Grossman Chiropractic and Physical Therapy Patient Information

Today's Date:_____

Patient Contact Information

First Name:_____ Last Name:_____

What would you prefer to be called? _____

How did you hear about our practice? _____

Date of Birth: _____ Gender: (circle one) Male Female Not Specified

Marrital Status: (circle one) Single Married Divorced Widowed Separated

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Referring Physician

Referring Physician (full name & office location): _____

_____

Primary Care Physician

Primary Care Physician (full name & office location): _____

_____

Emergency Contact Information

Name: _____

Relation: _____ Phone: _____

Describe Your Current Condition

Diagnosis/Reason for your appointment: _____

Date of Onset: (if chronic, date of most recent exacerbation) _____

Cause: _____

Have you had previous episodes of this condition? (circle one) Yes No

Date of previous episode: _____

Have you received previous treatment for this condition? (circle one) Yes No

Do you have numbness? (circle one) Yes No

Grossman Chiropractic and Physical Therapy Patient Information

Do you have tingling? (circle one) Yes No

Do you have any weakness? (circle one) Yes No

What worsens your condition? _____

What improves your condition? _____

Are you getting: (circle one) Better Worse Staying the same

How close to full normal functioning are you? (circle one) 25% 50% 75% 100%

Indicate any tests (and associated dates) you may have had to diagnose this condition (i.e XR, MRI, US, CT, etc.) _____

Physical Therapy Goals

What are your goals for physical therapy? _____

_____

Social History/Lifestyle Information

What type of residence do you live in? (i.e house, apartment, condo) _____

Who do you live with? (i.e. parents, spouse, children, pets) _____

What are your usual home responsibilities? (circle all that apply)

heavy cooking light meal prep heavy cleaning light cleaning laundry

gardening yard work self-care care for another snow removal

other: _____

Occupation: _____ Are you currently working? Yes No

Do you exercise? Yes No How many times per week? _____

Types of exercise: _____

Hobbies or other recreational activities: _____

How many hours each night do you sleep? _____ Times per night you get up: _____

General Medical Information

Please indicate any of the following conditions you currently have or have had in the past by circling "Y." If you do not or have not had the condition please circle the letter "N."

Y N Asthma

Y N AIDS

Y N Alcohol/Drug Abuse

Y N Artificial Joints

Y N Artificial Valves

Y N Bladder/Bowel Disorder

Y N Blood Clotting Disorder

Grossman Chiropractic and Physical Therapy Patient Information

Y N Cancer
Y N Cardiac Condition
Y N Chemotherapy
Y N Chronic Infection
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Fainting Spells
Y N Heart Attack
Y N ulcers/colitis
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hypoglycemia
Y N Immunocompromised
Y N Metal or other surgical implants
Y N Migraine Headaches
Y N Polio
Y N Pregnancy
Y N Radiation Therapy
Y N Respiratory Condition
Y N Rheumatic Fever
Y N Seizure disorder
Y N Sinus problems
Y N sleep disorder
Y N smoker
Y N stroke
Y N thyroid condition
Y N tuberculosis

Please list any assistive devices or orthotics you may use: _____

_____

Please list any allergies: _____

Please list any other medical conditions not listed above: _____

Please list past surgeries and procedure dates: _____

Medications

Please List all current Medications Below including over the counter medications and supplements.

_____

_____

_____

_____

_____

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.

Patient or Guardian Signature: _____ Date: _____

Consent to Treat/Release of Information

Please initial each line and then sign and date below.

_____ CONSENT TO EVALUATE AND TREAT: I do hereby consent to the evaluation and treatment by Grossman Chiropractic and Physical Therapy. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

_____ RELEASE OF INFORMATION: I authorize Grossman Chiropractic and Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payor (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to my physicians for communication and care coordination on by behalf.

_____ PRIVACY PRACTICES: I acknowledge receipt of the Grossman Chiropractic and Physical Therapy Privacy Practice, which I have received at the time of this initial visit or previously.

_____ ASSIGNMENT OF BENEFITS: I request that payment of Medicare and/or other insurance benefits be made on my behalf to Grossman Chiropractic and Physical Therapy for any services furnished to by Grossman Chiropractic and Physical Therapy.

_____ FINANCIAL AGREEMENT: The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of Grossman Chiropractic and Physical Therapy. As a courtesy, Grossman Chiropractic and Physical Therapy will attempt to verify insurance benefits on behalf of the patient. However, it is the patients sole responsibility to know their insurance benefits. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

_____ INSURANCE COVERAGE: I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances not covered by said insurance, including balances due to lack of authorization.

The undersigned certifies that I have read, understood and accept the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature Date

_____

Printed Name

Grossman Chiropractic and Physical Therapy General Office Policies

Please read our office policies below, initial each line and sign at the bottom.

_____ CANCELLATION AND NO-SHOW POLICY: We consider it an honor and privilege to be of service to you. In order to maximize the benefit of your treatment, our physical therapy staff provides one-on-one care during treatment sessions reserved especially for you. We do not double book in order to ensure quality care. Missing appointments will impede your progress. Make every effort to attend every scheduled visit according to the treatment plan recommended by your therapist and doctor.
You are responsible for your schedule. Make a habit of double-checking your next visit. Note changes to your schedule right away. Not showing up for your appointment or appointments cancelled less than 24 hours in advance affect us all. Available appointments are in high demand and your early cancellation will give another person the possibility to have the treatment they need.
Although we do understand that there may be extenuating circumstances, cancellations less than 24 hours will result in a $25 cancellation fee. Not showing up for your appointment without prior cancellation, for any reason, will result in a $40.00 fee. These charges are not covered by your insurance and will have to be paid by your personally. Three violations of this policy within a three month period will result in discharge from treatment, physician notification, and a referral to an alternate facility will be provided.

_____ LATE FOR APPOINTMENT POLICY: We encourage all patients to arrive 10 minutes early to each appointment to give adequate time to check in, schedule or alter additional appointments, complete any required insurance paperwork, etc prior to your treatment. We make every effort to run on time. As such, it is our policy to reschedule your appointment if you arrive more than 15 minutes late without notifying the clinic. We want clients to have sufficient time to work with their service providers and we may not be able to accommodate late arrivals. If you are concerned you may be running late for your appointment, please call the office as soon as possible so we may do out best to accommodate you and our other patients. If you arrive more than 15 minutes late without notifying the clinic, we will work with you to reschedule your appointment when you arrive.

_____ FINANCIAL POLICY: Our policy requires payments 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 if the date if service and no financial arrangements have been made, you will responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.with our clinic.

The undersigned certifies that I have read, understood and accept the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

_____ _____

Signature Date

_____

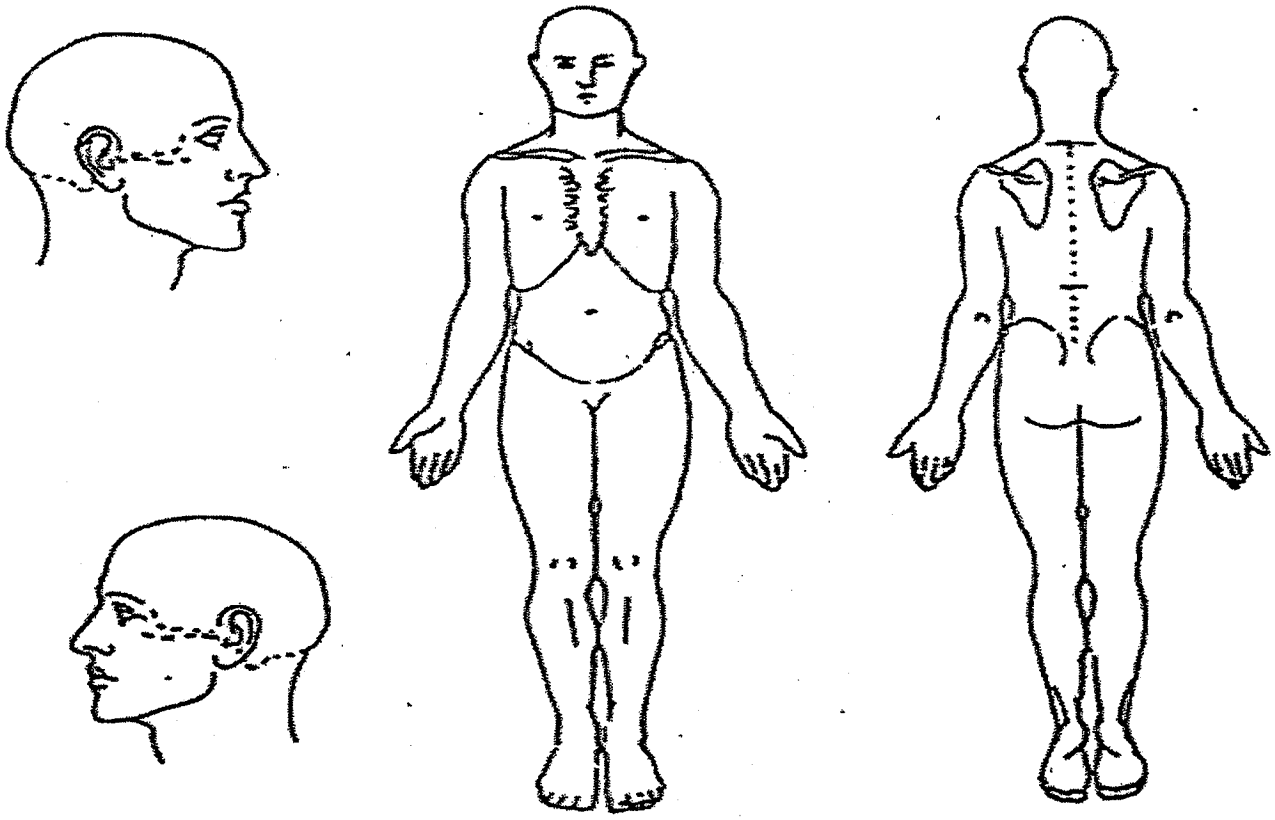
Printed Name

Numeric Pain Rating Scale and Body Diagram

Name:_____ Date:_____

Please mark the figure below by using the following symbols to indicate where your pain is and what kind of pain you are having.

Burning: xxxxx Stabbing: >>>>> Aching/Throbbing: ooooo Numbness/Tingling: ///////



Please let us know how severe your pain is with "0" being no pain at all while "10" is the worst pain imaginable. Circle the one number that most closely indicates your pain level.

Rate your **pain at this moment** (circle only one number):

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

Rate the **least amount of pain** you have had **in the past 24 hours** (circle only one number)

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

Rate the **most amount of pain** you have had **in the past 24 hours** (circle one number)

no pain										worst pain
0	1	2	3	4	5	6	7	8	9	10

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

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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