

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 disclosed 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 may 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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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 Chiropractic care available.

APPOINTMENT POLICY

This office is open five days a week including Saturday morning and evenings for your convenience, to minimize waiting and to facilitate please incorporate these appointments into your daily routine. If you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit. Failure to cancel an appointment within 24 hours will result in a fee of \$20.00. When entering the office on any given visit, please go directly to the front desk and "Sign-In". We attempt to honor all appointments at the scheduled time. Also, this office will accept walk-in appointments for your convenience.

FINANCIAL POLICY

Pay at the time of service (PTS):

1. Patients with limited or no Chiropractic Coverage:
Our office accommodates PTS, which we offer a discount on services rendered.
2. Patients with Insurance:
Co-payments are expected at the time of service. For patients that have deductibles, we will be collecting \$50/visit to go 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. After the third attempt, we will forward the account to a collection's agency. At this point, patient will be responsible for the amount due an additional 25% of the balance owed for the collections fee.

MEDICAL RECORDS

Medical records will not be emailed 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 patient representative with proper identification and completed authorizations.

For PIP patients who have retained an attorney, by signing below you acknowledge that you agree to have your initial consultation as well as any test results faxed to your attorney. Any additional medical records must be requested by the attorney with an accompanying signed medical records authorization. Please initial here if you **do NOT** want your initial visit and test results sent to your attorney. _____

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.



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Dear Patient,

Thank you for choosing our office for your chiropractic needs. Please note the following regarding your PIP accident:

- We will pre-authorize all treatments through your auto insurance carrier, if necessary.
- We will then bill your primary PIP carrier for any and all treatments rendered in our office. (If health care is primary as per your policy, we will bill health insurance first, then auto insurance).
- Your primary PIP carrier is _____ as per your policy.
- Our office will follow up with the insurance company if payments are not received. Please be sure to provide them with all the necessary information if they request it. **However, any outstanding balance not paid by the insurance company will be the patient's responsibility.**
- **If eligibility is not confirmed or invalid and/or policy limits are exhausted, the patient is responsible for payment in full.**
- Deductible, coinsurance and copay are a **Patient's Responsibility**. Any treatments rendered after the benefits are exhausted are the **Patient's Responsibility**.
- You have advised us that your attorney is _____. If you change attorneys during the course of treatment, please advise us immediately.
- We will provide your attorney your most up-to-date balance and will accept payment for your coinsurance and deductible upon the settlement of your case.
- We will not take payments during your visits to our office. Upon completion of the treatments, and all processing of claims, we will forward your balance statement to your attorney, if you have retained one. We will also send you a copy of the balance statement so you are aware of the amount owed to us upon settlement. Please be sure to remind your attorney of your balance with our office as settlement approaches. If your case is settled without the balance with our office paid, we will send you the statement of balance for 3 consecutive months. After the third attempt, we will forward the account to a collection's agency. At this point, the patient will be responsible for the amount due and an additional fee of 25% of the balance.
- If you do not have an attorney, we will send you the balance statement upon processing of all claims.
- If you'd prefer to pay towards your balance at each visit, please advise our office manager to arrange a payment plan.

Print Name: _____ File #: _____

Patient Signature: _____ Date: _____



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Protection of Assignment of Benefits

I hereby give Advanced Chiropractic & Wellness Center authorization to use my second Assignment of Benefits in the event the first assignment is invalidated due to treatment during the Pre-Service Appeal process.

Patient Name: _____

DOA: _____

Carrier: _____

Claim #: _____

Patients Signature _____

Date _____

Assignment of Benefits & LTD. Power Of Attorney

Patient Name: _____ Date of Loss: ____ / ____ / ____

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

Insurance Co: _____ Name Of Policy Holder: _____

Policy Number: _____ Claim Number: _____

I, the undersigned, hereafter referred to as "The Patient" do hereby assign all of my rights and interests to Advanced Chiropractic & Wellness Center, hereafter referred to as "The Medical Provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey. I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable request of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for the same. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same be deducted from any settlement made on my behalf.

I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the Health carrier and/or insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for payment of the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier. The provider will comply with the decision point review request as required by the plan. The provider shall submit disputes to personal injury protection dispute arbitration if the decision point review plan requires same.

In the event it is determined by Arbitrator and/or Court of Law that the imposition of a co-payment penalty was as result of the medical provider's failure to pre-certify treatment or comply with other decision point review requirements the provider will hold the patient harmless for such co-payment penalty.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for you medical services directly against the carrier in this case in my name, including filing an arbitration demand or lawsuit.

I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact.

I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and/or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

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

Assignment of Benefits & LTD. Power Of Attorney

Patient Name: _____ Date of Loss: ____ / ____ / ____

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

Insurance Co: _____ Name Of Policy Holder: _____

Policy Number: _____ Claim Number: _____

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I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact.

I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and/or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

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