FOSTER
Family & Sports
CHIROPRACTIC

Dr. Renee T. Foster **Dr. Alan K. Foster**

Patient Questionnaire – Auto-Accident

Patient Name: _____ Today's Date: ___/___/___

Date of Exam: ___/___/___ Provider: _____ New Patient ☐ Yes ☐ No

Basic Information about the Accident:

Date Accident Occurred or Started: ___/___/___ Time of Day when Accident Occurred or Started: ___:_____ AM / PM

Describe how the Accident took place: _____

_____

_____

_____

Describe the condition or symptoms caused by the Accident: _____

_____

_____

_____

Auto-Accident Specific Information:

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

Automobile you were in: Year _____ Make _____ Model _____

Damage to your car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender

Damage Amount Estimate: $_____ : ☐ Minor ☐ Major ☐ Totaled

Other Automobile: Year _____ Make _____ Model _____

Damage to other car: ☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender
☐ Minor ☐ Major ☐ Totaled

Where did the accident happen? Street Names: _____ City/State _____

Was it? ☐ Controlled Intersection ☐ Uncontrolled ☐ Not Intersection

Was there a traffic light? ☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign

Were you: ☐ Slowly Moving ☐ Moving ☐ Stopped

Weather Conditions: ☐ Sunny ☐ Rainy ☐ Cloudy

Street Surface: ☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other _____

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Dr. Renee T. Foster
Chiropractic Physician

3461 Rt 22 East Unit A, Branchburg, NJ 08876
*PH:732-537-0009 * FAX:732-537-9966*

Dr. Alan K. Foster
Chiropractic Physician

PATIENT INTAKE FORM

First Name: _____ Last Name: _____ Middle Initial: ___ Gender: ☐Female ☐Male

Date of Birth: _____ Age: ____ Marital Status: ☐Married ☐Single ☐Divorced ☐Widow ☐Separated

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

Home Phone: _____ Cell Phone: _____ Cell Phone Carrier: _____

Social Security # _____ E-mail: _____

Employer Name: _____ Occupation: _____

Employer address: _____ Phone: _____

How did you hear about us? ☐ Our website ☐ Insurance Company: Which? _____ Other? _____

☐ Patient referral: Who? _____ ☐ Physician Referral: Who? _____

Emergency Contact and/or Guardian information

Name: _____ Relationship: ☐ Spouse ☐ Parent/ Guardian ☐ Other _____

Cell Phone: _____ Work Phone: _____DOB: _____

Same address as above? ☐ Y ☐ N If no, please provide address: _____

Can we discuss your medical information with him/her? ☐ Yes ☐ No

Primary Care Physician Information

Doctor's Name: _____ Phone number: _____ Fax: _____

Address: _____City: _____State: _____ Zip: _____

Type of Impact: ☐ Rear end ☐ Front ☐ Side Impact ☐ Roll Over

Brakes on Impact: ☐ Locked Tight ☐ Loosely Applied ☐ Foot not on brake

How far did your car move? ☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft

Where were you seated in the vehicle: _____ Wearing Seat belt? ☐ Yes ☐ No

Shoulder harness: ☐ Yes ☐ No Headrest: ☐ Yes ☐ No Headrest Position: ☐ Up ☐ Down

Is the car equipped with airbags? ☐ Yes ☐ No Did they deploy? ☐ Yes ☐ No

Did you see the impact coming? ☐ Yes ☐ No Did you brace yourself for impact? ☐ Yes ☐ No

On impact, your head was looking: ☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

On impact were you: ☐ Thrown forward ☐ Thrown backwards ☐ Thrown sideways ☐ Other _____

Did your body hit anything inside the car? ☐ Yes ☐ No Body Part: _____

What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of Consciousness? ☐ Yes ☐ No For how long? _____

Do you remember the accident happening? ☐ Yes ☐ No

Hospital? ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low-back ☐ Other X-rays _____

Medication Given? ☐ Yes ☐ No RX: _____

Other instruction: _____ Follow-up: _____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it? _____

What aggravates it? _____

What relieves it? _____

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Describe: _____

_____

_____

_____

Please indicated any other healthcare providers who the Patient has seen for the condition or symptoms:

Name	Type of Licensure	Date of Last Visit
_____	_____	___/___/___
_____	_____	___/___/___

Please check any of the following symptoms you are now experiencing:

☐ Headache	☐ Dizziness	☐ Light Bothers Eyes	☐ Diarrhea	☐ Head seems too heavy	☐ Neck Pain
☐ Loss of Memory	☐ Clumsiness	☐ Feet Cold	☐ Neck Stiff	☐ Tingling in arms/hands	☐ Ears Ring
☐ Hands Cold	☐ Sleeping Problems	☐ Tingling in legs/feet	☐ Face Flushed	☐ Nausea	☐ Back Pain
☐ Numbness in arms/hands	☐ Buzzing in Ears	☐ Constipation	☐ Nervousness	☐ Numbness in legs/feet	☐ Loss of Balance

☐ Cold Sweats ☐ Tension ☐ Shortness of Breath ☐ Fainting ☐ Fever ☐ Fatigue
☐ Irritability ☐ Loss of Smell ☐ Chest pain/rib pain ☐ Pain in arms/hands ☐ Pain in legs/feet ☐ Jaw pain
☐ Loss of strength - arms ☐ Burning muscle pain ☐ Loss of strength - legs ☐ Difficulty swallowing ☐ Sharp/shooting pain
Other _____

Have you experienced changes to:

☐ Eyes (sight) ☐ Ears (hearing) ☐ Nose (smell) ☐ Mouth (taste) ☐ Bladder
☐ Bowels ☐ Sleep ☐ Emotion ☐ Appetite
Please Explain: _____

Have you missed work or school due to your injuries? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Number of packs: _____
Do you drink alcohol? ☐ Yes ☐ No Number of Drinks _____

Notes: _____
_____
_____
_____

Medical History:

Have you ever been in our office before? ☐ Yes ☐ No
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc.) and provide the accident date:

1) _____ __/__/__
2) _____ __/__/__
3) _____ __/__/__

Surgeries/Hospitalizations: _____

Allergies (please list all): _____

Do you now or have you ever had:

☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ High Blood Pressure ☐ Thyroid Problems
☐ Tuberculosis ☐ Prostate Disorder ☐ Kidney Problems ☐ Asthma ☐ Ulcer ☐ Seizure Disorder

Other: _____

FOSTER WELLNESS CORP.

3461 Route 22 East, Unit A
Phone (732) 537-0009

Branchburg, NJ 08876
Fax (732) 537-9966

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Dr. Alan K. Foster
Chiropractic Physician

2026 New Jersey Disclosure

New Jersey laws and the New Jersey Department of Health require healthcare providers to inform patients of the healthcare plan in which they participate and the facilities with which they are affiliated. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

A. Health Plans with which Our Practice participates:
Medicare / Blue Cross Blue Shield

B. Facility with which Our Practice affiliates:
FOSTER WELLNESS CORP.
3461 Route 22 East, Unit A
Branchburg, NJ 08876

C. Licensed Associate Healthcare Providers:
Alan K. Foster, DC
Renee T. Foster, DC

I understand the healthcare professionals with whom I am seeking healthcare services is "out-of-network" and does not participate with my insurance plan.

I understand the amount or estimated amount of my healthcare services may be beyond my "in-network" deductible, copayment, or coinsurance and I am responsible for those charges.

I understand I may contact my health insurance plan or administrator for further consultation regarding the cost and reimbursement of my healthcare charges.

I, the undersigned patient, acknowledge receipt of this disclosure from my healthcare provider, read and understand its content. I wish to receive evaluation and treatment at FOSTER WELLNESS CORP. with full notice of these disclosures. I certify I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures. I am not being coerced to sign this disclosure, and I do so of my own free will.

Name: _____

Signature: _____

Date: ____/____/____

Female Section Only

I hereby expressly acknowledge that I am not pregnant at the present time and that the Drs. Alan & Renee Foster and Foster family & Sports Chiropractic is hereby expressly authorized and directed to complete a radiographic examination (X-rays) in connection with my chiropractic treatment. **Initial:** _____

Minor Section Only

I hereby authorize Drs. Alan & Renee Foster at Foster Family & Sports Chiropractic, together with whomever my treating doctor may designate as an appropriate individual(s) to administer chiropractic care, including X-rays, and appropriate adjunctive services as my treating chiropractor deems is necessary to my child. I acknowledge that I have legal authority to provide such written consent on behalf of such child/ward. **Initial:** _____

Informed Consent for Chiropractic care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis. **Initial:** _____

Patient Authorization for open Adjusting Environment

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open-adjusting" involves several patients being seen in the same adjusting area. Patients are within sight of one another, and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care, and this is NOT the environment used for taking patient histories or providing examinations. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. **Initial:** _____

By signing below, I certify that all the above information is true to the best of my knowledge. I clearly understand and agree that all services are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Finally, I authorize the release of my medical information relevant to my condition and treatment at this office to any insurance company or doctor as may be needed in the normal course of my care and treatment.

Signature: _____ Date: _____

FOSTER Family & Sports CHIROPRACTIC

Alan K. Foster, D.C.
Chiropractic Physician
Renee T. Foster, B.S., D.C.
Chiropractic Physician

3461 Rt 22 E, Unit A
Branchburg, NJ 08846
Telephone: (732)-537-0009
Facsimile: (732)-537-9966

ASSIGNMENT OF BENEFITS AND INSTRUCTIONS FOR DIRECT PAYMENT TO DOCTOR

Primary Insurance

What Type? ☐ Commercial ☐ Self Pay ☐ Worker's Compensation ☐ Auto Insurance

Insurance Name: _____ Subscriber ID#: _____ Group#: _____

Who is the primary insured? _____ Date of Birth: _____

If auto or work-related injury; Date of Accident/Incident? _____ Was it REPORTED? ☐ Yes ☐ No

Secondary Insurance

Insurance Name: _____ Insurance Phone #: _____ Claim# _____

Name: _____ Subscriber ID#: _____ Group#: _____

Claim's Address (back of card) _____ Phone: _____

Who is the primary insured? _____ Date of Birth: _____

I irrevocably assign to FOSTER FAMILY & SPORTS CHIROPRACTIC, all my rights and benefits under any insurance contracts for payment for services rendered to me by FOSTER FAMILY & SPORTS CHIROPRACTIC. I irrevocably direct that all payments directly go to the above-named insurance company to pay by check issued, and mailed, directly to:

FOSTER WELLNESS CORP.

3461 Rt East, Unit A, Branchburg, NJ 08876

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by FOSTER FAMILY & SPORTS CHIROPRACTIC. to be released to FOSTER FAMILY & SPORTS CHIROPRACTIC. I irrevocably authorize FOSTER FAMILY & SPORTS CHIROPRACTIC to file insurance claims on behalf of services rendered to me. I irrevocably authorize FOSTER FAMILY & SPORTS CHIROPRACTIC to act in my behalf and report any suspected violations of proper claim practices to the proper claim practices to the proper regulatory authorities.

This is direct and irrevocable assignment of my rights and benefits under this policy. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____ _____ _____

Print Name Signature Date

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Health Information Privacy Act Notice

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS: I consent to the usage or disclosure of my protected health information by FOSTER Family & Sports CHIROPRACTIC for the purpose of diagnosing or providing treatment to me, obtaining the payment for my health care bills or to conduct health care operations of FOSTER Family & Sports CHIROPRACTIC. I understand that diagnosis or treatment of me by FOSTER Family & Sports CHIROPRACTIC may be conditional upon my consent as evidenced by my signature of this document.

I understand I have the right to request a restriction as to whom my protected health information is used or disclosed to carry out treatment, payment or healthcare operation of the practice. FOSTER Family & Sports CHIROPRACTIC is not required to agree to the restrictions that I may request. However, if FOSTER Family & Sports CHIROPRACTIC agrees to a restriction that I request the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that FOSTER Family & Sports CHIROPRACTIC has acted in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* prior to signing this document FOSTER Family & Sports CHIROPRACTIC's *Notice of Privacy Practices* has been provided to me. *The Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of FOSTER Family & Sports CHIROPRACTIC. The *Notice of Privacy Practices* so provided at the front office. *The Notice of Privacy Practices* also describes my rights and FOSTER Family & Sports CHIROPRACTIC's duties with respect to my protected health information.

FOSTER Family & Sports CHIROPRACTIC reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Print Name	Signature	Date

A photocopy shall be considered as effective and valid as the original.

Authorization for Use and Disclosure of Protected Health Information

Foster Family & Sports Chiropractic Authorization

By my signature below, I affirm, as a patient of Foster Family & Sports Chiropractic OR as the parent or legal guardian of a minor child that is a patient of Foster Family & Sports Chiropractic (the "**Patient**"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "**Images**"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's first name; (iii) to publicize the fact that Chiropractic services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "**Information**"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites. **Purpose:**

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

Expiration and Revocability:

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all redisclosure of information.

No Effect on Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

Name of Patient (printed): _____

Date of Birth of Patient: _____

Signature of Patient OR Parent/Legal Guardian (if signing for minor): _____

Printed Name of Parent or Guardian: (if signing on behalf of minor child) _____

Date of Signature: _____