Health First

CHIROPRACTIC CENTER

Auto / Work Related Accident Questionnaire

ABOUT YOU

Today's Date:____/____/____ File #:_____

Name:_____

WORK RELATED

Date & Time of Accident:_____

Was your accident directly related to your work?
☐ Yes ☐ No

Briefly describe the events that occurred just before and during your accident: _____

_____

_____

Give the address where the accident occurred (if other than the employer's address): _____

_____

Was anyone else present during your accident?
☐ Yes ☐ No

Did you report your accident to your employer?
☐ Yes ☐ No

What recommendations did your employer make just after your accident? _____

_____

_____

Has this type of accident happened to you before?
☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before? ☐ Yes ☐ No

In general:

Is your job physically stressful? ☐ Yes ☐ No
Is your job mentally stressful? ☐ Yes ☐ No
Is your workplace noisy? ☐ Yes ☐ No
Have you changed jobs in the last year?
☐ Yes ☐ No

AUTO RELATED

Date & Time of Accident:_____

Location: _____

Were you the: ☐ Driver ☐ Front Passenger
☐ Rear Passenger

If a traffic violation was issued, to whom was it issued?

_____

How did the accident occur? _____

_____

_____

_____

_____

Number of people in accident vehicle? _____

Did the police come to the scene? ☐ Yes ☐ No
Was a police report filed? ☐ Yes ☐ No
Were there any witnesses? ☐ Yes ☐ No
Were you wearing your seat belt? ☐ Yes ☐ No
Was this vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did they inflate? ☐ Yes ☐ No

What was the approx. speed of your vehicle? _____

Did the impact come from the:
☐ Front ☐ Rear ☐ R side ☐ L side ☐ Other

During impact, were you facing:
☐ Right ☐ Left ☐ Forward

Were you ☐ aware of or ☐ surprised by the impact?

Did any part of your body strike anything inside of the vehicle? ☐ Yes ☐ No
If yes, please describe:_____

_____

_____

AFTER INJURY

Did accident render you unconscious? ☐ Yes ☐ No
If yes, for how long? _____

How did you feel immediately after the accident? _____

_____

_____

Did you seek post-accident hospitalization? _____

If yes, at what hospital? _____

When did you go? _____

How did you get there? _____

Describe any treatment you received _____

_____

Were x-rays taken? ☐ Yes ☐ No
Was medication prescribed? ☐ Yes ☐ No

Have you been seen by any other doctors since this accident? ☐ Yes ☐ No
If yes, by whom? _____

_____

What are your current complaints? _____

_____

_____

Is your condition getting: ☐ Better ☐ Same ☐ Worse

Indicate symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw Problems
☐ Nausea	☐ Memory Loss	☐ Irritability
☐ Back Pain	☐ Arm/Shoulder Pain	☐ Headache(s)
☐ Fatigue	☐ Numb Hands/Fingers	☐ Low Back Pain
☐ Blurred Vision	☐ Back Stiffness	☐ Chest Pain
☐ Tension	☐ Buzzing in Ear	☐ Neck Pain
☐ Leg Pain	☐ Shortness of Breath	☐ Neck Stiffness
☐ Upset Stomach	☐ Numb Feet/Toes	

☐ Other _____

Have you retained an attorney? ☐ Yes ☐ No

Attorney's Name and Address: _____

_____

_____

His/Her Phone Number: _____

RECOVERY

To evaluate the effect that continuing work will have on your recovery, please complete the following:

How many hours/day do you work? _____

Have you been able to work since this injury? ☐ Yes ☐ No

If you lost any days of work, please list those dates:

_____

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

What are your job duties? _____

_____

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you can request? ☐ Yes ☐ No ☐ N/A

How was your health **prior** to the accident? (Please list all complaints) _____

_____

Have you had any previous accidents, auto or otherwise? _____ Describe: _____

_____

Were there any resulting injuries and if so, what were they? _____

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Second Insurance Type: _____ Co. Name: _____

Address: _____ Phone #: _____

Policy #: _____ Claim #: _____ Insured's Name: _____

Insured's SS#: _____ DOB: _____

Patient's Signature: _____ **Date:** ____/____/____

Health First

CHIROPRACTIC CENTER

Chiropractic Health Questionnaire

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. THANK YOU.

ABOUT YOU

Name:_____ SS#:_____ Today's Date:____/____/____

Address:_____ City:_____ State:_____ Zip:_____

What you prefer to be called:_____ Age:_____ Birthdate:____/____/____ ☐ Male ☐ Female

Home Phone:_____ Marital Status: ☐ S ☐ M ☐ D ☐ W Spouse:_____

Handedness:_____ Height:_____ Weight:_____ Number of Children:_____

Employer:_____ Occupation:_____

Work Phone:_____ E-mail address:_____ Referred by:_____

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No If yes, please explain:_____

_____

The reason for this visit is a result of: ☐ work ☐ sports ☐ auto ☐ trauma ☐ chronic ☐ other_____

Explain what happened:_____

_____

What is your major complaint?_____

When did condition begin?____/____/____ Have you had this or similar conditions in the past? ☐ Yes ☐ No

Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is this condition interfering with your: ☐ work ☐ sleep ☐ daily routine If so, please explain:_____

_____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No If so, where?_____

_____

Name and address of primary physician _____

INSURANCE INFO.

Ins. Company Name:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Policy and Group #'s:_____ Insured's SS #:_____

Insured's Name:_____ Relation:_____

Date of Birth:____/____/____ Insured's Employer:_____

Please inform front desk of 2nd insurance source.

HEALTH HISTORY

Are you currently taking any medication? ☐ Muscle Relaxants ☐ Blood Thinners ☐ Insulin ☐ Stimulants ☐ Tranquilizers ☐ Pain Killers ☐ Other(s)_____

Have you ever had any of the following diseases or medical conditions?

☐ Arthritis	☐ Asthma	☐ Sinus Trouble	☐ Joint Replacement	☐ Allergies
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Thyroid Trouble	☐ High/Low BP
☐ Emphysema	☐ Ulcer / Colitis	☐ Cancer	☐ Polio	☐ Rheumatic Fever
☐ Emotional Disorders	☐ Bone Fracture	☐ Multiple Sclerosis	☐ Prostate Trouble	☐ Kidney Disease
☐ HIV +	☐ Heart Attack	☐ Stroke	☐ Hepatitis	☐ Anemia
☐ Neck Pain	☐ Low Back Pain	☐ Headaches	☐ STD's	☐ Joint Pain

Please list any other notable conditions that you had / have_____

Family history of any of the previous or other? ☐ Yes (please note_____) ☐ No

What are your habits?

Smoking	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Alcohol	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Recreational Drugs	☐ Never	☐ Occ	☐ Moderately	☐ Excessively
Exercise	☐ Never	☐ Occ	☐ Moderately	☐ Excessively

List any previous surgeries/hospitalizations and dates_____

List any past serious accidents and dates_____

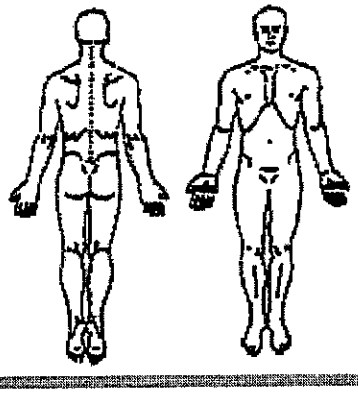
Are you wearing any: ☐ Heel lifts ☐ Inner soles ☐ Arch Supports What is the age of your mattress?_____

For Women: Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ Yes (How many mo._____) ☐ No

Date of your last period?_____ Are you under the regular care of an OB/GYN? ☐ Yes ☐ No

CURRENT COMPLAINT

Please mark the location of your pain on the following



PAYMENT

I will be paying today by:

☐ Cash ☐ Check ☐ Credit Card

☐ MasterCard ☐ Visa ☐ Discover ☐ AMEX

Acct. No. _____

Exp. Date _____

_____(initial) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

• I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process any insurance claims.

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

Patient's Signature_____ Date ____/____/____

Guardian or Spouse's Signature_____ Date ____/____/____

Health First
CHIROPRACTIC CENTER
468 HURFFVILLE - CROSS KEYS ROAD
SEWELL, NJ 08080

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4-14-2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we of our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Theodora C. Caraway, DC

Telephone: 856-218-2677

Fax: 856-218-2679

E-mail:

Address: 468 Hurffville – Cross Keys Road, Sewell, NJ 08080

Health First
CHIROPRACTIC CENTER
468 HURFFVILLE – CROSS KEYS ROAD
SEWELL, NJ 08080

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

0 Individual refused to sign

0 Communications barriers prohibited obtaining the acknowledgement

0 An emergency situation prevented us from obtaining acknowledgement

0 Other (Please Specify)

_____
_____
_____

Health First
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SEWELL, NJ 08080

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number.: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment, activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue revised Notice Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting

Contact Person: Theodora C. Caraway, DC
Telephone: 856-218-2677 Fax: 856-218-2679
Address: 468 Hurffville – Cross Keys Road, Sewell, NJ 08080

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____. Have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart

Health First

CHIROPRACTIC CENTER

Medical Reports and Doctor's Lien

Patient Name:_____ File No: _____

I do hereby authorize Dr. Theodora C. Caraway, DC, to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., in regard to the accident in which I was involved on _____.

I authorize the withholding of such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Dr. Theodora C. Caraway, DC and hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for services rendered me both by reason of this accident and by reason of any other bills that are due his office. And I hereby further give a lien to Dr. Theodora C. Caraway, DC, against any and all proceeds of any settlement, judgment, or verdict as a result of said accident which may be paid to you, my attorney or myself. In addition, this lien is irrevocable until Dr. Theodora C. Caraway, DC is paid in full.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and consideration of his 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 that I will also maintain responsibility for any bills which my insurance carrier denies payment. I understand and agree that although you, my attorney, or Dr. Theodora C. Caraway, DC may attempt to have any unpaid bills upheld and paid through arbitration hearings or a PIP suit against my insurance carrier, that I will maintain full responsibility for those charges even in the event of an unfavorable decision.

A photocopy of this lien shall be considered as valid as the original.

Date_____ Patient's Signature_____

I, the undersigned, being attorney of record for the above patient do acknowledge receipt of this lien and agree to honor all the terms of the above and agree to withhold such sums from any settlement, judgment or verdict after payment of legal costs and legal fees to adequately protect Dr. Theodora C. Caraway, DC.

Date_____ Attorney's Signature_____

Kindly sign and date one copy and return in enclosed envelope.
An additional copy has been provided for your records.

Health First
CHIROPRACTIC CENTER
468 HURFFVILLE - CROSS KEYS ROAD
SEWELL, NJ 08080

Durable Limited Power of Attorney

KNOW ALL MEN BY THESE PRESENCE:

That I, _____ of _____, referred to herein as PRINCIPLE, designate my provider Health First Chiropractic Center, LLC, of Sewell, New Jersey, to be my Attorney In Fact and agents (here and after called AGENT) for the following purposes:

1. **General grant of power under any applicable automobile Personal Injury Protection Policy:**

To exercise any act, power, right or entitlement whatsoever that I now have or may hereafter relating to my policy of automobile insurance, or any policy of automobile insurance relating to or in any way pertaining to my right to Personal Injury Protection Benefits (hereinafter called PIP benefits) which may arise out of my motor vehicle accident. I grant to my AGENT full power and authority to do everything necessary as fully as I may or could do if personally present. I gratify and confirm all that my agent shall lawfully do by this Power of Attorney:

A: **Powers of Collection**: to request, demand, recover, receive and deposit, execute, and endorse checks and drafts relating to the payment of first party PIP benefits arising out of my motor vehicle accident to take all lawfully means, legal remedies and perform any legal proceedings necessary for the collection and recovery thereof, including endorsing in my name releases, receipts, checks or drafts;

B: **Legal Representation**: to obtain counsel to pursue in my name litigation and or arbitration through the appropriate forum including the Superior Court of New Jersey and/or The American Arbitration Association for resolution of any disputes arising out of entitlement to any and all First Party Benefits against any automobile insurance companies which may be deemed responsible to pay me these benefits;

C: **Investigate**: to investigate, obtain and subpoena any and all necessary documents, conduct depositions and statements necessary to prepare for litigation.

2. **Interpretation and Governing Law**

This instrument is to be construed and interpreted as a General Durable Power of Attorney. In consideration of the services provided by my agent, this Power of Attorney is to be considered irrevocable. This instrument is executed and delivered in the State of New Jersey and laws of the State of New Jersey shall govern all questions of validity.

3. **Third Party Reliance**

All parties, individuals, companies are instructed to rely upon the representation of my agent as to all matters set forth in this Power.

4. Effective Date

The provisions of this Power of Attorney shall be effective upon the date of execution as indicated herein. This Power shall not be affected by my disability. This Power of Attorney shall end upon the conclusion of the collection of any PIP benefit whether the collection is obtained voluntarily, or by suit or settlement. I understand and agree that I may receive PIP benefit checks directly from my automobile insurance company. I agree to immediately forward these checks to my doctor who is acting as my Power of Attorney upon receipt of same.

In witness whereof I here into set my hand and sealed this on _____ day of _____, 20___.

_____

patient

_____

witness

Health First

CHIROPRACTIC CENTER

Medical Records Release

Date_____/_____/_____

To:_____

_____

_____

You are hereby requested and authorized to disclose, make available and furnish all information, records, x-rays, reports or copies thereof relating to my examination, consultation, confinement or treatment to:

Dr. Theodora C. Caraway
Health First Chiropractic Center, L
468 Hurffville – Cross Keys Road
Sewell, NJ 08080

And permit him to inspect and make copies or abstracts thereof.

Patient's Signature_____

Date_____

Patient's Name (please print)_____

Date(s) of Treatment:_____

Health First
CHIROPRACTIC CENTER
468 HURFFVILLE - CROSS KEYS ROAD
SEWELL, NJ 08080

Assignment of Benefits

I, _____, the insured and/or beneficiary of the policy or policies of the insurance providing medical benefits to me, do hereby authorize you to pay directly to the above named health care provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company:

_____
_____
_____
_____

Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above health care provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due it should sums not be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider including attending of any type of deposition, arbitration or court proceeding. I understand that if I fail to cooperate with legal counsel, I may be held personally responsible to the medical provider for any expenses not covered by the responsible insurance carrier. I realize that I am financially responsible for charges not covered by this assignment. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to the provider upon receipt of the same. It is understood and agreed that should the undersigned patient not forward any benefits to the provider, the provider does maintain the right to request said checks from the patient and initiate any and all collection efforts. If such action is taken by the provider, the undersigned agrees to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and court costs.

Insured:_____

Claimant:_____

Address:_____

Claim:_____

Legal Signature:_____

Parent Signature:_____

Health First

CHIROPRACTIC CENTER

Assignment of Benefits Agreement

I hereby authorize my insurance company to make payment of medical benefits to Health First Chiropractic Center for medical services rendered to me. I also authorize the release of any medical or other information necessary to process this claim.

Signature_____ Date____/____/____

MEDICARE PATIENTS

I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to Health First Chiropractic Center.

Signature_____ Date____/____/____

Health First
CHIROPRACTIC CENTER
168 HURFFVILLE – CROSS KEYS ROAD
SEWELL, NJ 08080

Appointment Cancellation – No-Show Policy

Effective January 1, 2022

Thank you for trusting your chiropractic care to Health First Chiropractic Center, our job is to help you reach your goals and achieve your maximum potential in chiropractic treatment. In order for us to help you reach your goals when you schedule an appointment with Health First Chiropractic, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than **12 hours** prior to your scheduled appointment. This gives us time to schedule other patients who may be in pain and waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least **12 hours** notice will be considered a No Show and charged a **$25.00 fee**. This applies to **Healthcare**, **Self-pay** and **Personal Injury Patients** alike. If you are a Personal Injury Patient be aware that your attorney will be notified of all missed appointments, and repeated cancellations/no-shows without reschedules may result in termination of all treatment by your insurance carrier.

- Any established patient who fails to show or cancels/reschedules an appointment without **12 hours** notice a **second time** will be charged a **$35.00 fee**.

- Any established patient who fails to show or cancels/reschedules an appointment without **12 hours** notice a **third time** will be charged a **$50 fee** and may be dismissed from care.

- Any new patient who fails to show for their initial visit will not be rescheduled.

- The fee is charged to the patient, **not the insurance company**, and is due at the time of the patient's next office visit.

- As a courtesy, we provide reminder text messaging for appointments, however, this is just a courtesy, you are responsible for the appointment you have scheduled. Our office is not responsible for "glitches"/failures in software or communications. If you do not receive a reminder text message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office and we may be able to waive the No

Show fee. You may contact Health First Chiropractic Center 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Thursday, or a weekend, you may **leave a message**. Thank you for trusting your healthcare to Health First Chiropractic

I have read and understand the Medical Appointment Cancellation/No Show Policy and agre to its terms.

Patient Signature _____ Date _____

DR. THEODORA C. CARAWAY

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