Spine and Balance Center of N.J., LLC
179 Cedar Lane Suite B
Teaneck, NJ 076663
Tel 201-907-5092
Fax 201-596-3630

PERSONAL INJURY QUESTIONNAIRE - MVA

PERSONAL INFORMATION

Name: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birth date: _____ Sex: _____ SS#: _____

Employer's Name: _____ Employer's Address: _____

Your Ins. Co.: _____ Policy #: _____

Name on Policy (If other than self): _____ ID #: _____

Responsible Party's Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Policy#: _____

ATTORNEY

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

NATURE OF ACCIDENT

Date of Accident: _____ Time of Day: _____

Were You: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of People in Your Vehicle ( ) Type of passive restraint: ( ) Airbags ( ) Lap Belt ( ) Shoulder Belt

Did Airbags Deploy? ( ) Yes ( ) No

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

Name of Street Accident Occurred? _____

Were you struck from ( ) Behind ( ) Front ( ) Left Side ( ) Right Side

Approximate speed of your car ( ) mph Other car ( ) mph

Your Vehicle Type: _____ Vehicle Size: _____ Were Police notified? ( ) Yes ( ) No

How was the Patient's vehicle hit? _____

Amount of damage to Patient's vehicle: _____

Amount of damage to offending vehicle: _____

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Weather Conditions: _____

Road Conditions: _____

DESCRIBE MOMENT OF IMPACT:

Body position at Impact: _____ Direction body was thrown: _____

Head position of Impact: _____ Direction head was thrown: _____

Position of headrest: _____ Did the patient brace for the impact: _____

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____

Were the Police notified? _____

In your "own" words, please describe the accident: _____

_____

IMMEDIATELY FOLLOWING THE ACCIDENT:

Initial Reaction: _____

Where did pain occur? _____

Type of emergency care provided: _____

Immediate destination after accident: _____

Who drove the patient? _____

Date of Hospital visit: _____ Name of Hospital: _____

Examining Physician: _____ Admitted ( ) Yes ( ) No

Date of Discharge: _____ What X-rays were taken: _____

CAT Scans _____ MRI _____

Hospital Diagnosis: _____ Treatment Administered: _____

Recommendation: _____ Medications Prescribed: _____

What are your PRESENT complaints and symptoms? _____

_____

Do you have any previous illnesses, which are not related to this case? _____

_____

If yes, please describe including date(s) and type(s) of accidents as well as injury(ies) received: _____

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Since the accident, have you been treated by another physician? ( ) Yes ( ) No

If "yes" please indicated Physician name and address: _____

_____

What type of treatment did you receive? _____

_____

Since the injury occurred, are your symptoms ( ) Improving ( ) Getting Worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

___ Headache	____ Irritability	____ Face Flushed	____ Feet Cold	____ Fatigue
____ Neck Pain	____ Chest Pain	____Buzzing in Ears	____ Hands Cold	____ Cold Sweats
____ Neck Stiff	____ Dizziness	____ Loss of Balance	____ Stomach Upset	____ Fever
____ Sleeping Problems	____ Head Seems too heavy	____ Depression	____ Fainting	____ Back Pain
____ Pins & Needles in Arms	____ Pins & Needles in Legs	____ Light bothers Eyes	____ Loss of Smell	____ Nervousness
____ Loss of Memory	____ Loss of Taste	____ Tension	____ Numbness	____ Ears Ring
____ Diarrhea				

Symptoms other than above: _____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If "yes", please complete this question: Last day worked: _____

Type of Employment: _____

Present Salary: _____ Are you being compensated for time lost from work? ( ) Y ( ) N

If "yes", please state type of compensation you are receiving: _____

Do you notice any activity restrictions as a result of this injury? ( ) Y ( ) N

If "yes" please describe in detail: _____

_____

Patient Signature_____ Date: _____

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ASSIGNMENT OF BENEFITS FORM

Patient's Name:

Accident Date:

I irrevocably assign to you, my medical provider, all my rights and benefits under my insurance contract for payment of services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills; I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance earner money due von for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient's Signature: _____

Date: June 22, 2019

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DOCTOR'S LIEN

To Attorney:

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself regarding the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due in his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself because of the injuries for which I have been treated or injuries in connection there with.

I 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. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

Dated: _____Patient's Signature: _____

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

Dated:_____ Attorney's Signature: _____

Patient:

Attorney: Please date, sign and return one copy to doctor's office at once.
Reply envelope attached.
Keep one copy for your records.

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Authorization for Health Information Disclosure

This form complies with HIPAA Privacy Rule

Date: _____

Patient Name: _____

Patient Address: _____City: _____ST:_____Zip:_____

I hereby authorize: _____
Name of physician's office/medical practice disclosing information

Requestor/Recipient Information

Spine and Balance Center of N.J., LLC
179 Cedar Lane Suite F
Teaneck, NJ 07666

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. **Unless otherwise revoked, this authorization will expire in six months or on the following date: _____.**

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics. IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

_____ _____
Signature of Patient or Authorized Representative (if applicable) Date

_____ _____
Description of Representative's Authority (witness signature required) Signature of Witness