WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

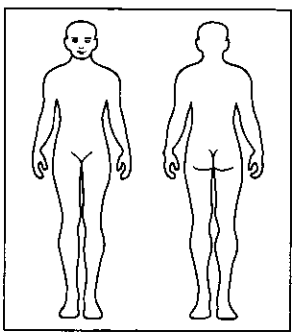
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

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

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray _____ Blood Test_____

Spinal Exam_____ Chest X-Ray _____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (____)_____

ALLERGIES

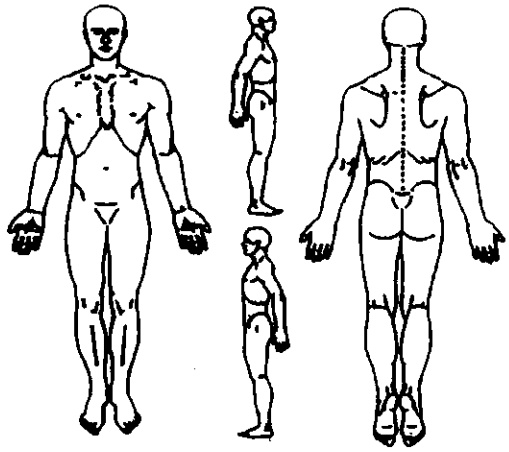
VITAMINS/HERBS/MINERALS

USE THE LETTERS LISTED BELOW TO INDICATE
THE *TYPE* AND *LOCATION* OF YOUR PAIN & SENSATIONS...

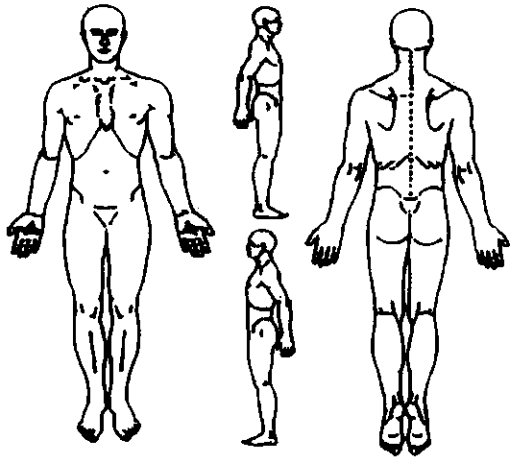
KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER

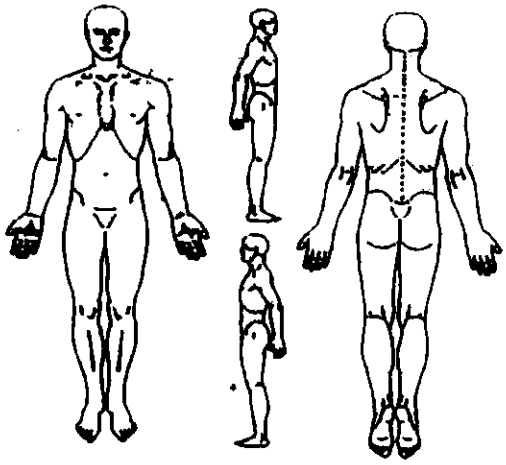
#1 DATE _____



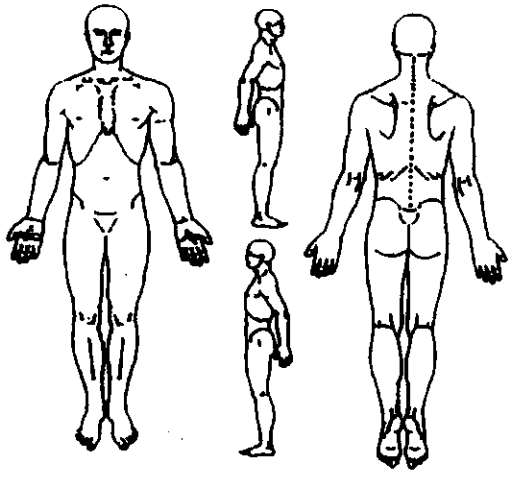
#2 DATE _____



#3 DATE _____



#4 DATE _____



Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

ASSIGNMENT OF BENEFITS, LIMITED POWER OF ATTORNEY RELEASE OF RECORDS, CONSENT FOR TREATMENT, MEDICARE AND MEDICAID PATIENTS CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST.

CONSENT FOR TREATMENT: I hereby consent to such treatment procedures and patient care which, in the judgment of my physician, may be considered necessary or advisable while a patient at Panaia Chiropractic and Rehabilitation of Cherry Hill LLC.

ASSIGNMENT: I irrevocably assigned to you, Panaia Chiropractic of Cherry Hill, LLC. (herein referred to as "Panaia Chiropractic") my health care provider, all rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file my insurance claims on my behalf rendered to me and this specifically includes filling arbitration/litigation in your name on my behalf against the health care/PIP carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payment go directly to you, my medical provider. I authorize you to act on my general health insurance coverage pursuant to the "benefit denial appeal process" set forth in the New Jersey Administrative Code.

As medical provider agreed to comply with the PIP carrier's decision point Review/pre certification plan to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this agreement.

LIMITED/SPECIAL POWER OF ATTORNEY: 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 the point and authorize your collection of Attorney as my agent and Attorney to collect payment for medical services directly against the carrier in this case in my name including filing any arbitration demand or lawsuit. I specifically authorize that Attorney to file against the carrier in my name and/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 to pay directly any moneys due to you for medical services you rendered to me.

RELEASE OF RECORDS: I authorize you and your Attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care providers to release information to you about me, including medical records, X-ray reports, narrative reports, and any other report of information regarding my physical condition.

AUTHORIZATION TO RELEASE INFORMATION:

_____ Insurance Company is hereby authorized to release to Panaia Chiropractic and Rehabilitation of Turnersville LLC. And /or their designated legal council, all or any part of my medical records, billing information, insurance, insurance policy information, EOB's and any information contained in my PIP file.

LETTER OF PROTECTION/ATTORNEY DIRECTIVE/IRREVOCABLE ASSIGMENT:

I hereby irrevocably authorize my attorney _____ ESQ., to pay directly to "Panaia Chiropractic" sums as may be due and owing for services rendered by "Panaia Chiropractic" and to withhold such sums from any bodily injury policies, disability, medical payment benefits, no fault benefits, health and accident benefits , workers compensation benefits, or any other insurance benefits obtained to reimburse the undersigned, or from any settlement, verdict or judgment which may be paid to me or my attorney as a result of the injury or illness for which I have received services from "Panaia Chiropractic" I irrevocably assign to "Panaia Chiropractic". I irrevocably assign to "Panaia Chiropractic" all rights and beneits under any insurance contracts for the payment of services rendered by "Panaia Chiropractic". I irrevocably authorize all information regarding my benefit under any insurance policy relating to any claims by "Panaia Chiropractic" be released to "Panaia Chiropractic" and/or their legal counsel. I irrevocably authorize "Panaia Chiropractic" file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to "Panaia Chiropractic".

I give "Panaia Chiropractic" and/or their legal counsel my power of attorney and have authorized them specifically to endorse/sign my name on any and all checks for payment of "Panaia Chiropractic" bills. I further acknowledge that I have a right to and have reviewed a copy of this agreement.

Date:_____

Print Patient's Name:_____

Patient Signature:_____

Assignment, Lien and Authorization Insurance
Benefits and Attorney

I hereby authorize and direct you, my insurance company, and or my attorney to pay directly to **Panaia Chiropractic and Rehabilitation of Cherry Hill** such sums as may be due and owing this office for services rendered me both by reason of accident, or illness and by reason of any other bills that are due the office, and to withhold such sums from any disability benefits, medical payment benefits. No fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of benefits form to the extent of the offices services provided.

In the event my insurance company refuses to make such payments upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this office to compromise, settle or otherwise resolve said claim or cause of action they see fit.

I understand that I am financially responsible to **Panaia Chiropractic and Rehabilitation of Cherry Hill** for the total amount due and/or for any amount not covered by my insurance for their services. I further understand and agree that this assignment, lien and authorization does not constitute any consideration of the office to await payment and they may demand payments from me upon rendering services at their option.

In the event your account with **Panaia Chiropractic and Rehabilitation of Cherry Hill** is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court costs will be added to your total amount.

I authorize **Panaia Chiropractic and Rehabilitation of Cherry Hill** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization and understand that **Panaia Chiropractic and Rehabilitation of Cherry Hill** will be using my social security number as identification. I agree that the above mentioned office be given the power of attorney and to endorse/sign my name on any and all checks for payment of services rendered.

I certify that the information provided to **Panaia Chiropractic and Rehabilitation of Cherry Hill** regarding the injuries I sustained in my accident is honest and truthful.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE LISTED ITEMS IN THESE PARAGRAPHS.

_____	_____
(Patient Name)	(Guardian)
_____	_____
(Patient / Guardian Signature)	(Date)

ELLERY PANAIA III, DC
1299 BRACE ROAD
CHERRY HILL, NJ 08034
PHONE 856-795-2424
FAX 856-795-2212

Dear Patient:

Please be advised that we are required by law to maintain the privacy of and provide individuals with notice of our legal duties and privacy practice with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practice.

Signature: _____ Date: _____

Print Patient Name: _____

In accordance with new federal regulations regarding patients' privacy, please read and sign the following:

I, _____ give permission to Ellery Panaia III, DC to do the following:

- Confirm appointments by phone
- Leave messages on answering machine to confirm appointments
- Release medical information requested by another treating physician or health institution.
- Give permission for Ellery Panaia III, DC to request records as needed from other physicians and/or institutions to assist in my ongoing treatment.

The following person is authorized to receive medical information about me, the patient in the event, that I cannot be available.

Contact Name: _____

Phone # _____ Relationship to contact: _____

Patient Signature: _____ Date: _____

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or object unless required by law.

You may revoke this authorization. At any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosures indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes: information complied in reasonable anticipation of or use in a civil criminal or administrative action or proceeding, and protected health information not be disclosed to family members or friends who may be involved in your care or for notification requested and to whom you want the restrictions to apply.

Your Physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use of disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively (i.e.) electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against for you filling a complaint.**

This notice was published and becomes effective on or before **April 14, 2013**

Ellery Panaia III, DC

PANAIA CHIROPRACTIC
1299 BRACE RD
CHERRY HILL N.J. 08034
(856)795-2424
(856)795-2212

DATE: _____

I _____, am requesting that a Letter of Protection be sent to Dr. Ellery Panaia III D.C.

I am aware that the Letter of Protection is assuring payment to Dr. Ellery Panaia III D.C. at the end of my treatment.

_____
Signature

Panaia Chiropractic & Rehabilitation
1299 Brace Road
Cherry Hill, NJ 08034

856-795-2424 (phone)
856-795-2212 (fax)

Please Read Carefully

The daily max cap is a limit placed on the amount your insurance company will allow for Treatment/CPT codes listed in subchapter Appendix, Exhibit 6 per day. Chiropractic Treatment Codes and Physical Therapy Codes both fall within subchapter Appendix, Exhibit 6. Therefore, are subject to the daily max cap. This limit applies to the entire day, regardless of the number of providers you, the patient, visits (NJAC 11:3-29.4 (m), effective 1/04/2013). If you choose to attend both Chiropractic Treatment & Physical Therapy on the same day, your insurance company will not cover the costs of both due to the daily max cap. Ultimately, resulting in an outstanding balance.

I,_____, have been informed by an employee of Panaia Chiropractic & Rehabilitation of the daily max cap (NJAC 11:3-29) and am aware that attending Chiropractic Treatment & Physical Therapy, regardless of the treatment provided or to which region of the body, on the same day may result in an outstanding balance.

I,_____, have read and agree to the above statements regarding the daily max cap. I understand that if I choose to attend both Chiropractic Treatment and Physical Therapy on the same day, that I will be responsible for any outstanding balance that may occur as a result.

_____ _____
(Patient Signature) (Date)

_____ _____
(Panaia Chiropractic & Rehabilitation) (Date)

Panaia Chiropractic & Rehabilitation
1299 Brace Road
Cherry Hill, NJ 08034

Please read carefully.

We will work with you and your lawyer in getting your bills paid. For motor vehicle cases, where your health insurance is secondary, we will bill them for any co-pays and deductibles you may have. Once the auto insurance has terminated your benefits, we will then bill your health insurance as primary. At that time, we will collect any co-pays or deductibles for which you are responsible. However, we expect that all bills be paid, whether or not you or your lawyer has successfully pursued a lawsuit. This includes all deductibles, co-pays, and any outstanding medical bills not covered or paid for by your insurance company or legal settlement.

I,_____, **understand that my medical insurance may make payments for my care directly to me, instead of the provider of my care, Panaia Chiropractic & Rehabilitation. I understand that the payments I receive are for the treatment provided to me by Panaia Chiropractic & Rehabilitation. Therefore, I must bring in these checks directly to Panaia Chiropractic & Rehabilitation immediately.**

Both the provider, Panaia Chiropractic & Rehabilitation, and the patient will receive copies of the explanation of benefits as well as detailed payment information. In the event that the Explanation of Benefits are sent to you, you are required to bring them directly to Panaia Chiropractic & Rehabilitation immediately. The exact amount of the insurance payment will be disclosed to both parties. Along with the amount, the date of payment will also be disclosed.

I,_____, have read and agree to the above statements concerning my medical insurance payments. I understand that any payments I receive from my insurance company are the property of Panaia Chiropractic & Rehabilitation and will surrender payments within 10 business days.

I also understand that as a result of my failure to comply with this agreement, Panaia Chiropractic & Rehabilitation will file legal action to obtain the full insurance reimbursement that is due.

_____

_____

(Patient) (Date)

_____

_____

(Panaia Chiropractic& Rehabilitation) (Date)

PANAIA CHIROPRACTIC OF CHERRY HILL
1299 BRACE ROAD
CHERRY HILL, NJ 08034
PHONE: 856-795-2424
FAX: 856-795-2212

PIP PATIENT INFORMATION FORM

PATIENT NAME: _____ D/A: _____

INSURED NAME: _____

DATE OF START TREATMENT: _____

CLAIM NUMBER: _____

POLICY NUMBER: _____ _____

INSURANCE CO NAME: _____

INSURANCE CO ADDRESS: _____

_____

INSURANCE CO PHONE #: _____

INSURANCE CO FAX: _____

ADJUSTER NAME: _____

ADJUSTER PHONE #: _____

CASE MANAGER AND PHONE #: _____ _____

ATTORNEY NAME: _____

ATTORNEY ADDRESS: _____

_____ _____

ATTORNEY PHONE #: _____

PANIAN CHIROPRACTIC OF CHERRY HILL
1299 Brace Road
Cherry Hill, NJ 08034
Phone: 856-795-2424
Fax: 856-795-2212

Dear Patient,

Under the new insurance reform for New Jersey automobile carriers, you must have the appropriate billing information in order to be seen in our office.

1. Current auto insurance card with a copy of your declaration page (breakdown of auto insurance policy.)
2. Claim Number
3. Drivers License
4. Police Report (may take approximately 10-12 days to obtain report)
5. Personal Health Insurance Card

Chiropractic treatment, MRI's CT Scans, and EMG's must be precerted with the auto carrier. This **cannot** be done if you have not reported the accident to your insurance company and receive a claim number.

I undestand that I am responsible for bringing in the correct billing information mentioned above in order to receive treatment with this office.

I understand that I am responsible for any balances due after the auto carrier and health insurance pays their portion of the claims. This is due on or before 30 days upon receipt of billing statement, unless you have obtained an attorney. If an attorney is obtained, all fees will be handled at a later date.

If you have any further questions or concerns please contact our office.

_____ _____

Patient Signature Date

Panaia Chiropractic & Rehabilitation of Cherry Hill

1299 Brace Road

Cherry Hill, NJ

(856) 795-2424 Phone

(856) 795-2212 Fax

Date:_____

Name: _____

D.O.B.: _____

D / A: _____

I would like my records to be released to _____.

No other records are to be released without my consent.

_____

Signature