CHIROPRACTIC *Naturally*
337 Belgrade Ave
Roslindale, MA 02131
Tel: (857) 273-4162 Fax: (857) 273-3946

New Patient Registration Form

Date: _____ ( ) Insurance ( ) Wellness/Maintenance ( ) Auto Accident ( ) Worker's Comp ( ) Slip and Fall

Patient name: _____ Patient SSN: ___-___-_____ DOB: ___/___/___

Address: _____City:_____ State: _____ Zip code: _____

Email: _____ **(Cell)** ___-___-____ **(Home)** ___-___-____ **(Work)** ___-___-____

Date of Accident/Injury_____ Date of first Symptoms_____ Emergency Contact (Name/#):_____

Occupation: _____ Sex: ( ) Male ( ) Female Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Minor

Patient Employer/School: _____ Spouse's name/DOB:_____

MAY WE SEND YOUR PHYSICIAN INFORATION ABOUT YOUR CONDITION? ( ) YES ( ) NO

Primary Care Physician Name: _____ Office Telephone: _____

INSURANCE INFORMATION

Insurance Company: _____Group#:_____Member#_____
Subscriber name and DOB (if different from patient):_____ Relationship to patient: _____
Do you have secondary insurance? (Provide information listed above): _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent (s), have insurance coverage with_____ and assigned directly to Dr. Imonti or Dr. Robin all insurance benefits, if any, otherwise payable to me services rendered. I understand that I am financial responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named Chiropractor may use my healthcare 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 1 year from the date signed below.

Patient/Representative Signature: _____ Date:_____
Print Patient/Representative Name: _____Relationship to Patient:_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The Patient Understands that: • Protected health information may be disclosed or used for treatment, payment, or health care operations. • The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice. • The Practice reserves the right to change the Notice of Privacy Practices. • The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions. • The patient may revoke this consent in writing at any time and all future disclosures will then cease. • The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by Printed Name: _____
Patient or Representative Signature_____ Date _____

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Informed Consent

Chiropractic: It is importatnt to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic healthcare seeks to restore through natural means with the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recupertative powers. The success of the chiropractic doctor's procedures often depend on enviroment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

Analysis: A doctor of chiropractic conducts a clinical analysis for the express purtpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VS) or Vertebral Subluxation Complexes (VSC). When When such VSS or VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers.

Diagnosis: Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed consent for chiropractic care: A patient, coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, increased pain, muscle spasms, or rib injury underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibilty of the patient to make it known or to learn through health care procedures whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient is provided a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health regime.

Results: The purpose of chiropractic services is to promote natural health through the reduction of VSS and/or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occassionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. May medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

Acknowledgement and Understanding: It is further understood that I, the undersigned, agree to pay the full amount of the charges should my condition be such that it is not covered by my policy, or if, for any reason, the insurance company and/or my attorney refused to pay my balance at this office. I understand that I am responsible for whatever fees my insurance company does not pay on my claim. (Typically, this includes deductibles and/or co-payments). _____

To the Patient: Please discuss any questions or problems with the doctor before signing this state of policy. I have read and understand the foregoing.

Patient Name (Print)	Patient Signature	Date
Patient name (If patient is under 18 yrs. old)	Parent or Legal Guardian	Relationship to Patient

CHIROPRACTIC *Naturally*
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Roslindale, MA 02131
Tel: (857) 273-4162 Fax: (857) 273-3946

MEDICAL RECORDS REQUEST

I, _____, do hereby authorize _____
Patients name Hospital Name

to furnish all my records concerning examination, diagnosis, x-rays, treatments, prognosis, etc. to:

Chiropractic *Naturally*
337 Belgrade Avenue
Roslindale, MA 02131

Date of Accident ____/____/____ **Records of** _____
Visit of ____/____/____ **Date of Birth** _____
Date of Request ____/____/____ **Social Security #** _____

_____ _____
Patient Signature Date

A copy of this authorization shall have the same force and effect as the original.
Please enclose any tests along with the medical records.
If the patient is a minor (under age 18), parent of legal guardian must sign below:

_____ _____ _____
Parent/legal guardian signature Relation to patient Date

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____ **Date** _____

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE which applies to you.*** *We realize you may consider that two of the statements in any one section relate to you but please just* ***mark the one box, which most closely describes your problem right now.***

SECTION 1 – Pain Intensity
A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (washing, dressing, etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading
A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 - Headaches
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I cannot concentrate at all.

SETION 7 – Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving
A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping
A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-5 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation
A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

_____

_____

_____

_____ SCORE: _____
Examiner

With Permission from: Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

CHIROPRACTIC *Naturally*, 337 Belgrade Avenue, Roslindale, MA 02131 Tel: (857) 273-4162, Fax: (857) 273-3946

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your 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 ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weight off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than ten minute without increasing pain.
F. I avoid standing, because it increases the pain straight away.

SECTION 7 – Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and give me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, My dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

COMMENTS: _____

PATIENT NAME: _____ **DATE:** _____ **SCORE:** _____

CHIROPRACTIC *Naturally*, 337 Belgrade Avenue, Roslindale, MA 02131 Tel: (857) 273-4162, Fax: (857) 273-3946

Patient Name:_____

Date:_____

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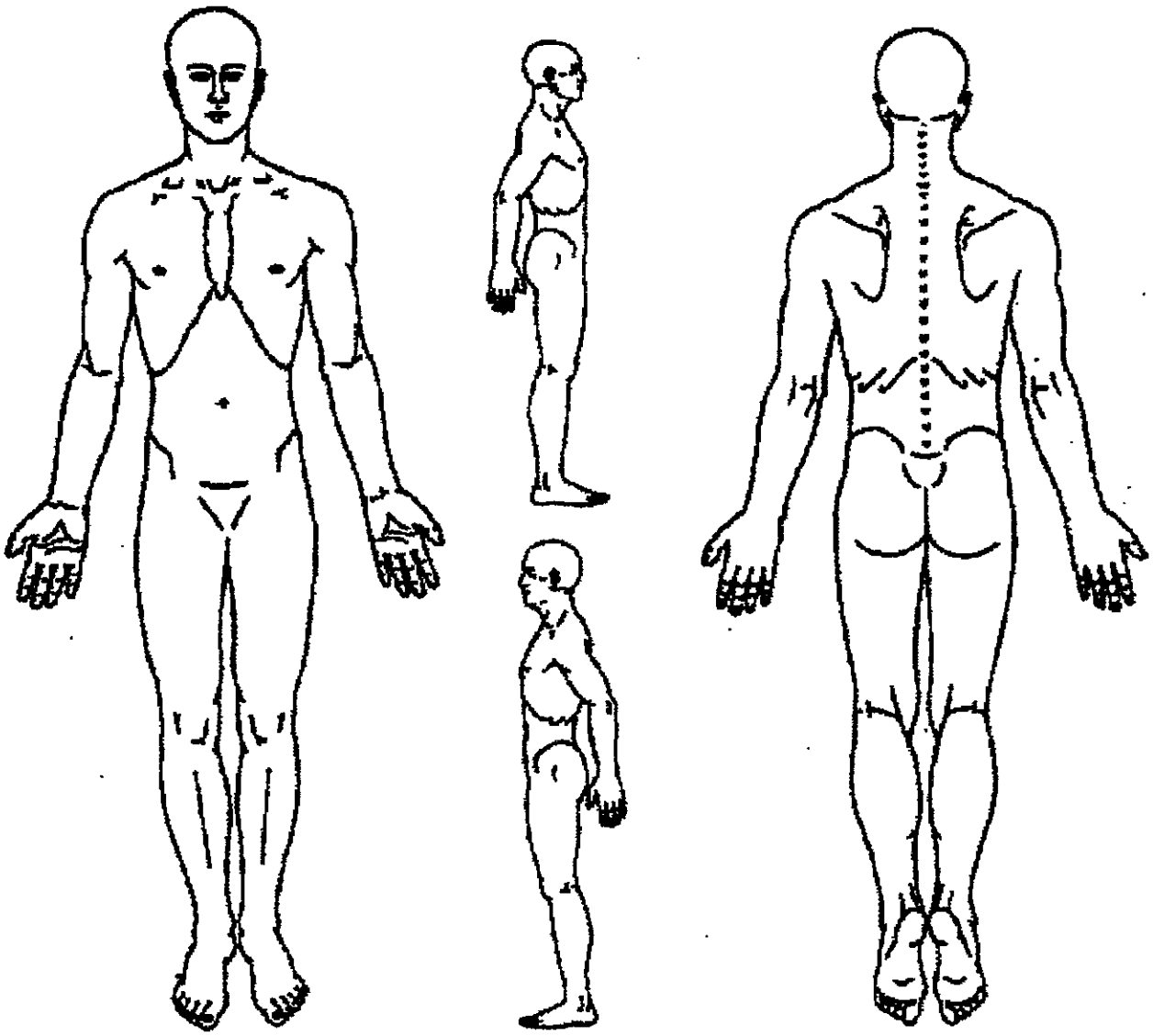
PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A -ACHE B -BURNING N -NUMBNESS
P -PINS & NEEDLES S -STABBING 0 -OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale:

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

FRAUD ALERT

DO NOT BE A VICTIM

DO NOT LET ANYONE TELL YOU IT IS OK TO FILE A FALSE INSURANCE CLAIM.

DO NOT LET ANYONE USE YOUR NAME, ADDRESS OR CAR TO FILE A FRAUDULENT INSURANCE CLAIM OF ANY KIND.

PRISON AND FINES WITH A CRIMINAL RECORD CAN RESULT

DO NOT LET OTHERS USE YOU!!

CALL 1-800-32FRAUD
TO REPORT ANYONE WHO TELLS YOU THAT INSURANCE FRAUD IS EASY

IN THE END IT WILL BE HARD ON YOU.

ALERTA DE FRAUDE

NO SE CONVIERTA EN UNA VÍCTIMA

NO PERMITA QUE NADIE LE DIGA QUE ESTÁ BIEN PRESENTAR UN RECLAMO DE SEGUROS FALSO

NO PERMITA QUE NADIE USE SU NOMBRE, DIRECCIÓN O AUTOMÓVIL PARA PRESENTAR UN RECLAMO DE SEGUROS FRAUDULENTO DE NINGÚN TIPO.

PUEDE RESULTAR EN PRISIÓN Y MULTAS CON UN EXPEDIENTE PENAL

¡NO PERMITA QUE OTROS SE APROVECHEN DE USTED!

LLAME AL 1-800-32FRAUD
PARA DENUNCIAR A CUALQUIER PERSONA QUE LE DIGA QUE EL FRAUDE DE SEGUROS ES FÁCIL

AL FINAL, SERÁ MUY DURO PARA USTED.

ALERTA DE FRAUDE

NÃO ACABE SENDO VÍTIMA

NÃO ACREDITE SE ALGUÉM LHE DISSER QUE É ACEITÁVEL DAR ENTRADA EM PEDIDO DE INDENIZAÇÃO DE SEGURO FALSO.

NÃO PERMITA QUE ALGUÉM USE SEU NOME, ENDEREÇO OU CARRO PARA DAR ENTRADA EM QUALQUER TIPO DE PEDIDO DE INDENIZAÇÃO DE SEGURO FRAUDULENTA.

O RESULTADO PODE SER PRISÃO E MULTAS COM O REGISTRO DE FICHA CRIMINAL

NÃO DEIXE QUE OUTRAS PESSOAS APROVEITEM DE VOCÊ!!

LIGUE PARA 1-800-32FRAUD
PARA DENUNCIAR QUALQUER PESSOA QUE LHE DIGA QUE FRAUDAR SEGURO É FÁCIL

O FINAL SERÁ DURO PARA VOCÊ.

AVÈTISMAN KONT FWÒD

PA TOUNEN YON VIKTIM

PA KITE PÈSONN MOUN DI OU PA GEN PWOBLÈM SI OU FÈ YON FO REKLAMASYON BENEFIS ASIRANS.

PA KITE PÈSONN MOUN SÈVI AK NON OU, ADRÈS OU OSWA MACHIN OU POU FÈ REKLAMASYON OKENN BENEFIS ASIRANS AN FWÒD.

KONSEKANS LAN SE PRIZON AK AMANN EPI YON DOSYE KRIMINÈL

PA KITE LÒT MOUN SÈVI AVÈK OU!!

RELE 1-800-32FRAUD
POU RAPÒTE NENPÒT MOUN KI DI OU LI FASIL POU FÈ FWÒD SOU ASIRANS

ALAFEN SE OU MENM KI VA SIBI.

Внимание обман

Не станьте жертвой

Не позволяйте никому рассказывать как легко предъявить ложный иск в страховую компанию.

Не позволяйте никому использовать ваши имя, адрес или машину для любого ложного заявления.

В результате все это можете привести к тюрьме, штрафу и появлению у Вас криминальной истории.

Не разрешайте никому использовать Вас.

Звоните по телефону 1-800-32FRAUD
сообщите о любом кто пытался предложить Вам обмануть страховую компанию.

В конце концов можете пострадать Вы.

CẢNH CÁO VỀ LƯỜNG GẠT

ĐỪNG BIẾN MÌNH THÀNH NẠN NHÂN

ĐỪNG TIN KHI CÓ NGƯỜI NÓI VỚI QUÝ VỊ RẰNG CÓ THỂ KHAI GIAN XIN TRẢ BẢO HIỂM.

ĐỪNG CHO NGƯỜI KHÁC DÙNG TÊN, ĐỊA CHỈ HOẶC XE CỦA QUÝ VỊ ĐỂ KHAI GIAN XIN TRẢ BẢO HIỂM DƯỚI BẤT KỲ DẠNG NÀO.

NGƯỜI PHẠM TỘI SẼ BỊ TÙ, PHẠT TIỀN VÀ CÓ HỒ SƠ TỘI PHẠM

ĐỪNG ĐỂ NGƯỜI KHÁC LỢI DỤNG QUÝ VỊ!!

XIN GỌI SỐ 1-800-32FRAUD
ĐỂ BÁO CÁO NẾU CÓ NGƯỜI NÓI VỚI QUÝ VỊ RẰNG GIAN LẬN BẢO HIỂM LÀ DỄ DÀNG

CUỐI CÙNG QUÝ VỊ SẼ GẶP RẮC RỐI

保險理賠詐欺—犯罪行為

受害者可能就是你!

假保險,偷借身份(當人頭)/串通去製造假理賠,不僅是犯罪的行為,更會導致牢獄之災和罰款!

不要被人利用了!
不要成為代罪的羔羊!

請電 1800-32FRAUD (37283)

請檢舉任何人利用假身份,騙保險,假理賠!

I, ______________________ have read and acknowledged the above notice. Date: ____________

SIGNATURE

CHIROPRACTIC *Naturally*
337 Belgrade Ave
Roslindale, MA 02131
Tel: (857) 273-4162 Fax: (857) 273-3946

LIEN FOR SERVICES RENDERED

I hereby authorize **Chiropractic Naturally** (hereinafter "CN") to furnish my Attorney and/or insurance carrier with a full report of my case history, examination(s), diagnosis, treatment(s), and prognosis of my injury which CN is treating or has treated. Said accident/injury occurred on or about _____.

I give a lien to CN on any settlement, claim, judgment, and/or verdict as a result of said accident/illness. Consequently, I receive notice of this lien and authorize and direct my Attorney and/or insurance carrier to pay directly to CN such sums as are due and owing to CN for services rendered. I authorize the withholding of such sums from any settlement, claim, judgment, and/or verdict and further understand thbt if I receive any money from my Attorney and/or insurance carrier as payment for the chiropractic treatments rendered, 1| am responsible to forward that money to CN.

I fully understand that I am directly and fully responsible to CN for all medical bills and reports submitted by them for services rendered to me. This agreement is made solely for CN's additional protection and in consideration of CN's awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, and/or verdict.

Date:	Patient's Name:
Patient's Signature:	Social Security #:

If patient is a minor (under 18 years of age), parent or legal guardian must sign below:

Date:	Parent/Legal guardian's Signature	Relationship to Patient:

Witness:

This undersigned, being above-referenced patient's attorney and/or authorized representative of the insurance carrier, does hereby acknowledge receipt of this lien and agrees to honor the same to protect interests of CN as it relates to the above said injury and services.

Authorized Signature:	Date:

It is understood that photocopies of this lien will be freely acceptable as though they were originals. Please keep a copy for your records and date, sign and return a copy to us.

Personal Injury Insurance Information

Patient _____ Accident Date _____

Attorney Information

Name: _____ Phone: _____

Address: _____

Auto Insurance Information

Company _____
Policy #: _____
Claim #: _____
Phone #: _____
Adjuster: _____
Address _____
_____

Other Party's Insurance Information

Company _____
Policy #: _____
Claim #: _____
Phone #: _____
Adjuster: _____
Address _____
_____

(For Office Use Only - Questions to Ask Attorney)

1. Does Liability look questionable? Yes ☐ No ☐
2. Is the insurance policy active and will cover this accident? Yes ☐ No ☐
3. Was a police report filed? Yes ☐ No ☐
4. Were there any witnesses? Yes ☐ No ☐
5. Amount of property damaged _____
6. Were there other people in the car? Yes ☐ No ☐ How Many? _____
7. Is there Med-Pay? Yes ☐ No ☐ What amount? _____
   Limits? _____

Med-Pay Verified Date _____ Spoke to _____
_____ Initial

APPLI[illegible]N FOR BENEFITS—PERSONAL INJURY PRO[illegible]TION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

TO: CURE
CLAIM DEPT.
214 CARNEGIE CENTER, SUITE 101
PRINCETON, NJ 08540

YOUR NAME	PHONE NO. HOME	BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / /	SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
BRIEF DESCRIPTION OF ACCIDENT	

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐

IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME:
ADDRESS:
PHONE:
FAX#:
E-MAIL:
POLICY/GROUP #/CERTIFICATE #:

2. NAME:
ADDRESS:
PHONE:
FAX#:
E-MAIL:
POLICY/GROUP#/CERTIFICATE #:

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? YES ☐ NO ☐ IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS	
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS	
AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $
IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN	DATE YOU RETURNED TO WORK	

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER

	YES	NO
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT $ _____ ☐ PER WEEK ☐ PER MONTH

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

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AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW
(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE: