IDENTIFICATION SHEET

NAME_____ DOB _____ SEX: Male Female

ADDRESS_____

CITY_____STATE_____ZIP_____

SOCIAL SECURITY # _____ EMAIL _____

PRIMARY PHONE # _____ SECONDARY PHONE # _____

MARITAL STATUS _____ OCCUPATION _____ RIGHT HANDED / LEFT HANDED

PHARMACY NAME/CITY/PHONE NUMBER: _____

_____

EMPLOYER NAME/PHONE NUMBER: _____

WHO REFERRED YOU HERE? (NAME & PHONE NUMBER) _____

_____

PRIMARY CARE PHYSICIAN (NAME, PHONE NUMBER, & ADDRESS) _____

_____

HAVE YOU PREVIOUSLY TREATED WITH A CHIROPRACTOR? YES/ NO

IF YES, (NAME, PHONE NUMBER, & ADDRESS) _____

_____

HOW DID YOUR INJURY HAPPEN? (PLEASE CIRCLE ONE)

AUTO WORK RELATED SLIP & FALL OTHER: _____

DATE OF ACCIDENT _____ ACCIDENT LOCATION (CITY/TOWN) _____

ATTORNEY'S NAME _____ TELEPHONE _____

PLEASE CIRCLE ONE: I AM MEDICARE BENEFICIARY: YES NO

PRIMARY INSURANCE INFORMATION

NAME _____

ADDRESS _____

_____

TELEPHONE _____

CLAIM # _____

POLICY NUMBER _____

ADJUSTER _____

INSURED _____

SECONDARY INSURANCE INFORMATION

NAME_____

ADDRESS _____

_____

TELEPHONE _____

CLAIM # _____

POLICY/GROUP _____

SUBSCRIBER _____

EFFECTIVE DATE _____

ATHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN: I HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY DIRECTLY TO COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. ALL FEES OUT OF ANY BENEFIT OR INDEMNITY DUE ME UNDER THE TERMS OF MY POLICY AND RECOGNIZE THAT PAYMENT IN THIS MANNER IS THE SAME AS PAYMENT TO ME. PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THIS ITEMIZED STATEMENT FOR SERVICES RENDERED TO ME. THIS POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME THAT SERVICES WERE RENDERED. PAYMENT OF THIS AMOUNT IS HEREIN DIRECTED IN WHOLE OR IN PART, SHALL BE CONSIDERED THE SAME AS IF PAID BY YOUR COMPANY DIRECTLY TO ME. THIS ALSO AUTHORIZES COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. TO RELEASE INFORMATION REGARDING MY ILLNESS TO MY REFERRING PHYSICIAN, ATTORNEY, AND INSURANCE

Uche Eneanya, M.D.
Adam Schreiber, D. O.
David Smith, M.D.

Michael Chan, M.S., PA-C
Michelle Raeuber, M.S., PA-C

COMPANY. I ASSIGN ALL MY RIGHTS, TITLE, AND INTEREST IN ANY SUCH BENEFIT TO COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. AND THIS ASSIGNMENT IS IRREVOCABLE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. FOR MEDICAL SERVICES RENDERED TO ME BY COMPREHENSIVE PAIN SOLTIONS OF NEW JERSEY, P.C.

DATE **[X]** _____ PATIENT'S SIGNATURE **[X]** _____

COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C.

1123 Campus Drive West • Morganville, New Jersey 07751
Tel: (732)617-9797 • Fax: (732)617-8899

IF TRANSLATED, SIGNATURE OF TRANSLATOR:

DATE _____ TRANSLATOR'S SIGNATURE _____

NOTICE OF DOCTOR'S LIEN

PATIENT: **[X]** _____

DATE OF ACCIDENT: **[X]** _____

I do hereby authorize COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. to furnish you, my Attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was recently involved.

I hereby authorize and assign you, my Attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me by reason of this accident, and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect and fully compensate said doctor. I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgement, or verdict which may be paid to you, my Attorney, or myself, as the result of the injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of Attorney(s) used by me in connection with this accident, and I instruct my Attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I authorize my Attorney to sign this form and this authorization is irrevocable.

[X] _____ **[X]** _____
DATE: PATIENT SIGNATURE

If translated, signature of translator:

_____ _____
DATE: TRANSLATOR'S SIGNATURE:

ATTORNEY'S NAME: _____

The undersigned being Attorney of record for the above patient does hereby agree to observe all of the terms above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named.

Uche Eneanya, M.D.
Adam Schreiber, D. O.
David Smith, M.D.

Michael Chan, M.S., PA-C
Michelle Raeuber, M.S., PA-C

_____ _____

DATE: ATTORNEY'S SIGNATURE

PLEASE DATE, SIGN AND RETURN TO DOCTOR'S OFFICE.

COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C.

P.O. Box 4160 • Cherry Hill, New Jersey 08034

Tel: (856)334-9600 • Fax: (856)334-9602

DATE: **[X]** _____

DATE OF ACCIDENT: **[X]** _____

CLAIM #: **[X]** _____

I, **[X]** _____, do hereby assign to COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. the right for them to receive direct payment for any insurance company that I may be entitled benefits from. Futhermore, I assign and authorize COMPREHENSIVE PAIN SOLUTIONS OF NEW JERESY, P.C. my P.I.P. benefits from any insurance policy that I may be entitled benefits from. My assignment of benefits includes, but is not limited to, the right to file a P.I.P. suite/arbitration on my behalf against any insurance company which I am entitled benefits from. I acknowledge that COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C., if they choose to file a P.I.P. suite/arbitration, is only filing a P.I.P. suite/arbitration for the protection of their bills and not to collect any other bills through which I may have the right to be paid through my P.I.P. benefits.

[X] _____ **[X]** _____

DATE: PATIENT'S SIGNATURE:

If translated, signature of translator:

_____ _____

DATE: TRANSLATOR'S SIGNATURE:

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ASSIGNMENT OF PIP MEDICAL BENEFITS FORM

PATIENT AUTHORIZATION: Claim # _____

I am the PATIENT described above and I authorize and direst the INSURER described above to pay the TREATING HEALTH CARE PROVIDER described above, the amount due under the terms of the policy described above for any PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

I further authorize the TREATING HEALTH CARE PROVIDER described above to file a DEMAND FOR ARBITRATION (PIP) against the INSURER described above for any PAYMENT DISPUTE for PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

PAYMENT DISPUTE shall include a denial and/or non-payment by the INSURER described above for PIP medical benefits rendered by the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office. PAYMENT DISPUTE shall also include a denial and/or refusal to authorize by the INSURER named above any recommended medical benefits as part of the TREATMENT PLAN of the TREATING HEALTH CARE PROVIDER described above and/or all staff associated with that office.

RELEASE FOR MEDICAL RECORD: It is understood that certain privacy rights are attached to my medical record as created by federal and/or state legislative bodies and/or state regulatory bodies. In order to prove the medical necessity, reasonableness and/or casual relationship of the treatment rendered to me, and/or proposed to be rendered to me. I authorize release of the medical record to the assignee and/or its agents as necessary for any DEMAND FOR ARBITRATION (PIP). A photocopy of this document shall serve as an original.

[X] _____ **[X]** _____

Patient Name: (Please Print) Patient Signature:

TREATING HEALTH CARE PROVIDER REPRESENTATION:

I am the TREATING HEALTH CARE PROVIDER described above and provide the following representations to the INSURER named above in order for the ASSIGNMENT OF BENEFITS executed by the PATIENT named above to be honored. Specifically:

- All requirements of the DECISION POINT REVIEW PLAN and/or PRE-CERTIFICATION PLAN of the INSURER named above that are in accordance with the regulations promulgated by the DEPARTMENT OF BANKING AND INSURANCE (DOB) shall be complied with: and
- In the event of a failure to comply with the aforementioned requirements, the PATIENT described above will not be held financially liable for any imposed penalty.
- In the event of any dispute with the INSURER, resolution of the dispute shall be adjudicated by the filing of a DEMAND FOR ARBITRATION (PIP) through the administration by DOBI.

It is understood that an INSURER may apply to DOBI pursuant to N.J.A.C. 11:3-4.9 (a) for “approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of the coverage.” As such, please provide me within ten days of receipt of this FORM with any documentation required to effectuate the intent of the PATIENT described above. Failure to provide any documentation will be construed as a constructive acceptance of this FORM and the intent of the PATIENT described above.

Provider Signature _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C.

This form provides authorization to our Practice to use or disclose certain personal health information of yours for the purpose(s) described below. It is intended to properly inform you of how this information will be used or disclosed. You should carefully read the information on this form before signing it.

PATIENT NAME: **[X]** _____

1. Name of person or entity, or category of persons/entities authorized to make the requested use or disclosure: Comprehensive Pain Solutions of New Jersey, P.C.

2. Name of person or entity, or category of persons/entities, to whom the use or disclosure may be made:

   All health care providers involved in your care, your representing attorney, all insurance companies, & pre-cert decision point review organization included in billing of services provided to you.

3. The following is a specific description of the information to be used or disclosed, including, but not limited to, the date(s) of service, type of service provided, level of detail to be released, origin of information, etc.:

   Any and all records contained in your medical file.

4. This information is being used or disclosed for the specific purpose(s) listed below. If you have requested the use or disclosure of the information but do not, or elect not to, provide a statement of purpose, we will state “at the request of the individual.”

   For the purpose of treatment, payment and health care operation as described in the Privacy Notice to provide copies of records to your Attorney for your claim if applicable.

5. This authorization will be in force and effect until the following date event, at which time this authorization expires:

   Upon destruction of records by our practice as allowed by applicable law.

   I understand that I have the right to revoke this authorization at any time, in writing, by mailing such written notification to: Comprehensive Pain Solutions of New Jersey P.O. Box 489, Morganville, NJ 07751

COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C.

P.O. Box 4160 • Cherry Hill, New Jersey 08034
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I understand that a revocation is not effective to the extent that COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. has taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy or to contest the policy itself.

I understand that COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C. will not condition my treatment on whether I provide authorization for the requested use or disclosure; doing so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of that fact and of the consequences to me of refusing to sign this authorization.

I understand that there is a potential for information used or disclosed pursuant to this authorization to be subject to redisclosure by the recipient if the recipient is not required by law to protect the privacy of the information.

I understand that I will receive a copy of this authorization, if signed by me.

I hereby authorize the use or disclosure of my health information as described in this form.

_____ **[X] Signature of Patient or Personal Representative**

_____ **[X]** Date

_____ Name of Patient or Personal Representative

_____ Description of Personal Representative's Authority

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices for COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C.

Date: **[X]** _____

Print Patient Name: [X] _____

Signature of Patient: [X] _____

- If person signing is not the patient, please print your name and relationship to patient:

Name: _____

Relationship: _____

I, _____, request a copy of the Notice of Privacy Practices: Yes No

---

For Office Use Only:

If patient/representative requested a copy of Notice, date copy was provided: _____

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment:

_____

_____

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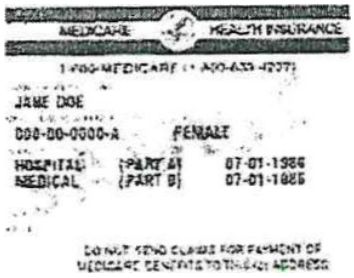
A new Federal Law, "Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007" has been enacted that requires insurance companies to provide the government agency called "The Centers for Medicare & Medicaid Services" with specific information. This means that _____ Insurance Company needs to collect information requested below in order to identify Medicare Recipients.

Please Review the picture of the Medicare card Below to determine if you have, or have ever had, a similar Medicare card:



Section I:

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?

☐ Yes ☐ No

Claimant Name: (Please print the name exactly as it appears on your SSN or Medicare card, if available)
Medicare Claim Number:
Date of Birth:
Sex: ☐ Male ☐ Female
Social Security Number: (If Medicare Claim Number is unavailable)

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Section II:

I understand that the federal government requires _____ Insurance Company to collect the information requested about to be submitted to The Centers for Medicare and Medicaid Services.

Claimant Name: **[X]** _____

Name of Person providing information: **[X]** _____

Signature of Person completing this form: **[X]** _____

Date: _____

If you have completed Sections I – II above, stop here.
If you are refusing to provide the information requested in Sections I – II, proceed to Section III.

Section III:

Claimant Name: _____

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating my obligation as a Medicare beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Name of Person providing information: _____

Signature of Person completing this form: _____

Date: _____

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Patient Name: _____ Age: _____ Height: _____

Date: _____ Sex: **M** **F** Weight: _____

Referred By: _____ I am RIGHT / LEFT handed

Date of Injury: _____ Town where accident occurred: _____

I was injured as a result of: (1) CAR ACCIDENT **Y** **N** WAS SEATBELT WORN? **Y** **N**
(Circle answers.)

If YES, I was the:

- Driver
- Front seat passenger
- Back seat passenger
- Pedestrian Crossing the Road
- Riding a Bicycle

If YES, the vehicle I was riding was hit from:

- Behind (rear ended)
- Driver's Side (left side of vehicle)
- Passenger's Side (right side of vehicle)
- Front collision

(2) SLIP & FALL
(3) WORK INJURY

Describe Accident: _____

_____

_____

Did you experience whiplash? **Y** **N**

PROVIDER DETAIL SECTION (to be filled out by the provider)

_____

_____

_____

Did you go to the hospital? **Y** **N** If YES, which hospital? _____

Were X-Rays taken at the hospital? **Y** **N**

If X-Rays were done, which of the following were taken? (Circle answers.)

- X-Ray of the Neck
- X-Ray of the Lower Back
- Others (please specify): _____
- X-Ray of Face
- X-Ray of Ribs

Were you told that you had any broken bones and/or other abnormalities? **Y** **N**

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- If YES, please specify: _____

Did you hit your head/face during the accident? **Y** **N**

If YES, on what did you hit your head/face? (Circle answers.)

- Dashboard
- Windshield
- Car door/ Window/ Side Beam
- Seat Head Rest
- Roof of Vehicle
- Steering Wheel

If you recall hitting your head, which part got hit?

- Forehead
- Left Side of Head
- Right Side of Head
- Back of Head

Did you lose consciousness? **Y** **N**

At the present time, do you suffer from any of the following? 0 = NO PAIN 10 = SEVERE PAIN

- Headaches: **Y** **N** 0 1 2 3 4 5 6 7 8 9 10

If YES, where is the ache?

- Front of Head
- Back of Head
- Left side of Head
- Right side of Head
- Other: _____

- Neck Pain: Y N 0 1 2 3 4 5 6 7 8 9 10
- Low Back Pain: Y N 0 1 2 3 4 5 6 7 8 9 10
- Mid-Back Pain: Y N 0 1 2 3 4 5 6 7 8 9 10
- Shoulder/Elbow/Wrist Pain Y N 0 1 2 3 4 5 6 7 8 9 10
- Hip/Knee/Ankle Pain Y N 0 1 2 3 4 5 6 7 8 9 10

Do you experience any of the following with your headaches?

* Lightheadedness/ Dizziness: Y N
* Sensation of Room Spinning: Y N
* Blurry Vision: Y N
* Ringing in Ears: Y N
* Double Vision / Floaters: Y N
* Nausea: Y N
* Vomiting: Y N
* Loss of Consciousness: Y N
* Seizures: Y N

FOR OFFICIAL USE ONLY:
Alleviating Factors: _____
_____

Exacerbating Factors: _____
_____

Do you suffer from any of the following?

Pain radiating to the arms / shoulders / hands: Y N RIGHT LEFT BOTH
Pain radiating to the legs / hips / feet: Y N RIGHT LEFT BOTH

Numbness / Tingling in the arms / shoulders / hands: Y N RIGHT LEFT BOTH
Numbness / Tingling in the legs / hips / feet: Y N RIGHT LEFT BOTH

Weakness / Easy fatigue of the arms / hands: Y N RIGHT LEFT BOTH
Weakness / Easy fatigue of the legs / feet: Y N RIGHT LEFT BOTH

Please circle the appropriate description(s) of your pain:

Aching Throbbing Burning Stabbing Shooting Other: _____

Have you ever been injured before? **Y** **N**
If YES describe when and what injuries you had: _____

Have you ever treated with a chiropractor before? **Y** **N**

Did you recover fully from the injuries sustained then: **Y** **N**
If "NO" to above, where are you still experiencing pain: _____

Have you had any of the following medical problems prior to your injuries?

- High Blood Pressure: Y N
- Diabetes: Y N
- Heart Disease / Chest Pains: Y N
- Heart Rhythm Problems: Y N
- Neurological Problems: Y N
- Stomach / Intestinal Problems: Y N
- Bleeding Disorder: Y N
- Tuberculosis: Y N
- Asthma / Breathing Problems: Y N
- Thyroid Disease: Y N
- Cancer: Y N
- Arthritis: Y N
- Use a Pacemaker: Y N
- High Cholesterol: Y N
- Others: Y N

Are you HIV positive? **Y** **N**

Have you had any operations? **Y** **N**

If YES, list date and type: _____

_____

Are you presently working? **Y** **N** Occupation: _____

Which of the activities below at work or at home cause your neck / back pain?

- Lifting Objects Y N
- Bending Y N
- Sitting for Prolonged Periods Y N
- Using my Arms / Hands for Prolonged Periods Y N
- Standing Up for Prolonged Periods Y N
- Walking for Prolonged Periods Y N

Are you pregnant? **Y** **N**

List any medications allergic to: _____

List any medications that you are taking: _____

_____

_____

Do you smoke? Y N If YES, how much: _____

Do you drink alcohol? Y N If YES, how much: _____

Do you use recreational drugs? Y N If YES, which and how much: _____

Family History: Married _____ Single _____ Divorced _____

Number of Children: _____

Is your mother alive? Y N

If deceased, age and cause of death _____

Is your father alive? Y N

If deceased, age and cause of death _____

Date: **[X]** _____ Patient's Signature: **[X]** _____

If Translated:

Date: _____ Translator's Signature: _____

Translator's Name (Please Print): _____

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P.O. Box 4160 • Cherry Hill, New Jersey 08034

Tel: (856)334-9600 • Fax: (856)334-9602

PATIENT NAME: _____ DOB: _____

Records Release

Doctor/Hospital: _____

I, _____, hereby authorize the release of my records or copies of such to COMPREHENSIVE PAIN SOLUTIONS OF NJ, P.C.

Please fax at your earliest convenience to 856-334-9602.

Patient Signature: _____ Date: _____

COMPREHENSIVE PAIN SOLUTIONS OF NEW JERSEY, P.C.

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PATIENT NAME _____ DATE _____

BLOOD PRESSURE: RIGHT LEFT _____/_____

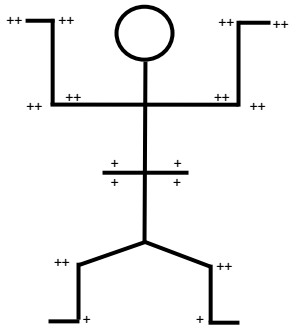
Head and Neck: PERLA RIGHT LEFT
FUNDUS
NYSTAGMUS
CN II-XII
OCCIPITAL NERVE

Range of Motion

CERVICAL	DEC	SPASM	Y	N	PAIN:	Y	N
THORACIC	DEC	SPASM	Y	N	PAIN:	Y	N
LUMBO-SACRAL	DEC	SPASM	Y	N	PAIN:	Y	N

CLONUS YES NO HOFFMAN'S YES NO
SLR: RIGHT LEFT TVE SPURLING'S RIGHT LEFT

DTR:



Scoring Deep Tendon Reflexes

Grade	Deep Tendon Reflex Response
0	No response
1+	Sluggish or diminished
2+	Active or expected response
3+	More brisk than expected, slightly hyperactive
4+	Brisk, hyperactive, with intermittent or transient clonus

TRIGGER POINTS

Muscle	Right	Left
Cervical paraspinals		
Trapezius		
Thoracic paraspinals		
Rhomboids		
Lumbar paraspinals		
Joints		
Cervical facets		
Thoracic facets		
Lumbar facets		

Sensation:	Normal	Abnormal
Upper extremities	_____	_____
Lower extremities	_____	_____

Strength:	Normal	Abnormal
Upper extremities	_____	_____
Lower extremities	_____	_____

CEREBELLAR:	N	ABN _____
STATION & GAIT:	N	ABN _____
CHEST:	N	ABN _____
CARDIOVASCULAR:	N	ABN _____
ABDOMEN:	N	ABN _____

SI JOINT R or L	Positive	Negative
Yeoman's	_____	_____
Illiac	_____	_____
Beatty's test	_____	_____
Gaenslen's	_____	_____
Faber's	_____	_____

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Patient Referral Form

Name: _____

Diagnosis: _____

Date of Accident: _____

Referral To:

- Orthopedic Surgeon: Dr. _____
  - Reason _____
  - Address: _____
  - Phone Number ( ) -
- Chiropractor: Dr. _____
  - Reason _____
  - Address _____
  - Phone Number ( ) -
- Neuro Surgeon: Dr. _____
  - Reason_____
  - Address _____
  - Phone Number ( ) -
- Psychology: Dr. _____
  - Reason_____
  - Address _____
  - Phone Number ( ) -
- Other: Dr. _____
  - Reason_____
  - Address _____
  - Phone Number ( ) -

Signature: [X] _____ Date: [X] _____

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PATIENT NAME _____ DATE _____

MONTH	DATE	YEAR	SUBSEQUENT VISITS AND FINDINGS

Uche Eneanya, M.D.
Adam Schreiber, D. O.
David Smith, M.D.

Michael Chan, M.S., PA-C
Michelle Raeuber, M.S., PA-C