

**40 South Street  
Eatontown, NJ. 07724**

**Jordan L. Kovacs, D.C., CCSP, DAAML  
732-389-2800**

In order to properly process your Personal Injury Protection (PIP) insurance benefits, we will need some information from you.

- 1. Have you reported the accident to YOUR insurance company?**
- 2. We need the claim number ASAP**
- 3. Please bring in the police report as soon as you get it**
- 4. We need your Insurance ID card**
- 5. If you have obtained an attorney, we will need their name and phone number**

## **CONFIDENTIAL CASE HISTORY**

### **PERSONAL INFORMATION**

Date: \_\_\_/\_\_\_/\_\_\_ Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birthday: \_\_\_/\_\_\_/\_\_\_ Sex: M / F  
Home Tel.# (\_\_\_\_) \_\_\_\_\_ Work Tel. #(\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_ Marital Status: S or M Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Employer name & address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Job duties include: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Spouse's work Tel.#: (\_\_\_\_) \_\_\_\_\_  
Spouse's employer's name & address \_\_\_\_\_

**How did you hear about our office?**

<input type="checkbox"/> Friend	<input type="checkbox"/> Referred by PCP	<input type="checkbox"/> Insurance	<input type="checkbox"/> Booklet
<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Website / Internet	<input type="checkbox"/> Other	

### **YOUR HEALTH CONDITION**

What is your major complaint? \_\_\_\_\_  
When & how did it occur? \_\_\_\_\_  
Other doctors seen for this condition: \_\_\_\_\_  
Is your condition the result of an auto accident? **Y** or **N**      Is your condition a work related injury? **Y** or **N**  
**Rate pain on a scale from 1-10 (Circle One, 10=Most Painful)** 1   2   3   4   5   6   7   8   9   10  
Does the pain wake you up at night? **Y** or **N**    Any excessive weight loss / gain? **Y** or **N**    Any dizziness or fainting? **Y** or **N**  
Does this interfere with your: Work? **Y** or **N**    Sleep? **Y** or **N**    Daily Routine? **Y** or **N**    Recreation? **Y** or **N**

**Check those that best describe your condition:**

Dull	Numb	Burning
Sharp	Migraine	Shock-like
Achy	Cramping	Constant
Stiff	Knifelike	Comes & Goes

**Your past medical history. Mark all that apply:**

Cancer	Hypertension
Heart disease/Stroke	Diabetes
Kidney disease	HIV
Musculoskeletal disorders	Spinal surgery

List any medication(s) you are currently taking: \_\_\_\_\_  
Past medical or chiropractic treatment: \_\_\_\_\_  
Describe any past surgery or broken bones: \_\_\_\_\_  
*Female Patients:* Are you currently or do you have any reason to believe you are pregnant? **Y** or **N**

### **HEALTH INSURANCE INFORMATION**

Insurance Name & Address: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Are you covered by Medicare? **Y** **N**  
Secondary Insurance carrier: \_\_\_\_\_  
Secondary Insurance Subscriber's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

# Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

### 1. Your vehicle type

Car     Station Wagon  
 Van     Pickup Truck  
 Large Truck     Bus  
 Other \_\_\_\_\_

### 2. Your position in vehicle

Driver     Front Passenger  
 Left Rear Passenger  
 Right Rear Passenger  
 Other \_\_\_\_\_

### 3. What was your vehicle doing at the time of the accident?

Stopped at intersection     Stopped in traffic     Stopped at light  
 Making a right turn     Making a left turn     Parking  
 Proceeding along     Slowing down     Accelerating  
 Other \_\_\_\_\_

### 4. Time/Speed/Damage

Time of accident \_\_\_\_\_  
 Your vehicle's speed: \_\_\_\_\_ mph  
 Their vehicle's speed: \_\_\_\_\_ mph  
**Damage to your vehicle**  
 Mild     Moderate  
 Totaled

### 5. Details of Accident

**Visibility at time of accident**  
 Poor     Fair     Good  
**Who hit who/what?**  
 You hit other vehicle  
 Other vehicle hit you  
**You hit...(object)**  
 \_\_\_\_\_

### 6. Road conditions

**Road conditions at time of accident**  
 Icy     Wet     Sandy     Dark     Clean and dry  
**Point of impact**  
 Head-On     Left Front     Right Front  
 Read-End     Left Rear     Right Rear

### 7. Body Position, etc.

Did you see the accident coming?    Yes  No   
 Were you braced for the impact?    Yes  No   
 Did you have a seat belt on?    Yes  No   
 Did you have a shoulder harness on?    Yes  No

**Does your vehicle have headrests? Yes  No**   
**What was the position of your headrest at the time of the impact?**  
 Even with top of head     Even with bottom of head     Middle of neck  
**What was the direction of your head at the time of the impact?**  
 Facing straight forward     Turned to the right     Turned to the left

Did driver side air bags deploy? Yes  No  Did passenger side airbags deploy? Yes  No  Did side airbags deploy? Yes  No

### 8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

### 9. During the accident:

Did your body strike the inside of your vehicle?    Yes  No   
 If yes, describe: \_\_\_\_\_  
 Did you lose consciousness during the injury?    Yes  No   
 If yes, for how long? \_\_\_\_\_  
 Your vehicle's estimated damage? \_\_\_\_\_  
**Damage to their vehicle:**     Mild     Moderate     Totaled  
 Did police show up at the scene?    Yes  No   
 Was an accident report filled out?    Yes  No

### 10. After the accident:

**Check off your symptoms right after and a few days following:**  
 Headache     Dizziness     Mid back pain     Cold hands  
 Neck pain     Nausea     Low back pain     Cold feet  
 Neck stiffness     Confusion     Nervousness     Diarrhea  
 Fainting     Fatigue     Loss of taste     Depression  
 Ringing in ears     Tension     Toe numbness     Anxious  
 Loss of smell     Irritability     Constipation     Chest Pain  
 Pain behind eyes     Shortness of breath     Sleeping problems  
 Others: \_\_\_\_\_

### 11. Emergency Room?

**Where did you go after the accident?**  
 Home     Work     Hospital ER     Private Doctor  
**How did you get there?**  
 Drove self     Somebody else     Ambulance     Police  
**Were X-rays done?** Yes  No  **Was lab work done?** Yes  No   
 Body parts X-rayed? \_\_\_\_\_  
 What lab work? \_\_\_\_\_  
 The X-rays revealed: \_\_\_\_\_  
**Treatments:**  Cervical Collar     Ice    **Other:** \_\_\_\_\_  
 Medications: \_\_\_\_\_  
 Follow-up instructions: \_\_\_\_\_

### 12. Treatment History:

**Fill in any other doctor(s) seen prior to your first visit to this office.**  
**1. Dr.** \_\_\_\_\_ First visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Specialty: \_\_\_\_\_ X-rays done?    Yes  No   
 Types of treatments received: \_\_\_\_\_  
 How many treatments received? \_\_\_\_ Currently treating? Yes  No   
 Did treatments benefit you? Yes  No   
 Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**2. Dr.** \_\_\_\_\_ First visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Types of treatments received: \_\_\_\_\_  
 How many treatments received? \_\_\_\_ Currently treating: Yes  No   
 Did treatments benefit you? Yes  No   
 Last visit date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by Dr. Kovacs at the Eatontown Elite Care Center, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **OFFICE POLICIES**

While we will assist in the insurance verification process, You the patient are ultimately responsible to check with your insurance company to verify Chiropractic coverage before treatment begins, i.e., if a referral is needed. Patients are responsible to obtain all referrals (if needed). If your policy requires a referral, you must present referral to front desk, before you are seen by the doctor. If treatment is rendered and referral was not obtained/presented, you the patient will be responsible for payment.

Co-Payments are due at the time chiropractic services are rendered. Insurance companies forbid the waiving of deductibles or co-payments by healthcare providers. Co-Insurance must be paid in full.

ALL appointment cancellations must be confirmed within 24 hours of your scheduled time. Office charges for time reserved will apply for ANY appointments cancelled without proper notice.

I understand that health and accident policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me and/or my attorney (if applicable, charges may apply) in making collection or settlement from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I irrevocably authorize, direct and instruct my attorney (if applicable) to make payment to Dr. Kovacs from my settlement, fees due, to his office as mandated within the PIP fee schedule. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment.

I hereby attest all information given above is true to the best of my knowledge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PATIENT HEALTH INFORMATION CONSENT FORM**

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECURITY AGREEMENT & ASSIGNMENT OF AN INTEREST  
IN A PERSONAL INJURY CLAIM**

**TO: Attorney/Insurance Carrier**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Doctor**

Jordan L. Kovacs, D.C., CCSP  
Hamilton Elite Care Center, LLC  
1351 Kuser Road, Suite 2  
Hamilton, NJ. 08619  
609-585-2881

RE: Patient's records and Security Agreement & Assignment of an Interest in a Personal Injury Claim.

I do hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of his 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 doctor on any settlement and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered to me, and to withhold such sums from such settlement, claim, judgment or verdict as may be necessary to protect said doctor adequately. Prior to dispersing any such fees, it is the responsibility of the payor to verify with this office all outstanding balances.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic 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. And 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 also understand and agree that I am responsible for any reasonable collections fees required to secure the doctor's payment.

I further understand that there is likely to be an outstanding balance at the end of my treatments. This balance may be due to uncovered expenses such as orthopedic supplies and/or any medically necessary treatment beyond that authorized by my health insurance coverage. I agree to make any/all co-payments as per my health insurance contract.

Dated: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

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

Dated: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

**Attorney/Insurance Carrier:**

**Please date, sign and return to doctor's office at once. Keep a copy for your records.**