CONFIDENTIAL CASE HISTORY File #_____

Advanced Chiropractic and Wellness Center · 3840 Park Avenue, Suite D108 · Edison, NJ 08820

1 PERSONAL INFORMATION

FIRST NAME:_____ MI _____
LAST NAME: _____
BIRTHDATE: ___/___/___ AGE: _____
SOCIAL SECURITY NO. _____
ADDRESS: _____Apt.____
TOWN: _____ ZIP _____
E-MAIL: _____
GENDER: _____
OCCUPATION: _____
EMPLOYER/SCHOOL: _____
ADDRESS: _____
TOWN: _____ ZIP _____

RACE: White Hispanic African American
Asian American Indian Other
Unknown Prefer not to answer

MARITAL STATUS: S M W D OTHER
NAME OF SPOUSE: _____
SPOUSE'S EMPLOYER: _____

2 INSURANCE INFORMATION

ARE YOU COVERED BY ANY **HEALTH** INSURANCE? YES NO
(If yes, please provide the receptionist with any and all insurance cards!
If no, please move to section 3)

NAME OF INSURED: _____
RELATIONSHIP TO YOU:

3 PHONE NUMBERS

HOME PHONE NO. (___) _____-_____
WORK PHONE NO. (___) _____-_____
CELL PHONE NO. (___) _____-_____
CELL PHONE CARRIER: _____
In case of an **EMERGENCY**, who should we contact? NAME: _____
RELATIONSHIP: _____
PHONE NUMBER: (___) _____-_____

4 PATIENT CONDITION

REASON FOR VISIT: _____ DATE OF LAST EXAMINATION ___/___/___
HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS? YES NO
NAMES AND ADDRESSES OF DOCTORS YOU HAVE SEEN

_____ _____ _____
_____ _____ _____
_____ _____ _____

ANY SERIOUS ILLNESSES? (please specify) _____
ANY OPERATIONS? (please specify) _____
ARE YOU TAKING ANY MEDICATIONS? (please specify) _____

HAVE YOU **EVER** SUFFERED FROM ANY OF THE FOLLOWING? (PLEASE CHECK)

Dizziness ____	Arthritis ____	Anemia _____	Backaches_____	Headaches_____
Cancer_____	Neck Pain_____	Numbness_____	Sinusitis _____	Diabetes _____
Asthma _____	Digestive disorder _____		Neuritis _____	Heart trouble _____

I understand and agree that health and accident insurance policies are an agreement between the insurance company and myself. Furthermore, I understand that Dr. Norayr Ozbalik will prepare any necessary reports and forms needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Norayr Ozbalik will be credited to my account.
I clearly understand and agree that all services rendered to me are charged directly to me and I am responsible for payment. I hereby request and authorize the release of any medical records and information concerning diagnosis, care and treatments furnished, including all laboratory tests, x-ray reports, and findings. I also give permission to leave messages at the insurance companies' and/ or attorneys' phone numbers regarding my condition AND at the above home or work phone numbers regarding scheduling of appointments and care.

PATIENT SIGNATURE: (Guardian's signature if patient is a minor) _____

New Patient Consent to Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Advanced Chiropractic and Wellness Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or discloses to carry out treatment, payment, or health care operations

I understand that Advanced Chiropractic and Wellness Center is required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization my refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Advanced Chiropractic and Wellness Center reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Advanced Chiropractic and Wellness Center change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

_____
Patient's Signature

_____
Date

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

ADVANCED CHIROPRACTIC AND WELLNESS CENTER

Dr. Norayr Ozbalik, D.C.

3840 Park Avenue, Suite D108
Edison, NJ 08820-2563
Office Tel: 732-902-2302
Office Fax: 732-902-2305

As a result of being under care at the office of Advanced Chiropractic and Wellness Center, Dr. Norayr Ozbalik, DC, it may be necessary for the staff to contact you. Most communication pertaining to your treatment is done by telephone or email. Please give specific information as to what telephone numbers may be called where a message may be left, and who we may speak with, as well as an email address we can send messages to:

1) Email where messages can be sent: _____ Do not email__

2) Home Phone: Please circle: May Call / Do NOT Call- Home Phone #: _____

_____May leave message on voicemail to confirm appointments

_____May leave detailed informational message on voicemail

May leave message with: No one / Person/People listed: _____

3) Cell phone: Please circle: May Call / Do NOT Call- Cell Phone #: _____

_____ May leave message on voicemail or text to confirm appointments

_____ May leave detailed informational message on voicemail or text

Cell phone carrier: _____

May leave message with: No one / Person/People listed: _____

I give permission to Advanced Chiropractic and Wellness Center, Dr. Norayr Ozbalik, DC to release medical records or discuss information in medical chart with (please provide contact information if you have not already):

Other treating physicians: _____

_____

Attorney: _____

Family: _____

Other: _____

Signed: _____ Date: _____

Print Name: _____

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understands both the objective and the method that will be used to attain the objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and prevention of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interface to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name	Signature	Date

Patient: _____
File #: _____
Employer: _____
Policy # or Group #: _____
SS#/ID#/ Claim #: _____

I hereby instruct and direct _____ Insurance Company to pay by check and make out and mailed to:

DR. NORAYR OZBALIK
ADVANCED CHIROPRACTIC AND WELLNESS CENTER
3840 PARK AVENUE
SUITE D-108
EDISON, NJ 08820

OR

If my current policy prohibits direct payment to the doctor, I hereby also instruct you to make out the check and mail it out to me as follows:

DR. NORAYR OZBALIK
ADVANCED CHIROPRACTIC AND WELLNESS CENTER
3840 PARK AVENUE
SUITE D-108
EDISON, NJ 08820

for the professional or medical expenses allowable and otherwise payable to me under current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said any professional service charges over and above this insurance payment. I understand that I am responsible for all co-payments, deductibles, and any other amount not covered by my insurance contract/plan.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also hereby authorize Dr. Ozbalik to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance company Commissioner or to assign benefits for any reason on my behalf.

Date: _____

_____ _____
Signature of Policyholder Signature of Witness

_____
Signature of Claimant, if other than Policyholder

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NOTICE OF MEDICARE COVERAGE FOR CHIROPRACTIC CARE

You Medicare coverage of chiropractic care is limited. It does not pay for all services. It will ONLY pay for your chiropractic adjustment (manipulative treatment) when it meets Medicare's specific rules. There are three categories of Medicare services:

1) Non-covered 2) always- covered and 3) perhaps-covered.

NON-COVERED SERVICES

According to existing Medicare law, most of the services in our office are NON – COVERED. Here is a summary:

Example of Non-Covered Services

All Services Other than Chiropractic Adjustments:

Office Visits –to evaluate & manage, re-evaluate, Give counsel regarding health.
Physiotherapy- such as massage, traction, electrical Stimulation, neuromuscular re-education, etc.
X-rays, Blood work, Supplies, Vitamins, etc.

Various Chiropractic Adjustments or treatments:

Non –spinal Manipulations shoulder, arm, leg
Maintenance Care – stable not making improvements
Wellness Care- to promote better health

ALWAYS-COVERED SERVICES

A Medicare COVERED service (manipulation) is for when you are injured or when you are in pain due to a bad spinal condition. Medicare pays for your rehabilitation as long as you are IMPROVING; this phase of care is called "Active treatment." It will be shown on your Medicare claim form and payment reports with your service code. For example,"98941-AT"

PERHAPS-COVERED SERVICES

Your chiropractic Adjustments must be clinically needed to correct a problem of the spine, according to Medicare rules. If Medicare determines that your condition is not "Medically Necessary" they will not pay. When we know or believe that your chiropractic adjustments is no longer covered, we will discuss this matter with you. We will also give you a Medicare form known as the Advance Beneficiary Notice (ABN) which will show your financial obligation for the continued care.

MY FINANCIAL RESPONSIBILTY

I have read the above Medicare information. I understand that I am personally **financially responsible** for all services not covered by Medicare. I am also responsible for applicable annual deductible or coinsurance/copays.

X_____ _____

Signature of patient or person acting on patients behalf Date

MY AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

X_____ _____

Signature of patient or person acting on patients behalf Date

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OFFICE POLICY

We believe that a clear definition of our policies will allow both you, the patient, and us, the doctor, to concentrate on the big issue: **REGAINING AND MAINTAINING YOUR HEALTH.** It is the goal of this office to provide you with the finest quality of Chiropractic care available.

APPOINTMENT POLICY

This office is open five days a week including evenings and Saturday mornings for your convenience. To minimize waiting, please incorporate these appointments into your routine when you visit our office. If you are unable to keep your appointment for any reason, we require that you call ahead of time and reschedule your visit. Failure to cancel an appointment within 24 hours, will result in a fee of $20.00 per missed appointment. When entering our office on any given visit please go directly to the front desk and "sign-in". We attempt to honor all appointments at the scheduled times. Also, this office will accept "walk-in" visits for your convenience as long as our schedule allows.

FINANCIAL POLICY

Pay at the time of service (PTS)

1. Patients with limited or no Chiropractic coverage:
   Our office accommodates PTS, which we offer as a discount on services rendered.
2. Patients with insurance:
   Co-payments/ coinsurances are expected at the time of service. For patients that have deductibles, we will be collecting $50/ visit towards the deductible.
3. HMO subscribers & insurance that require a PCP referral:
   You must have a referral from your PCP. If no referral is received, you are responsible for your visit in full.
4. All patients: All patients with outstanding balances on their account will be billed monthly for a total of three (3) months in a row. After the third attempt, we will forward the account to a collections agency. At this point, the patient will be responsible for the amount due plus a $35.00 collections fee.

MEDICAL RECORDS

Medical records will not be mailed or faxed to personal emails or fax numbers. As per HIPPA regulations, they are to be picked up at our office by the patient or an authorized representative. Proper identification must be presented and paperwork must be filled out prior to authorize release.

By signing this consent, I am acknowledging that I understand the policies of Advanced Chiropractic and Wellness Center. I have read the above, understand it fully and undertake chiropractic care on this basis.

PATIENT'S SIGNATURE: _____DATE___/___/___

PRINT NAME: _____

As a courtesy to our patients our office will perform the following tasks:

- Submit patient information to Insurance Company for authorization to treat. Send initial consults for primary physician's records if requested in writing.
- Verify insurance benefits; verification is not a guarantee of payment. Patient is responsible for any balance not covered by the insurance.

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score