one WELCOME

ABOUT YOU

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

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Other Phone #s: _____

E-Mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

two

INSURANCE INFO

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Please inform front desk of 2nd. Insurance source.

REASON FOR VISIT

The reason for this visit is a result of (*Please circle*): work, sports, auto, trauma or chronic.

(*Explain what happened*): _____

_____

Please describe the pain & its location: _____

_____

When did condition begin? ____/____/____

Is this condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes

Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine.

If so, please explain: _____

Have you had this or similar conditions in the past? ❑ Yes ❑ No

If so, please explain: _____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? _____

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, whom? _____ Phone#: _____

three

PLEASE CONTINUE ON BACK

four

IN EVENT OF EMERGENCY

Who should we contact? _____

Relation: _____

Home Phone #: _____ Work Phone #: _____

Who is your Medical Doctor? _____ Phone #: _____

HEALTH HISTORY

five

Are you taking any of the following medications?

❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema / Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes / Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Problems	Y N Artificial Bones / Joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:

_____

Please list anything that you may be allergic to: _____

_____

List previous surgeries/treatments with dates: _____

_____

List any **past** serious accidents with dates: _____

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ❑Yes ❑ No / Exercise? ❑Yes ❑ No

Are you on a special diet: ❑ Yes ❑ No / Since: ____/____/____

Do you smoke? ❑ No ❑ Yes / How Much? _____ How Long? _____

Are you wearing: ❑ Heel Lifts ❑ Sole lifts ❑ Inner soles ❑ Arch supports

What is the age of your mattress? ____ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? ____ Nursing? ❑ Yes ❑ No

six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____

CITY STATE ZIP

SSN: _____

D.L.#: _____

Work Phone#: _____

Payment method: ❑ CASH ❑ Check

_____ /____

❑ Credit Card - Enter card # above (if accepted)

_____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

- 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.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

PAIN CHART

ABOUT YOU

Name: _____ File #: _____

What is your current weight: _____ lbs., and height, _____ Ft. _____ In..
Please describe your condition:

_____

_____

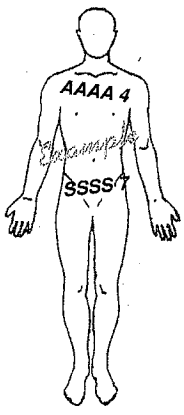
Signature: _____ Date: ____/____/____

SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

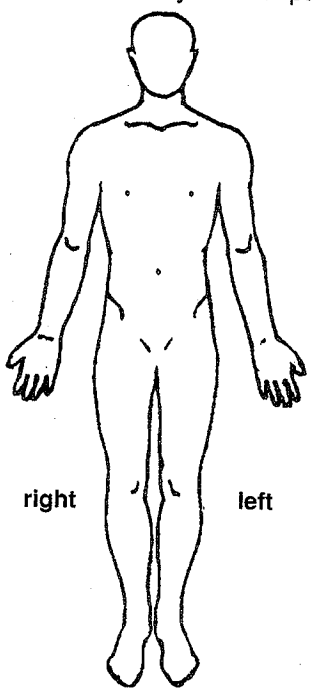
Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	NNNN	PPPP	BBBB	AAAA	SSSS

◯ Circle any area of pain not represented by a symbol.



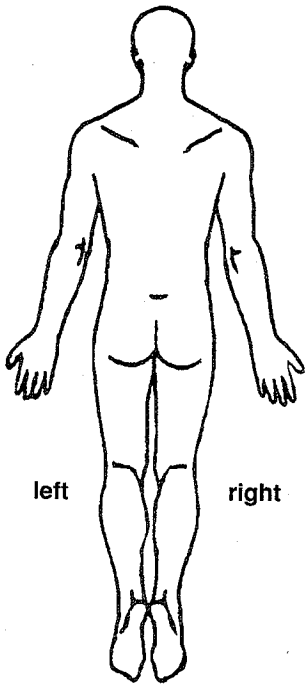
Example

Right



right left

Front



left right

Back

Left

_____

_____

_____

_____

_____

_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

GROSSMAN
CHIROPRACTIC
Health & Wellness Center

Adam Grossman, D.C.

395 Ridge Rd., Suite #3
Dayton, N.J. 08810
P: (732) 438-8700

Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Grossman Chiropractic, LLC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

AUTO / WORK RELATED ACCIDENT

one

ABOUT YOU

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

Name: _____

two a

AUTO RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.
Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger
If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____
Did the police come to the accident site? . .❑ 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 it/they inflate? . . . . . .❑ Yes ❑ No
In relation to the base of your skull, where was the headrest? . . . . . .❑ Above ❑ Below ❑ At base of skull
What did your vehicle impact? ❑ Another vehicle ❑ Other

If other, explain: _____
Did any part of your body strike anything in the vehicle?❑ Yes ❑ No

If yes, please describe: _____

_____

Make & model of the vehicle you were occupying?

_____

Name of the location/street on which you were traveling?

_____

In which direction were you headed? ❑N ❑S ❑E ❑W

What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the:
❑ Front ❑ Rear ❑ Right Side ❑ Left Side ❑ Other
During impact, were you facing: ❑Right ❑Left ❑Forward
Were you ❑ aware or ❑ surprised by the impact?
If accident vehicle made impact with another vehicle...
Make and model of that other vehicle? _____

_____

Direction other vehicle was headed? ❑N ❑S ❑E ❑W

Speed of the other vehicle? _____

In your words, please describe the accident: _____

_____

_____

_____

two b

WORK RELATED ACCIDENT

Date & Time of Accident: _____ ❑ a.m. ❑ p.m.
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 accident occurred: (if other than 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

PLEASE CONTINUE ON BACK

three

AFTER INJURY

Did accident render you unconscious? . . . . . ❑ Yes ❑ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

_____

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑ No

When did you go? ❑ Just after accident ❑ The next day ❑ 2 days plus

How did you get there? ❑ Ambulance or ❑ Private transportation

Name of Hospital and/or Attending doctor: _____

_____

Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S.

Describe any treatment you received: _____

_____

Were X-rays taken? . . . . . ❑ Yes ❑ No

Was medication prescribed? . . . . . ❑ Yes ❑ No

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

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

Indicate ☑ the symptoms that are a result of this accident:

❑ Dizziness	❑ Difficulty sleeping	❑ Jaw problems	❑ Nausea
❑ Memory loss	❑ Irritability	❑ Arms/Shoulder pain	❑ Back pain
❑ Headache(s)	❑ Fatigue	❑ Numb Hands/Fingers	❑ Lower back pain
❑ Blurred vision	❑ Tension	❑ Chest pain	❑ Back stiffness
❑ Buzzing in ear	❑ Neck pain	❑ Shortness of breath	❑ Leg pain
❑ Ears ringing	❑ Neck stiff	❑ Stomach upset	❑ Numb Feet/Toes

❑ Other _____

Is your condition getting worse?

❑ Yes ❑ No ❑ Constant ❑ Comes & goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable even if only sometimes	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Lovemaking	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Lifting	❑	❑	❑
Bending	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑

Have you retained an attorney: ❑ Yes ❑ No

If yes, whom: _____

His/Her Phone #: _____

four

RECOVERY

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

How many hours are in your normal work day? _____

Please indicate ☑ your daily job duties and any activities which you are occasionally asked to perform.

❑ Standing	❑ Driving	❑ Operating equipment
❑ Sitting	❑ Twisting	❑ Work with arms above head
❑ Walking	❑ Crawling	❑ Typing
❑ Lifting	❑ Bending	❑ Stooping

❑ Other _____

What positions can you work in with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? . . ❑ Yes ❑ No ❑ N/A

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 could request? . . . . . ❑ Yes ❑ No ❑ N/A

five

ADDITIONAL INSURANCE

2nd Insurance Source or Auto Insurance

Type of Insurance: _____

Co. Name: _____

Address: _____

Phone #: _____

Insured's Name: _____

Policy #: _____ Claim #: _____

Insured's SS #: _____ D.O.B. ___/___/___

Insured's Employer: _____

Agent's Name: _____

If any of your medical or account information has changed, please inform our front desk personnel.

Please remember you are ultimately responsible for your account.

_____ ___/___/___

SIGNATURE DATE

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

21 DAY NOTICE

NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT

PROVIDER INFORMATION
NAME, ADDRESS, PHONE NUMBER OF TREATING PHYSICIAN

Adam D. Grossman, D.C.
Grossman Chiropractic & Physical Therapy, LLC
397 Ridge Rd., Suite #2
Dayton, New Jersey 08810
Phone: (732) 438-8700
Fax: (732) 438-8705

NAME AND ADDRESS OF PATIENT:

NAME AND ADDRESS OF INSURED (IF DIFFERENT):

INSURER NAME AND ADDRESS

POLICY # _____

CLAIM # _____

DATE OF ACCIDENT: _____/_____/_____

DATE OF INITIAL TREATMENT: _____/_____/_____

DATE NOTIFICATION SENT: _____/_____/_____

ACCIDENT INFORMATION

Since the new automobile insurance laws of January 1, 1989, there is an initial deductible of $250.00 plus 80-20% co-payment, which means you are responsible for the 20% as well as your deductible. However, we can submit this balance to your personal insurance company.

In order for us to assist your attorney in your accident case and to assure prompt payment from your automobile and personal health insurance, we need copies of the following information:

1. Driver's License
2. Auto Insurance Declaration sheet
3. Insurance Card
4. Personal Health Insurance Card
5. Attorney's name, address and telephone numbers
6. Accident Report

PIP NOTIFICATION BILL - CHAPTER 407 - LAWS OF NEW JERSEY 1995
APPROVED JANUARY 10, 1996 AMENDING P.L. 1992, C .70

In the case of claims for medical expense benefits, written notice shall be provided by the insured and by the treating medical provider no later than 21 days following the commencement of treatment. Failure to do so will result in a denial from the insurance company to pay y our claim and you are therefore responsible for all unpaid bills.

If you have not done so, please contact your automobile insurance company and report the accident. Please provide our office with the claim number, Adjuster and telephone number.

Since you are ultimately responsible for your bill, it would be in your best interest to supply our office with the above information as soon as possible.

Thank you for your cooperation in this matter.

_____ Date _____

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 BILL S YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

YOUR NAME | PHONE NO. HOME | BUSINESS

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE) | DATE OF BIRTH / / | SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M. | PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

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

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐
WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? YES ☐ NO ☐ IF YOUR ANSWER IS YES COMPLETE THE REST OF THIS FORM. IF NO SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐ | DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐ | HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE: $ | WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐ | AT TIME OF YOUR ACCIDNT 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: _____

A 3965A (1-95)

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: _____

PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS

Policy Number: _____ Claim Number: _____
Patient's Name: _____
Medical Provider's Name: _____

I authorize and request _____to pay directly to the above-named medical provider, the amount due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ Date: _____
Patient's Signature or Parent/Legal Guardian

I have read the information contained in the _____informational letter concerning the Decision Point Review Plan, including Medical Services Review, Decision Point Review and precertification requirements (collectively, "Plan") and, as a condition precedent to _____acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (We) have complied and will comply with all the requirements of the Plan.
2. I (We) will initiate all pre-certification review and decision point review requests as required by the Plan.
3. I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, I (we) will submit disputes not resolved by the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
4. I (We) will submit all disputes not subject to the Internal Dispute Resolution process to the personal injury protection dispute resolution process set forth in N.J.A.C. 11:3-5.
5. I (We) will submit medical records with clinically supported findings to support the diagnosis, causal relationship to the accident, and care plan.
6. In the event that I (we) fail to comply with paragraphs one (1) though five (5) above, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.

I (we) agree that this assignment is the only valid assignment of benefits. I (we) agree that this assignment of benefits may require _____written consent. I (we) agree that _____ has the right to reject, terminate or revoke this assignment of benefits.

_____ Date: _____
Provider's Signature

Adam Grossman, D.C. TIN Number: 20-4608353
Provider's Name (Please Print)

Address: 395 Ridge Rd.
Suite #3
Dayton, New Jersey 08810