CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date ___________________________________

Patient Name ___________________________________

____

Address ___________________________________

City ___________________________________

State ______________________ Zip __________

Email ___________________________________

Social Security # _________ - ______ - _________

Sex ☐ M ☐ F Age ______________________

Birth date ___________________________________

Marital Status

☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Minor ☐ Single ☐ Partnered for _____ years

Occupation ___________________________________

Patient Employer/ School ______________________

Employer/ School Phone (_____)__________________

Primary Doctor ______________________________

Whom may we thank for referring you

☐ Walk-in ☐ Insurance ☐ Gift card ☐ Attorney

☐ Former Patient: ______________________________

Internet: ☐ Google ☐ Yelp ☐ Website

☐ Other: ___________________________________

INSURANCE

Who is responsible for this account? __________________

Relationship to patient ______________________________

Insurance Co. ___________________________________

Group # ___________________________________

Policy ID ___________________________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______________________________

Birth date ___________________________________

Relationship to patient ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and my dependant(s), have insurance coverage with ________________ and assign directly to Dr. Colaizzo all insurance benefits, if any, otherwise payable to me for service 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 name 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 (_______)__________________________

IN CASE OF EMERGENCY, CONTACT

Name ________________ Relationship ___________

Phone (______)_______________________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes, Date __________ ☐ No

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto insurance ☐ Employer ☐ Workers 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 the 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

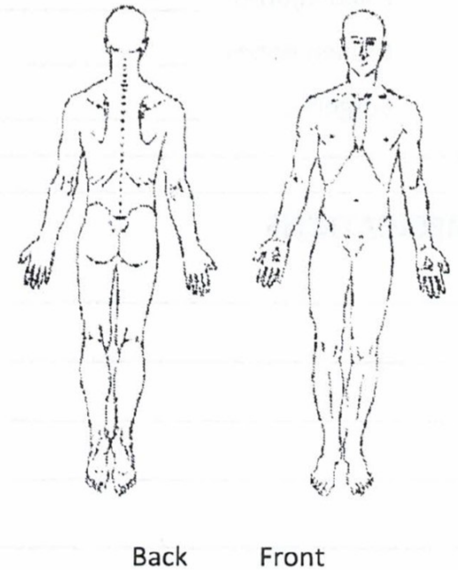
How often do you have this pain? ___________________________

Is it constant of does it come and go? ___________________________

Does it interfere with: ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are difficult to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Laying down



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other ________________________________

Name and addresses 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:

Condition			Condition			Condition			Condition		
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 disorder	☐ 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 disc	☐ 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 Problems	☐ Yes	☐ No	Other ______________		
Chicken Pox	☐ Yes	☐ No	High cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	______________		
Chemical Dependency	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE	WORK ACTIVITY	HABITS	
☐ None	☐ Sitting	☐ Smoking	Packs/ Day ______________
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/ Week ______________
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine drinks	Cups/ Day ______________
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason ______________

Are you pregnant? ☐ No ☐ Yes, Due Date ______________

Injuries/ Surgeries you have had

	Description	Date
Falls	______________	______________
Head injuries	______________	______________
Broken Bones	______________	______________
Surgeries	______________	______________

MEDICATIONS	ALLERGIES	VITAMINS/ HERBS/ MINERALS
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

HIPAA 2024

Catherine Colaizzo, D.C. 1075 Easton Ave. Somerset, NJ 08873

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

In the course of your care as a patient here we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including of your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may responsible for the payment of your services.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: US DEPT of Health & Human Services.

This notice is effective as of Jan 1, 2014. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

____________________________ _______________________________ ____________________________

Name (Printed) date Signature Parent or Guardian

Coronavirus (COVID_19) Screening Questionnaire

Patient Name: ___________________________________ Today's Date: _____________

Patient DOB: ____________________________ Age: ___________________

1) Have you traveled anywhere in the last 3 weeks (especially outside the USA)?
   NO____ YES ____ If yes please explain.

____
____

2) Have you been in contact with anybody that was sick in the last 3 weeks?
   NO____ YES ____ If yes please explain (this could be a friend, family or co- worker).

____
____

3) Have you been to a region designated as an epicenter (AREAS OF HIGH CONTAGION)?

   NO___ YES____ If yes please explain.

____
____

4) Do you have symptoms of a cold or flu? YES____ NO____
5) Do you have a cough? YES____ NO____
6) Do you have any difficulty breathing? YES____ NO____
7) Do you have a runny nose? YES____ NO____
8) Do you have a sore throat? YES____ NO____
9) DO you have any illness related body aches? YES____ NO____

I attest that I have fully and properly answered the above questions and the information is complete.

Patient's/ Guardian's Signature: ________________________ Date: _______________

-Chiropractic & Therapy Center-
Catherine Colaizzo, D.C.

Date: _____________

Authorization to Release Medical Information

I hereby authorize the following healthcare provider to release and/or exchange my personal medical records between all relevant medical providers and attorneys (where applicable) on my behalf. Information exchanged can include but is not limited to: office notes, exam reports, diagnostic tests, referrals, billing records, insurance records, and records furnished by other healthcare providers.

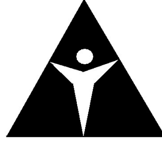
Chiropractic and Therapy Center
Catherine Colaizzo, DC
1075 Easton Avenue Suite 9
Somerset, NJ 08873
Phone (732) 545-5999
Fax (732) 545-3439

Patient name (printed) ________________________________

Patient DOB: _______________________________________

Patient Signature: ___________________________________

Date of signature :___________________________________



Chiropractic & Therapy Center
Catherine Colaizzo, D.C

Auto Accident Basic Information

Please provide our office with the information below for our billing Department

Patient Name: ____

Date of Birth: ____

Date of Accident: _____________________________________

Auto Insurance Company:_______________________________

Claim#____

Adjuster First & Last Name: _____________________________

Adjuster Phone number: ________________________________

PIP Policy Limits:_____________________________________

Additional information we should know of regarding this case:

____

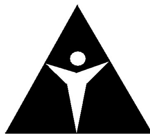
____

____

____

____

Village Plaza, 1075 Easton Avenue, Somerset, NJ 08873
732-545-5999 ● Fax: 732-545-3439
www.chiropracticandtherapycenternj.com



The Chiropractic & Therapy Center

CONDITIONAL ASSIGNMENT OF RIGHTS AND GUARANTEE TO COOPERATE

The limited assignment of rights and guarantee to cooperate is made between, Chiropractic & Therapy Center, herein referred to as the "Provider", and the following individual hereinafter referred to as the "Patient".

Patient Name: ________________________________

In consideration of services rendered, the Patient authorizes this Conditional Assignment of Rights and Guarantee to Cooperate to the benefit of the Provider. The Patient agrees to the following terms of the condition:

1. The patient assigns directly the Provider the payment of, and the right to collect payment of, any no-fault automobile insurance benefits to which the patient may be entitled for services rendered by the Provider.

2. The patient agrees to comply with any policy provisions effecting no-fault automobile insurance benefits.

3. The patient authorized, assigns, and directs payment of no-fault automobile insurance benefits to the Provider for invoice upon with payment is due for medical services rendered. Further, the Patient assigns to the Provider the right to prosecute claim(s), including but not limited to arbitration(s) or lawsuit(s) against the no fault carrier (the "carrier") named herein, for payment of no-fault automobile insurance benefits to which the patient is entitled in accordance with the applicable provisions of the following insurance policy:

Insurance Carrier: ____

Policy or Claim number: ____

4. In the event that the Patient fails to file an application for benefits under the New Jersey State no-fault laws, and the carrier for medical services rendered to the Patient has no paid the Provider, the Provider is hereby authorized to file an application on the Patient's behalf in order that the Provider may realize payment.

5. The patient agreed to fully cooperate with the Provider's efforts to prosecute a claim against the carrier in the event timely payment for medical benefits is not made to the Provider for the services rendered.

6. This limited Assignment of Rights and Guarantees shall be deemed a "limited assignment" to the Provider solely for the Purpose of collecting payment from the carrier for medical services rendered. However, nothing contained herein requires the Provider to prosecute a claim(s) against the carrier to collect payment of no-fault automobile insurance benefits or relieves the patient of the responsibility to ensure that the Provider is paid in full for the services rendered.

Approved and Agreed by:

Patient Signature: ____ Date: ___________

Witness Signature: ____ Date: ___________

Village Plaza, 1075 Easton Avenue, Somerset, NJ 08873
732-545-5999 • Fax: 732-545-3439

-Chiropractic & Therapy Center-
Catherine Colaizzo, D.C.

MUST BE SIGNED BY PATIENT AND ATTORNEY
TO: ATTORNEY/ INSURANCE CARRIER

____
____
____

RE: DOCTOR'S LIEN
PATIENT'S NAME: _______________________________
DATE OF LOSS: __________________________________

I do hereby authorize the above provider to furnish you, my attorney/insurance carrier with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/ illness which occurred/began on __________________.

I hereby give a lien to said provider on any settlement, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said provider such sums from such settlement, claim, judgment, or verdict as may be necessary to protect said provider adequately.

I fully understand that I am directly and fully responsible to said provider for all bills submitted by him/her for service rendered me, and in consideration of his/her awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrues due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance will be subject to a 1% per month service charge.

Patient's Signature: _______________________________________ Dated: _________________

The undersigned, being attorney of records or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of above lien, and does agree to honor the same to protect adequately the above named provider.

Attorney's Signature: ____________________________________ Dated: __________________

Please sign, retain a copy for your records, and return this copy to us promptly.

Village Plaza, 1075 Easton Avenue, Suite 9, Somerset, NJ 08873
732-545-5999 ● 732-545-3439