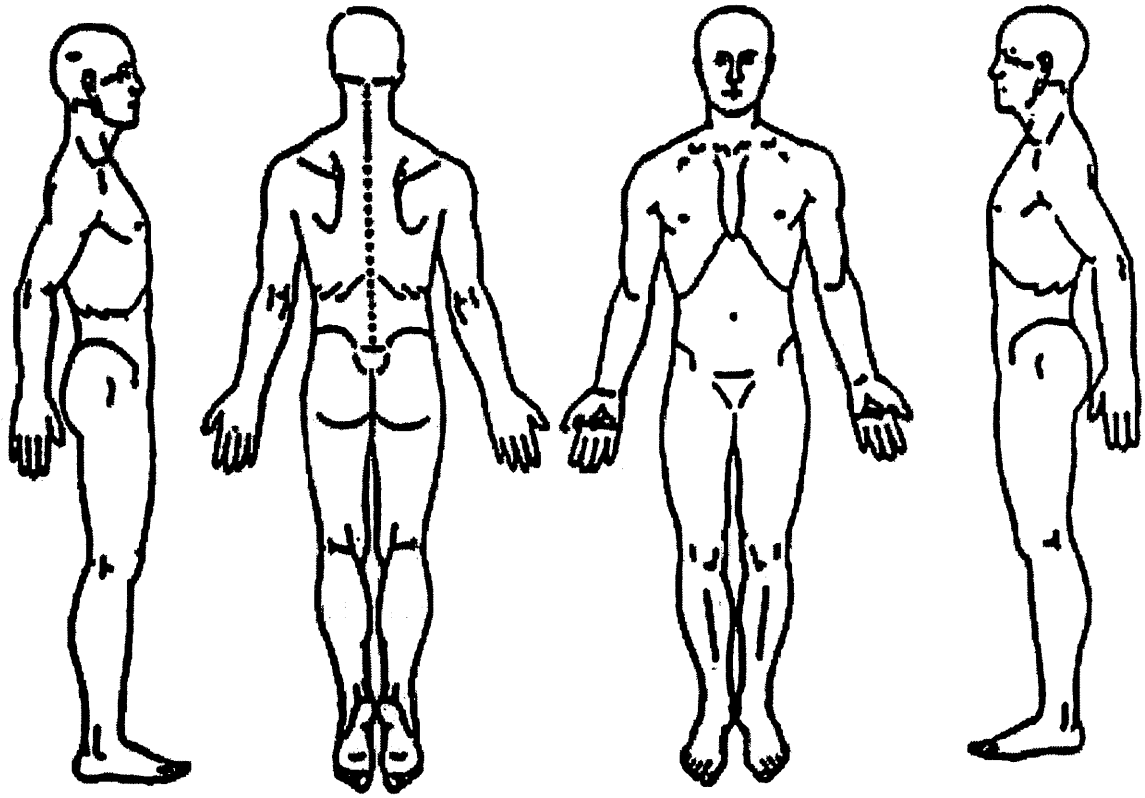
_____

_____

Please indicate if you are interested in the following wellness options:

Foot Orthotics Y N

Medical Weight Loss Y N



Please indicate on the diagram where you are experiencing pain

Does your pain travel? Yes No If yes, please draw this on the diagram

Do you have numbness/tingling in your arms, hands, legs, or feet? If so, please mark on the diagram where you are experiencing these symptoms by writing Numbness or Tingling

What is the severity of your problem? (You may also write numbers on the diagram if you prefer)

(Best) 1 2 3 4 5 6 7 8 9 10 (worst)

How are your symptoms affecting your lifestyle? (I.e. job, relationships, recreational activities, household chores)

_____

_____

_____

_____

_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorneys' fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits for me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature:_____Date_____

Signature of Parent or Guardian if a patient is a minor_____Date

CORE SPINE & WELLNESS
180 Tices Lane
Ste 105
East Brunswick, NJ 08816
732-253-5450
732-253-5451 Fax

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: _____

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.

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____

DOCTOR'S LIEN

TO: Attorney

_____
_____
_____

Protected Doctor:

Core Spine & Wellness LLC
Frank J Spano Jr., DC
Carmine Gargano, DPT

RE: Patient Records and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of the case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident, which occurred on _____. I understand that there is a fee for such information.

I hereby give a lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident, and authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing for service rendered to me, and to withhold such sums from such settlement, claim, judgement, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic/physical therapy bills submitted by the office for service rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee. I also understand that in the event my private insurance carrier has a subrogation clause, and chooses to recoup any monies paid to our office, the patient understands they are responsible to pay said balance in full, regardless of outcome of any potential settlement.

Dated:_____ Patient's Full Name: _____

Patient's Signature: _____

The undersigned, being attorney of record for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Date:_____ Attorney's Name: _____

Attorney's Signature: _____

Notice: Please sign, date, and return one copy to doctor's office at once and keep a copy for your records!