Spine One
chiropractic center

Main Office
300 Philadelphia Avenue
Egg Harbor City, NJ 08215
Fax 609.965.8865
Phone: 888.888.9260

Victor J. Rossi, DC
Director

Helpful Patient Information:

The following is a check list of documents we will need to ensure proper billing for your accident case:

- ☐ **Auto Insurance Card**
- ☐ **Auto Adjuster's Name and Phone Number**
- ☐ **Auto Insurance Declaration Page from your auto policy**
- ☐ **Your Claim #**
- ☐ **Police Report**
- ☐ **Attorney Information**
- ☐ **Drivers License**
- ☐ **Health Insurance Card**

If at any time you have any questions or concerns regarding your insurance, billing or treatment; please contact our office and we would be happy to assist you.

Thank You,
Spine One Billing Department

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NEW PATIENT INFORMATION

Patient Name: _____ Today's Date: _____

Address: _____ City _____ State _____ Zip _____

Social Security No. _____ Date of Birth: _____ Home Phone: _____

Cell Phone: _____ Cell Carrier: (to enable texting) _____

Employer: _____ Work Phone: _____ E-Mail: _____

Primary Care Physician: _____ ☐ Married ☐ Single Children #_____

Any Previous Chiropractic Care? ☐ Yes ☐ No If yes, Who? _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company: _____

Policy ID#: _____ Group Plan #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

Secondary Insurance: *(if applicable)*

Insurance Company: _____ Address: _____

Policy ID#: _____ Group Plan #: _____

Insured Name: _____ DOB: _____ Social Security #: _____

Insured's Employer: _____ Relationship to Insured: _____

AUTO INSURANCE INFORMATION
(IF APPLICABLE)

Auto Insurance Co.: _____ Phone: _____

Insurance Co. Address: _____

Policy Holder Name & Address (if other than yourself): _____

Relationship to Patient: _____ Did you report your accident? ☐ Yes ☐ No

Policy# _____ Claim# _____ Date of Accident: _____

Insurance Adjuster Handling Claim: _____ Phone/Ext: _____

Patient/Guardian Signature: _____ Date: _____

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_____

_____

_____

Do you have an attorney? ☐ Yes ☐ No If yes, Who?_____

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

How many people were in the accident vehicle?_____

ACCIDENT SITE

Road/Street Name_____

City/State_____

Nearest intersection with road/street_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed?_____

Speed you were traveling?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_____

Which direction was other vehicle headed?_____

Speed other vehicle was traveling_____

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No ☐ **Male** ☐ **Female** **Height**_____ **Weight**_____ **Age**_____

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital_____ Name of doctor_____

Diagnosis_____

_____

Treatment received_____

X-rays taken_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

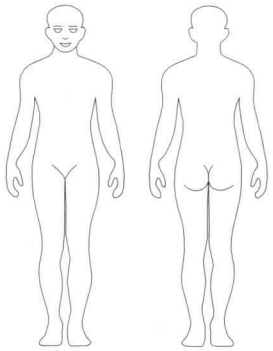
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

☐ Arm/shoulder pain	☐ Feet/toe numbness	☐ Neck pain
☐ Back pain	☐ Hand/finger numbness	☐ Neck stiff
☐ Back stiffness	☐ Headaches	☐ Shortness of breath
☐ Chest pain	☐ Irritability	☐ Sleep difficulty
☐ Dizziness	☐ Jaw problems	☐ Stomach upset
☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred
☐ Fatigue	☐ Nausea	

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Aching	☐ Shooting	☐ Burning	☐ Tingling
☐ Cramps	☐ Stiffness	☐ Swelling	☐ Other_____

How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Copenhagen Neck Functional Disability Scale

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday activities. In response to each question, please mark the one box that applies to you.

	Yes	Occasionally	No
1. Can you sleep at night without neck pain interfering?	☐	☐	☐
2. Can you manage daily activities without neck pain reducing activity levels?	☐	☐	☐
3. Can you manage daily activities without help from others?	☐	☐	☐
4. Can you manage putting your clothes on in the morning without taking more time than usual?	☐	☐	☐
5. Can you bend over the sink to brush your teeth without getting neck pain?	☐	☐	☐
6. Do you spend more time than usual at home because of your neck pain?	☐	☐	☐
7. Are you prevented from lifting objects weighing 5-10 pounds due to neck pain?	☐	☐	☐
8. Have you reduced your reading activity due to neck pain?	☐	☐	☐
9. Have you been bothered by headaches during the time you have had neck pain?	☐	☐	☐
10. Do you feel that your ability to concentrate is reduced due to neck pain?	☐	☐	☐
11. Are you prevented from participating in your usual leisure time activities due to neck pain?	☐	☐	☐
12. Do you remain in bed longer than usual due to neck pain?	☐	☐	☐
13. Do you feel neck pain has influenced your emotional relationship with your family?	☐	☐	☐
14. Have you had to give up social contact with other people during the past two weeks due to neck pain?	☐	☐	☐
15. Do you feel that neck pain will influence your future?	☐	☐	☐

Patient Name _____ Date _____

Activities Discomfort Scale

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity).

Activity	Doesn't Hurt At All	Hurts A Little	Hurts Very Much	Almost Unbearable	Unbearable Pain Prevents Activity
1. Walking					
2. Sitting					
3. Bending					
4. Standing					
5. Sleeping					
6. Lifting					
7. Running or jogging					
8. Climbing Stairs					
9. Carrying					
10. Pushing or Pulling					
11. Driving					
12. Dressing					
13. Reading					
14. Watching TV					
15. Household Chores					
16. Gardening					
17. Sports					
18. Employment					

ADDITIONAL COMMENTS:

PATIENT NAME _____ PATIENT SIGNATURE _____

EXAMINER _____ DATE _____ Score _____ [72]

Turner JA, Robinson J, McCreary CP. Chronic low back pain: Predicting response to nonsurgical treatment. *Arch Phys Med Rehabilitation* 1983; 64: 560-563

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300 Philadelphia Avenue, Egg Harbor City, NJ 08215
1701 New Road, Northfield, NJ 08225
1128 Atlantic Avenue, Atlantic City, NJ 08401
1034 Marlton Pike East, Cherry Hill, NJ 08034

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Chiropractic Practice, Spine One Chiropractic Center, in accordance with the federal Privacy Rule, 45 CFR parts 160 & 164 (the Privacy Rule) and applicable state law, is committed to maintaining the privacy of your protected health information (PHI). PHI includes information about your health condition and the care and treatment you receive from the Practice and is often referred to as your health care or medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice also details your rights regarding your PHI.

HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The practice, in accordance with this notice and without asking your express consent or authorization may use and disclose your PHI for the purpose of:

A. **TREATMENT** – For coordination, planning and management of your health care.
B. **PAYMENT** – To get paid for services directly through you, billing service, and insurance company or health plans.
C. **HEALTHCARE OPERATIONS** – To evaluate performance of the Practice's personnel providing care to you.
D. **ADVISE OF APPOINTMENT SERVICES** – Following appointment reminders may be used by the practice:
   1. Postcards
   2. Telephoning home
   3. Email
   4. Telephoning cell phone and/or texting
E. **DIRECTORY/SIGN-IN LOG** – Practice maintains a sign-in log at the reception area where staff can readily see. Others seeking services/care at the Practice may see this information.
F. **FAMILY/FRIENDS** – Disclose PHI to family member, other relative, friend or other person identified by you for involvement in care or payment of care.
G. **USE OF NAME** – Your name may be used in a verbal or written manner when requesting information over the phone or between staff members or when using a social media that you have agreed to by "liking or following", such as FACEBOOK or TWITTER. This in no way implies your PHI has been disclosed.
H. **EMAIL/TEXTING** - You may be contacted thru email and/or text to convey information/correspondence regarding you and this practice.

OTHER USE & DISCLOSURES WHICH MAY BE PERMITTED OR REQUIRED BY LAW

A. **DE-IDENTIFIED INFORMATION** – Disclose PHI, for sake of your care, which cannot identify you.
B. **BUSINESS ASSOCIATE (BA)** – BA includes entity that assists the Practice in some essential function.
C. **TCPA** - Telephone Consumer Protection Act - our office and/or our agents may contact you by telephone, including wireless numbers by call or text, which could result in charges from your wireless carrier. Methods may include pre-recorded voice messages or an automatic dialing device. We may also contact through email.
D. **PERSONAL REPRESENTATIVE** – A person who has the authority to represent your decisions.
E. **EMERGENCY SITUATIONS**
F. **PUBLIC HEALTH EMERGENCY** – To prevent or control disease.
G. **ABUSE, NEGLECT OR DOMESTIC VIOLENCE**
H. **HEALTH OVERSIGHT ACTIVITIES** – PHI for criminal investigation, disciplinary actions or relating to community's health care system.
I. **JUDICIAL & ADMINISTRATING PROCEEDING** – For court order or lawfully issued subpoena.
J. **LAW ENFORCEMENT PURPOSES** – Use PHI when authorized to Law Enforcement official.
K. **CORONER OR MEDICAL EXAMINER**
K. **ORGAN, EYE, OR TISSUE DONATION** – May disclose your PHI if you are a tissue or organ donor.
L. **RESEARCH** – May disclose PHI subject to legal requirements if the Practice is involved in research.
M. **AVERT THREAT TO HEALTH AND SAFETY** – Disclose PHI necessary to prevent serious threat to health or safety.
N. **FINANCIAL HARDSHIP** - Financial agreements are available for those who qualify at time of service & who are unable to meet their total financial obligation.
O. **SPECIALIZED GOVERNMENT FUNCTION** – Use PHI, authorized by law, for military and veteran activity.
P. **WORKERS COMPENSATION OR MVA**
Q. **NATIONAL SECURITY AND INTELLIGENCE ACTIVITES**
R. **MILITARY AND VETERANS** – Disclose PHI, if member of armed forces, required by military command authorities.
S. **TIME OF SERVICE PAYMENT** – All patients are eligible for a discount if payment for services rendered are made at time of service. If payment is not made at the time of service the patient is responsible for full charges incurred.

PRACTICE REQUIRMENTS

A. Is required by federal law to maintain the privacy or your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
B. Maybe required by State Law to maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal Law.
C. Is required to abide by the terms of this Privacy notice.
D. Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
E. Will distribute any revised Privacy Notice to you prior to implementation.
F. Will not retaliate against you for filing a complaint.

YOUR RIGHTS

A. Revoke any authorization or consent given to the Practice in a written request.
B. Request restrictions on certain uses & disclosures of your PHI in written form.
C. Inspect & copy your PHI. Practice can charge fee for copying, mailing or other supplies associated with request.
D. Amend your PHI as provided by federal Law. You must submit written request to the Practices Privacy Officer (PPO).
E. Receive accounting disclosures or PHI as provided by the Federal Law. Time period may be no longer than six (6) years and may not include dates before April 14, 2003. The first list within a 12-month period is free. Practice may charge for additional lists.
F. Receive paper copy of Privacy Notice from Practice.
G. Complain to Practice or Secretary of HHS if you believe your rights have been violated.

To file a complaint with the Practice or to obtain more information about your rights contact the Practice's Privacy Officer.

Name: Christi Murphy *Address*: 300 Philadelphia Ave., Egg Harbor, NJ 08215 *Telephone*: 888.888.9260

AUTHORIZATION

Uses and/or disclosures other than those described above will be made only with your written request.

This notice is in effect as of 4.15.03 (Revised 8/19/2020)