

**OLIVIERI CHIROPRACTIC CENTER
PIP CHECK LIST
FOR AUTOMOBILE ACCIDENTS**

Please be advised that under the revised auto law in New Jersey we are required to seek pre-certification for all accident related and medically necessary treatment as a result of an auto accident. Please be further advised that your first visit in this office will take between 1 – 1 ½ hours as the doctor will conduct a very thorough examination.

Please provide our Personal Injury Claims Representative with the following data at your first appointment or as soon it becomes available. Your cooperation in obtaining all of the above information as quickly as possible so that we can expedite the required pre-certification process under the new auto law in the State of New Jersey is appreciated.

- Name and address of your attorney when available.
- Name of any referring physician (if applicable)
- You will need copies of all MRI reports, emergency room records and any x-rays you have had taken (if applicable).
- A copy of the Declaration Sheet (cover sheet) on your own auto policy (showing the deductible and PIP benefits). **VERY IMPORTANT that we have on file.**
- Copy of the Police Department's accident report when available. A copy must be kept in your file, **please obtain a copy as soon as possible.**
- Signed Notice of Doctor's Lien Form, which is included in paperwork, signed by you, which we will send to your attorney to sign which protects any unpaid balance you may have at settlement (deductible/co-insurance) for which you are responsible.
- Secondary insurance information (health insurance) for submission of any balance (**any referrals required are your responsibility**). We submit auto deductible and co-insurance to your health insurance for payment as secondary payer.
- Claim Number and the name of the PIP Adjuster who will be handling your medical claim.
- A copy of your PIP Application for Benefits form (large yellow or white form sent by your auto insurance carrier upon opening your medical claim). **This must be filled out as quickly as possible and sent back to the auto carrier or no payments will be issued to any medical provider you have seen. Please keep a copy for your files! VERY IMPORTANT!**
- Copy of your Auto Insurance Card and your Driver's License.

NOTE: Please be aware that under NJ Personal Injury Protection Law you are responsible for the first 20% of your medical charges up to \$5,000, as well as your PIP deductible chosen on your automobile policy. These amounts are your responsibility. We collect a fee of \$10 per visit to be applied to this balance until the auto insurance begins paying at 100%. This helps reduce any balance you may have at settlement. The fee is to be paid at each visit!

Thank you,

Personal Injury Representative

PATIENT INFORMATION

Date: _____

Please print all information as clearly as possible. Please fill out form completely, all information is necessary to complete file and send claims on your behalf.

First Name (**no nicknames**) _____ M.I. _____ Last Name _____

Sex: M F Birthdate ____/____/____ Age _____ Social Security (required) ____/____/____

Marital Status: S M D/S W Spouse's Name _____

Permanent Mailing

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

Temporary Mailing

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

Home Phone: () _____ - _____ Work Phone: () _____ - _____ Cell Phone: () _____ - _____

If you would like text message appt reminders, please tell us your mobile provider: _____

Employment Status: Full Time ___ Part Time ___ Student ___ Homemaker ___ Unemployed ___ Retired ___

Employer (required) _____ Type Of Work _____

Family Doctor: _____ Would you like us to send a Report to your Dr.? _____

Emergency Contact: Name: _____ Phone: () _____ - _____

Relationship: Spouse Parent Child Other

E-Mail Address: _____

How were you referred to our office?

TV _____ Newspaper _____ Internet _____ Radio _____ Yellow Pages _____ Direct Mail _____

Doctor ___ Friend ___ Relative ___ Name: _____

Primary Insurance (Auto)

Insurance Company Full Name: _____

Policy ID #: _____ Group #: _____

Relationship to Insured: ___ Self ___ Spouse ___ Child/Step ___ Child ___ Parent ___ Other

Insured's First Name : _____ M.I.: _____ Last: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Birthdate: ____/____/____ Insured's Social Security # (required): _____ - _____ - _____

Insured's Employer: _____ Work Phone: () _____ - _____ - _____

Secondary Insurance (Health)

Insurance Company Full Name: _____

Policy ID #: _____ Group #: _____

Relationship to Insured: Spouse ___ Child/Step Child ___ Parent ___ Other _____

Insured's First Name: _____ M.I.: _____ Last: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____

Insured's Birthdate: ____/____/____ Insured's Social Security # (required): _____ - _____ - _____

Insured's Employer: _____ Work Phone: () _____ - _____ - _____

Cause Of Complaint: Auto Accident ___ Work Injury ___ Other Accident ___ Illness ___ Congenital ___ Unknown

If Accident: * Attorney Name: _____ Phone: () _____ - _____

OLIVIERI CHIROPRACTIC & REHABILITATION CENTER

NOTICE OF PRIVACY PRACTICES

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

Olivieri Chiropractic and Rehabilitation Center is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

“On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with Olivieri Chiropractic and Rehabilitation Center.”

“It is our policy to provide a substitute healthcare provider, authorized by Olivieri Chiropractic and Rehabilitation Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations. (Example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Olivieri Chiropractic and Rehabilitation Center for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the healthcare services received.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:
(Example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. “If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Olivieri Chiropractic and Rehabilitation Center sponsored fund-raising events.”

Change of Ownership

In the event that Olivieri Chiropractic and Rehabilitation Center is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Olivieri Chiropractic and Rehabilitation Center is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Olivieri Chiropractic and Rehabilitation Center amend your protected health information. Please be advised, however, that Olivieri Chiropractic and Rehabilitation Center is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Olivieri Chiropractic and Rehabilitation Center.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Olivieri Chiropractic and Rehabilitation Center reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Olivieri Chiropractic and Rehabilitation Center is required by law to comply with this Notice.

Olivieri Chiropractic and Rehabilitation Center is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Ronald Glover by calling this office at 609-886-8585. If Ronald Glover is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

Complaints

Complaints about your Privacy Rights, or how Olivieri Chiropractic and Rehabilitation Center has handled your health information should be directed to Ronald Glover by calling this office at 609-886-8585. If Ronald Glover is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201

This notice is effective as of April 14, 2003.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Olivieri Chiropractic and Rehabilitation Center with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

OLIVIERI CHIROPRACTIC & REHABILITATION

Informed Consent for Chiropractic Care, Physical Therapy, Spinal Manipulation, Diagnostic X-Rays and Treatment, Authorization and Release.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic or physical therapy procedures, including various modes of therapy or modalities and diagnostic x-rays, on myself (or on the patient named below for whom I am legally responsible) by the licensed doctors of chiropractic of the Olivieri Chiropractic and Rehabilitation Center or any other doctor or physical therapist, who now or in the future, works in relief.

I have had the opportunity to discuss with my doctor the nature and purpose of chiropractic adjustments and other procedures and understand that spinal manipulation involves the doctor placing his or her hands on my spine and delivering a quick thrust or impulse to the involved area(s). I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy, there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical modality injuries and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I authorize payment of insurance benefits directly to Olivieri Chiropractic and Rehabilitation Center. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations, testimonial and coordination of care and authorize Olivieri Chiropractic and Rehabilitation Center to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all cost of chiropractic care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor or therapist, any fees for professional services will be immediately due and payable.

I am also aware that this office offers physical therapy services, provided by a licensed physical therapist. Patients that may benefit from this form of rehabilitation will be given the recommendation to seek these physical therapy services. I understand that I may seek these services at any facility I choose and I am under no obligation to have them performed here.

I have read the above information regarding consent, or it has been thoroughly explained to me. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients (for X-Ray purposes): By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____	_____	_____
(Print) Patient's Name	Patient's Signature	Date
_____	_____	_____
Relation/Authorized Person if Not Signed by Patient	Witness	

Consent to Treatment of Minor Child

I hereby authorize Dr. Robert Olivieri, Dr. Peter Olson, Ronald Glover, P.T. and whomever they may designate as an assistant to administer treatment as deemed necessary to my (son, daughter, step-son, step-daughter, other).

Child's Name _____ Guardian _____ Date _____

Motor Vehicle Accident Patients ONLY: Consent for Permanent Impairment Rating

By virtue of my signature on this form, I give my permission to any and all authorized representatives of this office known as Olivieri Chiropractic and Rehabilitation Center, to disclose and release in writing or any other format, the results of my permanent medical impairment evaluation. Furthermore, I have been informed of the medically rated permanent impairments and reduced functional capabilities that relate to my status. I have acknowledged and been made aware of any and all bodily losses, as well as future ramifications as they may apply to me.

_____	_____	_____
Patient Signature	Witness	Date

Road conditions at time of accident: Icy Rainy Wet Clear Dark

Your car: Hit another car Was hit by another car in the: Right Left Rear Front Side

Type of Accident: Head-on collision Broad side collision Rear-end collision
 Front impact, rear ended car in front Non-collision

Were you pre-warned that the accident was about to happen? Yes No

Did you brace for impact? Yes No

Were you gripping the steering wheel? Yes No If yes: Regular grip Tight grip N/A

Were shoulder harnesses worn? Yes No Were lap belts worn? Yes No

Did your car have headrests? Yes No

If yes, what was the position of headrests compared to your head before the accident?

- Top of headrest even with **bottom** of head
 Top of headrest even with **top** of head
 Top of headrest even with **middle of neck**
Distance from **back of head** to **headrest** _____ inches.

Was your car stopped? Yes No

If yes, was your foot firmly on the brake? Yes No

If no, was your car Slowing down Maintaining speed Accelerating

If your car was moving, what was your approximate speed? _____ M.P.H. (estimate)

How fast was the other car traveling? _____ M.P.H. (estimate)

Head/body position at time of impact:

- Head turned right left Body straight in sitting position
 Head looking back Body rotated right left
 Head straight forward

At the time of accident, describe what parts of your **head** or **body** hit what parts on the inside of your car:

As a result of the accident were you: Rendered unconscious Dazed Circumstances vague
 Shaken up but could function Other: _____

Could you move all parts of your body? No Yes If no, what parts and why?

Were you able to get out of the car and walk unaided? Yes No If no, why not?

--

Did you get bruises? Yes No If yes, where are your bruises?

--

Did you get cuts? Yes No If yes, where were you cut?

Did you need stitches? Yes No If yes, where and how many?

Were the Police notified? Yes No

Did you receive medical assistance at the scene of the accident? Yes No

If yes: Backboard Back brace Bandages Neck brace Other _____

Where did you go after the accident? Hospital Home Family Doctor Resumed activities

How did you get there? Ambulance Drove self Some else drove: Who? _____

At what hospital were you examined? _____

Please check tests that were performed: Brief Exam Extensive Exam CT scan EKG Blood Test
 Urine Test Bone Scan X-rays: Body parts? _____

Were you released after your examination? Yes No

Were you admitted into the hospital: Yes No If yes, how many days did you stay? _____

Were you given medication? Yes No If yes, what? _____

Were you given a neck or back brace? Yes No If yes, what type? _____

What was the name of the ER Physician? Dr. _____

Upon discharge, what recommendations did the Doctor make? _____

PRIOR TO COMING TO THIS OFFICE LIST ALL DOCTORS, TESTS, AND TREATMENTS RECEIVED.

Prior to coming to this office are you: Getting Better Getting Worse Same Comes and Goes

PREVIOUS MEDICAL TREATMENT AND DIAGNOSTIC TESTS:

Please list all doctors (MDs, Chiropractors or therapists) you have seen for your problem, and when you first saw them.

<u>DOCTOR OR THERAPIST SEEN</u>	<u>DATE</u>	<u>TREATMENT – PRESCRIPTIONS – TESTS ORDERED</u>

Which of the following diagnostic tests have you had?

<u>TESTS</u>	<u>YES</u>	<u>BODY PARTS</u>	<u>DATE</u>	<u>LOCATION</u>	<u>RESULTS (if known)</u>
Plain x-rays					
CT scan					
Myelogram					
MRI scan					
Diskogram					
Bone scan					
EMG					
Thermogram (TG)					
Other					

TREATMENT BENEFITS: Please **CHECK** the treatment you have received for this injury, **PRIOR** to coming to this office.

<u>Treatment</u>	<u>Helped</u>	<u>Made Worse</u>	<u>Little Change</u>	<u>Comments</u>
Hot Packs				
Ultrasound				
Ice				
Massage				
Electrical Stimulation				
TENS Unit for home use				
Body Mechanics Training				
Strengthening Exercises				
Aerobics (e.g. exercise bike)				
Gravity Inversion				
Traction				
Bed Rest				
Chiropractic Manipulative Therapy				
Biofeedback				
Local Trigger Point Injections				
Epidural Injections				
Facet Joint Injections				
Back Brace/Neck Brace				
Acupuncture				
Antiinflammatory Medication				
Narcotic Pain Medication				
Muscle Relaxant Medication				
Antidepressant Medication				
Other				

Are you currently getting any treatments listed above? Yes No

If yes, which one(s) and frequency of treatment?

If you are not getting any of the treatments listed above, approximately when was the last time you did get any of them?

MEDICATIONS

Please list all medications you take – even if only occasionally. Include how often you take the medication, how much you take, and/or how long you have taken it. Please note any aspirin, Tylenol or vitamins you might take as well.

<u>MEDICATION</u>	<u>HOW OFTEN</u>	<u>HOW MUCH</u>	<u>FOR HOW LONG</u>

PAST SURGICAL HISTORY

List **all** surgeries/operations you have **ever had during your lifetime**. Also list when these were done, where they were done, who the surgeon was, and if you have had any remaining problems associated with these procedures. (Attach separate sheet if necessary)

<u>DATE</u>	<u>TYPE OF SURGERY</u>	<u>WHERE</u>	<u>SURGEON'S NAME</u>	<u>COMPLICATION/REMAINING PROBLEMS</u>

PAST HOSPITALIZATIONS

Please list all hospitalizations you have had in the past which **did not** involve surgery. Also list any remaining problems you attributed to these illnesses.

<u>DATE</u>	<u>CAUSE OF HOSPITALIZATION</u>	<u>REMAINING PROBLEMS</u>

ALLERGIES

Are you allergic to anything (medications, lotions, etc)? Yes No

If yes, list: _____

SOCIAL HISTORY

Do you smoke or did you ever smoke: Yes No

If yes, how many years? _____ # of packs per day: _____

If no, when did you quit? _____

Marital status: Married Single Divorced Widowed Separated

Do you use caffeine products (coffee, tea, chocolate, colas)? Yes No. If yes, how often? _____

Please check your level of formal education

Less than High School College Degree High School Diploma Advanced Degree in _____
 Some College Vocational Training in _____

FAMILY HISTORY

Do you have children? Yes No

<u>AGE</u>	<u>SEX (M/F)</u>	<u>MEDICAL PROBLEMS (if any)</u>

Have you returned to work? If yes, please list any limitations you have as a result of your injuries:

Please describe in detail your current job and what your duties consist of.

How long have you held this job? _____ How many hours per week do you work? _____

Does your work involve predominantly:

- Standing: No Yes – For how long at a time? _____
Driving: No Yes – For how long at a time? _____
Walking: No Yes - For how long at a time? _____
Sitting: No Yes - For how long at a time? _____
Lifting: No Yes – How many _____ pounds.

WHEN WAS THE LAST DAY YOU WORKED “FULL DUTY”? ____ / ____ / ____

If you are currently not working because of your pain or injury, would you want to return to your old job?

- Yes – When? ____ / ____ / ____
 No - What are your present goals with respect to return to work, further schooling, etc.?

If you are not working are you currently receiving wage compensation? Yes No

ATTORNEY

Do you have an attorney on this case? Yes No

Attorney Name	
Firm Name	
Street Address	
City	
State & Zip	
Phone Number	

Revised Oswestry Low Back Pain and Disability Questionnaire

Patient Name: _____ MR#: _____ Date: _____

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

SECTION 1--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 is severe but comes and goes.
5. The pain is severe and does not vary much.

SECTION 2--Personal Care

0. I would 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 increase the pain, but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I it necessary to change my way of doing it.
4. Because of the pain, I am unable to do any washing and dressing without help.
5. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--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 the table.
4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights, at the most.

SECTION 4 --Walking

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than one mile.
2. Pain prevents me from walking more than one mile.
3. Pain prevents me from walking more than 1/2 mile.
4. I can only walk while using a cane or on crutches.
5. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

0. I can sit in any chair as long as I like without pain.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than ten minutes.
5. Pain prevents me from sitting at all.

SECTION 6 -- 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 one hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I can't stand for more than 10 minutes without increasing pain.
5. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

0. I get no pain in bed.
1. I get pain in bed, but it does not prevent me from sleeping.
2. Because of pain , my normal night's sleep is reduced by less than one-quarter.
3. Because of pain, my normal night's sleep is reduced by less than one-half.
4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

SECTION 8--Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of my pain.
2. Pain has no significant effect 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. Pain prevents me from sleeping at all.

SECTION 9--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 any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts all forms off travel.
5. Pain prevents all forms of travel except that done lying down.

SECTION 10--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 at present.
3. My pain is neither getting better nor worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

NECK DISABILITY INDEX

Patient Name: _____ MR#: _____ Date: _____

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

SECTION 1--Pain Intensity

0. I have no pain at the moment
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain is severe but comes and goes.
5. The pain is severe and does not vary much.

SECTION 6 -- Concentration

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

SECTION 2--Personal Care (Washing, Dressing etc.)

0. I can look after myself 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 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.

SECTION 7--Work

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can 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.

SECTION 3--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 if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

SECTION 8--Driving

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

SECTION 4 --Reading

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

SECTION 9--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).

SECTION 5--Headache

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

SECTION 10--Recreation

0. I am able engage in all recreational activities with no pain in my neck at all.
1. I am able engage in all recreational activities with some pain in my neck.
2. I am able engage in most, but not all recreational activities because of pain in my neck.
3. I am able engage in a few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.

ACTIVITIES OF DAILY LIVING ASSESSMENT

Name: _____ Date: _____

Please circle the number which most closely describes your chief complaint(s) today:

1. Pain Intensity

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) ----- (5) ----- (6) ----- (7) ----- (8) ----- (9) ----- (10) -----
 No Pain Worst Possible Pain

2. Frequency Of Pain

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Occasional Pain Intermittent Pain Frequent Pain Constant Pain
 25% Of The Day 50% Of The Day 75% Of The Day 100% Of The Day

3. Personal Care (Washing, Dressing, etc.)

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
 No Restrictions No Restrictions Need to go slowly Need some assistance Need 100% Assistance

4. Travel (Driving, Riding, etc.)

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Mild Pain Moderate Pain Moderate Pain Severe Pain
 On Long Trips On Long Trips On Long Trips On Short Trips On Short Trips

5. Work

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 Can Do Usual Work Can Do Usual Work Can Do 50% Can Do 25% Cannot Work
 Plus Extra Work No Extra Work Of Usual Work Of Usual Work

6. Recreation

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 Can Do All Can Do Most Can Do Some Can Do A Few Cannot Do Any
 Activities Activities Activities Activities Activities

7. Sleeping

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 Perfect Mildly Moderately Greatly Totally
 Sleep Disturbed Disturbed Disturbed Disturbed

8. Lifting

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Increased Pain Increased Pain Increased Pain Increased Pain
 With Heavy Weight With Heavy Weight With Mod Weight With Light Weight With Any Weight

9. Walking

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Increased Pain Increased Pain Increased Pain Increased Pain
 Any distance After One Mile After Half Mile After Quarter Mile With All Walking

10. Standing

----- (0) ----- (1) ----- (2) ----- (3) ----- (4) -----
 No Pain Increased Pain Increased Pain Increased Pain Increased Pain
 After Several Hours After Several Hours After One Hour After Half Hour With Any Standing

What would you like to be able to do again that you presently cannot? _____

CIRCLE THE TYPE OF CARE YOU WOULD LIKE TO RECEIVE (YOU MAY CHOOSE MORE THAN ONE OPTION):

Acute Care Corrective Care Home Exercise Program In-Office Exercise Program Physical Therapy

NOTICE OF DOCTOR'S LIEN
INSTRUCTIONSTO MY ATTORNEY

TO: _____ DATE: _____

RE: _____ DATE OF INJURY: _____

I hereby authorize and direct you, my attorney, to pay directly to Olivieri Chiropractic Center, such sums as may be due and owing to them of services rendered to me by reason of my accident, which occurred on _____ and to withhold from my settlement such sums as may be necessary to adequately protect and compensate Olivieri Chiropractic Center, whether derived from an action for first or third party benefits and whether achieved by amicable resolution or verdicts. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover and is subject to the NJ PIP fee schedule.

Prior to my being treated, I executed an Insurance Assignment of Benefits and payment order, whereby I directed the insurance company responsible for the payment of my medical expenses to pay Olivieri Chiropractic Center directly for their services. I fully understand that I am directly and fully responsible to Olivieri Chiropractic Center for all medical bills submitted for services rendered me, and that this agreement is made solely for Olivieri Chiropractic Center's protection and in consideration of them awaiting payment.

As my attorney in this matter, I wish to inform you of the assignment and request your cooperation with Olivieri Chiropractic Center to insure that their claims are paid directly by the insurance company.

I also agree to notify Olivieri Chiropractic Center of any change or addition of attorney(s) used by me in connection with this accident, and I instruct you, my attorney, to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

I understand that no distribution of any settlement proceeds can be made to me until such time as you, my attorney, have confirmed, in writing that Olivieri Chiropractic Center's charges have been paid in full. You are also notified not to take any action, as my representative, to compromise or reduce Olivieri Chiropractic Center's charges without first obtaining written permission from Olivieri Chiropractic Center.

DATE:

PATIENT (OR GUARDIAN) SIGNATURE:

The undersigned, being attorney for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Olivieri Chiropractic Center. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

DATE:

ATTORNEY'S SIGNATURE

Kindly sign and date both copies and return one copy to our billing office and keep one copy for your records.

ADDRESS: Olivieri Chiropractic & Rehabilitation Center, LLC
1501 Rt. 47 South
Rio Grande, NJ 08242

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO
DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH
INSURANCE

I hereby instruct and direct The _____ Insurance
Company to pay by check made out and mailed directly to:

Olivieri Chiropractic & Rehabilitation Center
1501 Route 47 South
Rio Grande, NJ 08242

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for 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 professional service charges over and above this insurance payment. I understand the above doctor has a financial interest in any diagnostic testing.

I irrevocably authorize all information regarding my benefits be released to the Olivieri Chiropractic & Rehabilitation Center. Further, I irrevocably authorize Olivieri Chiropractic & Rehabilitation Center to act in my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

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

Dated this _____ day of _____ in the year _____.

Signature of policyholder

Signature of Claimant, if other than policyholder