CHARSCHAN CHIROPRACTIC
AND SPORTS INJURY ASSOCIATES
FEEL BETTER IN AS LITTLE AS ONE VISIT

CONFIDENTIAL PATIENT HISTORY

490 Georges Rd. North Brunswick, NJ 08902 (732) 846-6400
1281 Raritan Rd. Scotch Plains NJ 07076 (732) 829-0009

DATE_____

(Please Print)

PATIENT'S NAME_____SOC SEC #_____

ADDRESS_____CITY_____STATE_____ZIP_____

AGE_____BIRTH DATE_____MARITAL: M S D W #CHILDREN_____ HEIGHT_____WT_____

HOME PHONE # _____ CELL PHONE # _____CELL CARRIER _____

OCCUPATION_____EMPLOYER _____

EMPLOYER ADDRESS_____EMAIL_____

GUARANTORS NAME:_____DATE OF BIRTH_____

RELATION TO GUARANTOR_____CELL PHONE#_____

WHO CAN WE THANK FOR REFERRING YOU?_____

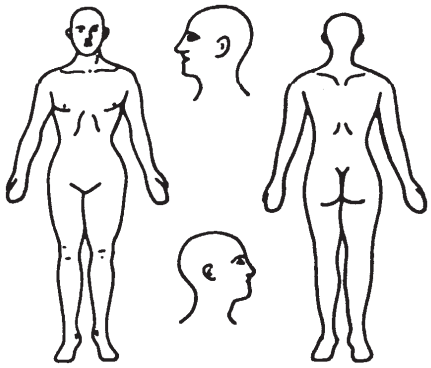
NAME AND ADDRESS OF NEAREST LIVING RELATIVE_____
(NOT LIVING WITH YOU)

Purpose of this appointment_____

Have you seen any physician for this condition (check all that apply) ☐Chiropractor ☐MD ☐None

What medications are you taking? _____

Please mark your areas of pain below:



Women: Are you pregnant at this time?
☐Yes ☐No

List surgeries and years

_____

_____

Have you suffered from:

☐Dizziness	☐High Blood Press	☐Neuritis
☐Backaches	☐Diabetes	☐Nervousness
☐Headaches	☐Arthritis	☐Digestive Probs
☐Heart Trouble	☐Asthma	☐Sinus Trouble
☐Allergies	☐Cancer	☐Neck Pain

Present Family Doctor_____

Address_____

Date of last Physical exam_____

By Whom_____

List conditions that you are most interested in getting corrected in order of importance and when each started.

1._____

2._____

3._____

4._____

What functions are you unable to perform or induce pain upon performance? (example: sit, bend, walk)

1._____

2._____

3._____

4._____

Have you ever had chiropractic care before? ☐Yes ☐No

Doctors name_____

Have you been treated for any health conditions by a physician in the last year? ☐Yes ☐No

If it determined that your health could be improved, would you want to receive chiropractic care at this office?
☐Yes ☐No

IF YOUR CONDITION IS THE RESULT OF AN INJURY, PLEASE COMPLETE THIS SECTION

IS YOUR CASE: ☐ Workers Compensation ☐ No Fault (Auto accident) ☐ Personal Injury

Date of Injury:_____ Time:_____ Location:_____

Please describe how the injury happened: _____

_____

Did you report your injury? ☐ Yes ☐ No To whom? _____

Were you Hospitalized? ☐ Yes ☐ No Where? _____

By ambulance? ☐ Yes ☐ No X-rays taken? ☐ Yes ☐ No By whom?_____

Date(s) of hospitalization_____ Medications prescribed_____

Are You presently working? ☐ Yes ☐ No Dates of time lost from work_____

Have you been treated by any other chiropractor or physician for this injury? ☐ Yes ☐ No If yes, Doctor's name and specialty _____

_____

List any previous injuries:

1. Type_____ When_____Hospitalized ☐ Yes ☐ No

2. Type_____ When_____Hospitalized ☐ Yes ☐ No

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Yes	No
1.During the past month, have you often been bothered by feeling down, depressed, or hopeless? down, depressed, or hopeless?	☐	☐
2.During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐

PAYMENT ACKNOWLEDGEMENT (Please sign)

I understand and agree that my health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Charschan's office will prepare any necessary reports and forms to assist me in making collection from the insurance carrier and any amount authorized to be paid directly to Dr. William Charschan's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payments, co-payments and non-covered managed care services. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the case of managed care plans, I agree to abide by the protocols designed by my plan and understand that any care not authorized by my plan is my responsibility. Charschan Chiropractic will do their best to preauthorize all my care and I am fully responsible for any care not preauthorized by my carrier.

If I violate this agreement and Dr. Charschan's office sends my account to a collection agency or attorney for collection, I will be responsible for all collection and court costs as well as yearly interest on the unpaid balance.

Patient's (or legal guardian) signature_____Date _____

Insured Signature_____Date _____

CHARSCHAN CHIROPRACTIC
AND SPORTS INJURY ASSOCIATES
IT'S ALL BETTER IN AS LITTLE AS ONE VISIT

490 Georges Rd. No. Brunswick, NJ 08902 732-846-6400
1281 Raritan Rd. Scotch Plains, NJ 08902 732-8290009
William D. Charschan D.C.,I. C.C.S.P., Director
www.backfixer1.com, www.whypeoplehurt.com

HIPAA patient authorizations Form.
Patients must read and sign at each x.
This form is to be placed in the patient file

Patient Authorization for appointment reminders, scheduling related matters, health products and other office communications

It is our desire to for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations or other appointment related issues. Our patients also receive our newsletter which has informative articles, health tips and products that can help you stay healthy

The use of this information is intended to make your experience with our office more efficient, productive and offer ideas and products than can help you stay healthy. If you choose not to authorize this information use your decision will have no adverse effect on your care from ___/_____/____(today's date) or on your relationship with our staff.

Your signature indicates your authorization of this activity.

x_____ x_____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

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 at Charschan Chiropractic and Sports Injury Associates, 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 judgment 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.

You can request medical records (EPHI) in electronic format if available in either Microsoft Word or PDF Formats. This can include super bills and other information you are requesting.

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

If there is a Breach of PHI (Private Health information released without permission unintentionally), we are required under the Breach Notification Rule to do the following

Notice to Individuals: Our office must notify any affected individuals without reasonable delay, within 60 days.

Notice to Media – If a breach affects more than 500 residents of a state or local jurisdiction our office must notify a prominent media outlet that is appropriate for the size of the location with affected individuals.

Notice to HHS – Notices on breaches affecting 500 or more individuals must be submitted to HHS(health and human services) at the same time that notices to individuals are issued. If a breach affects fewer than 500 individuals, our office is required to report the breach to HHS within 60 days after the end of the calendar year in which the breach occurs via the HHS web portal.

Notice by Business Associates to Covered Entities – A business associate of our office must notify us if the business associate discovered a breach of unsecured PHI. Notice must be provided without unreasonable delay and no case later than 60 days after the discovery of the breach.

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: Constance Amaczi, office manager or Dr. William Charschan, owner.

If you would like further information about our privacy policies and practices please any of our office staff. We also have an explanation posted in our reception area.

This notice is effective as of ___/____/___ (today's date). 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.

x_____ x _____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

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Patient Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Charschan Chiropractic and Sports Injury Associates to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our main office at (732) 846 6400. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

x_____ x _____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

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MEDICARE CONSENT TO RELEASE INFORMATION: (Please sign if you have Medicare only)
I certify that the information given by me in applying for payment under Title XVIII and *I* or Title Xl of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

x_____ x _____ x_____
Name (Printed please) Signature Date

If you are a minor, or if you are being represented by another party

x_____ x _____ x _____
Personal Representative Printed Personal Representative Signature Date

Version 1-20-2015

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** 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 box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

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

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** 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 box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

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

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____
%ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

CHARSCHAN CHIROPRACTIC
AND SPORTS INJURY ASSOCIATES
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William D. Charschan D.C.,C.C.S.P, I.C.C.S.P.., Director
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Our policies for insurance assignment and health plans.

HMO/PPO/EPO policies

(Plans we are currently under contract with)

1. Our office contracts with your insurance carrier directly and your insurance company will pay for your care up to the policy limits which will be explained to you by our staff. **We are not responsible if you exceed the limits of your policy**. We treat you, not your insurance and some plans are restrictive. Patients must keep count of their yearly visits for their particular plan.
2. Office co-payments are either due on the day of service prior to your visit or pre-paid weekly if this is more convenient. The co-payment you are required to pay is on your card or on your referral slip. Because managed care contracts are very strict on how they are administrated; we cannot make any exceptions. Insurer's that display bad faith and have not paid us are your responsibility.
3. We will not enter into a dispute with your carrier but will offer to help you get your claims paid if this happens. We bill weekly and do our best to make sure a problem does not develop.
3. Deductible based plans and HSA Plans - You are given our in network fee discounts however, you must meet your yearly deductible before we can accept assignment on your behalf. Office visits must be paid for daily until your deductible is met, using any of our payment methods such as credit, debit, check or cash.
4. If your plan requires a referral to receive "in network" benefits, the referral form must be in our office at the time of your visit. *You* are responsible for making sure our staff has the referral form, even if your doctor has faxed us a copy. Please be aware we will not honor backdated referrals under any conditions.
5. *You must present a valid insurance card on the day of your first visit* with your driver's license (or first visit under a new insurance plan or first visit with a new problem). If your card is not presented, you will be considered a cash patient responsible for our regular fees until you present the card. Our policy (and that of most insurance carriers) is to verify coverage for all insurance and to precertify care when appropriate by your second visit to our office. Non compliance prevents us from doing this, creates problems, extra work and billing errors. You may also find out that your plan may not allow us to retroactively correct the problem leaving you with a bill, therefore, you must present the card.
6. *Our office will not wait for your insurance to pay on devices such as foot orthotics, mouth gards, lumbar belts and other devices*. These items are to be paid for in advance. Although we will bill for them on your behalf, these devices may or may not be covered under your plan. If your insurance company reimburses our office for such a device, we will reimburse you the amount they sent to us when your account is paid in full. Since these items are not a chiropractic service, the insurance company's fee schedule is irrelevant to these items.
7. Treatment expiration dates - Under certain insurance plans, precertifications and referrals have either treatment limits or time limits. Missing appointments will assure you of not receiving your entitled benefit amount so it is best to keep your appointments.
8. Our office will try our best to keep you informed of your referral date expiration although it is not our responsibility. You will responsible for our regular fees once the referral expires/benefits are exhausted or if you come in for periodic maintenance care. Your insurance carrier considers these services optional and you are responsible for paying for those visits in full.
9. We do not bill secondary insurance.

Policies for "out of network" care

(Applies to any patients who choose to go outside their plan network to come to our office)

Since we are not contracted with your plan when service is performed "out of network", you are responsible for our normal office fees. We will be happy to take insurance assignment,

which is a form of credit, issued to patients at the time of service. When we take assignment, we are willing to wait for your insurance to pay us, and you are expected to pay the yearly deductible and any percent your insurance does not cover.

Insurance assignment is accepted under the following conditions:

1. A completed insurance form if required must be presented and completely filled out by you on your second visit. You must also present a current insurance card and your driver's license on your first visit to our office to allow us to verify your plan eligibility. No card means you pay cash.
2. You must meet your yearly deductible prior to us taking assignment since an insurance carrier will not pay anything until the deductible is met. HSA plans work the same way.
3. You must pay the percentage of your responsibility as you go along (e.g. 30%). Most patients usually pay us a weekly set amount that we apply to their deductible. This method is easier although there may be a balance due at the end of care.
4. You must sign our "**AUTHORIZATION TO PAY PHYSICIAN**" form in you file and any other forms required by your insurance carrier by your second visit.
5. If you discontinue care without the doctor's authorization, payment in full is due on any outstanding balance, regardless if your insurance has been filed.
6. This courtesy can be withdrawn if your insurance carrier displays bad faith.
7. Insurance carriers should by law pay within 30 - 60 days or less. If the insurance carrier has not done so, you must pay the balance and go after your insurance carrier for payment. We will not enter into a dispute with your insurance carrier since we are not the subscribers.
8. Our office never guarantees that your insurance carrier will pay, even though they suggested they would do so during initial insurance verification. You are responsible for anything your insurance does not pay for. Insurance carriers will sometimes quote benefits in error. Review your insurance manual for accurate benefit information.
9. If your insurance carrier sends assigned fees to you instead of to us, you must immediately bring in or mail the checks and the explanation of benefits to us. Not doing so is in direct violation of this agreement and you will be billed for the full amount.
10. We do not bill secondary insurance.

Uninsured "Out of Network"

1. If you choose to go out of network and don't have out of network benefits, wish to pay as you go and be reimbursed directly or do not have any health care coverage, you can just pay your visits as you go or weekly if this is more convenient. If you do not have coverage, you should ask about our cost effective HMA4 cash plan. Ask the doctor to discuss this option with you if you qualify.

Medicare

1. Medicare at this time only will pay for one service, the chiropractic adjustment. They will not pay for therapies including Myofascial Release, x-rays or examinations performed by chiropractors at this time. Medicare also is known to reject valid claims calling them medically unnecessary. You are responsible for all fees not paid or covered by Medicare and your secondary carrier if one exists. Our office accepts Medicare assignment, meaning that payments are sent to our office directly and to secondary carriers if they exist. It does not mean Medicare will pay everything.
2. Our office will not get involved with appeals or disputes on unpaid Medicare claims for any reason.

I have read the above policies and understand them.

_____ _____

PATIENT NAME DATE

Please fill out, sign and give this copy to our front desk personnel

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize **Dr. William D. Charschan** to administer treatment as they so deem necessary to my

_____
(Relationship)

_____
(Childs name)

Date _____

Signed: _____

Witness:_____

GENERAL RELEASE

Date: _____ No. Brunswick, NJ

KNOW ALL MEN BY THESE PRESENTS: That I,

_____ have requested the release of x-rays which are a part of the office records of **Charschan Chiropractic and Sports Injury Center** relating to my case, and I hereby acknowledge receipt of these x-ray films. In consideration of the foregoing, I hereby release and forever discharge the aforesaid Charschan Chiropractic and Sports Injury center from any and all responsibility of liability of any kind, nature or character whatsoever from the beginning of the world to this day. This transaction is consummated at my specific request.

_____
Witness

_____
Patient

IRREVOCABLE
ASSIGNMENT, LIEN AND AUTHORIZATION
INSURANCE BENEFITS AND ATTORNEY

To Whom it May Concern:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to **Charschan Chiropractic and Sports Injury Center** 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 this office, and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, heath and accident benefits, Workers' Compensation benefits, or any other insurance benefits obligated to reimburse me from any settlement, Judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to 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 my rights and benefits to the extent of the Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services 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 I authorize this Office to compromise, settle or otherwise resolve such claim or cause of action as they see fit

I understand that I remain personally responsible for the total amounts due the Office for their service & I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize the Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including but not limited to all court costs and all attorney fees.

Date _____Signed_____

CHARSCHAN CHIROPRACTIC
AND SPORTS INJURY ASSOCIATES
FEEL BETTER IN AS LITTLE AS ONE VISIT

1281 Raritan Rd. Scotch Plains, NJ 07076 **(732) 829-0009**
490 Georges Rd. No. Brunswick, NJ 08902 **(732) 846-6400**
William D. Charschan D.C.,I. C.C.S.P., Director
www.Backfixer1.com
www.njrunningdoc.com

Authorization for Charschan Chiropractic to file an appeal on my behalf

Your insurance company requires us to pre-certify chiropractic care on your behalf. We may need to appeal certification and claim decisions as well.

By signing this form, you authorize our office to appeal decisions from your insurance carrier. You are authorizing us to appeal claims, treatment decisions by insurers and their vendors as well as appeals and complaints sent to the Department of Banking and insurance.

I, _____ authorize Charschan Chiropractic and Sports Injury Associates to act on my behalf to make sure medically necessary care is fully covered by my insurance carrier.

_____ _____ _____
Patient Name Print Patient name sign Date