SLIP-AND-FALL ACCIDENT FORM

Patient Name: _____ **Date:** _____

Address: _____ City _____ Zip _____

Home Telephone: _____ Work Telephone: _____

Date of Birth: _____ Social Security No: _____

***DATE OF SLIP-AND-FALL_____

HOW DID YOU FALL?

☐ Slippery floor. Describe what was on floor: (water, food, etc) _____

☐ Tripped over object.

☐ Fell down stairs

☐ Fell down fell, did not hit anything. Was able to catch self before landing on floor

☐ Slipped and fell, landing on:

- ☐ Wood floor
- ☐ Carpeted floor
- ☐ Concrete floor
- ☐ Stairs (Circle if wood, concrete or carpet)
- ☐ Outside pavement/concrete surface
- ☐ Other

☐ Off ladder or other structure. How much distance between your body and where you landed _____feet?

☐ Riding a horse

☐ Other: _____

DESCRIBE HOW THE FALL HAPPENED

(Include details such as: Why it happened, how did you respond (i.e., hands reached forward), if your body twisted, if you hit the floor/ground, and parts of your body that hit. Indicate if you had bruises.)

Where did the accident happen? _____

Describe: _____

WHERE DID YOU HAVE PAIN AND/OR INJURY AFTER THE FALL?

(Circle specific areas after checking area where you have had an increase of pain or had injury in)

☐	Head/Face region	☐	Left Elbow/Wrist	☐	Left Hip/Thigh area
☐	Neck area	☐	Right Elbow/Wrist	☐	Right Hip/Thigh area
☐	Middle Back/Chest Wall region	☐	Left Hand/Fingers	☐	Left Knee/Ankle/Foot/Toe area
☐	Left Shoulder/Upper arm area	☐	Right Hand/Fingers	☐	Right Knee/Ankle/Foot/Toe area
☐	Right Shoulder/Upper arm area	☐	Low Back/Sacroiliac area	☐	Other

(Doctor's Name, Address, Telephone)

FORT LEE CHIROPRACTIC CENTER, INC.
DR. ROBERT M. MONAHAN, D.C.
1067 PALISADE AVENUE
FORT LEE, NJ 07024

Phone: 201-886-8184
Fax: 201-886-8483

Form 2400

AUTHORIZATION & ASSIGNMENT

TO: Dr. Robert M. Monahan, D.C.

In consideration of your undertaking to treat me, I agree to the following:

RELEASE OF INFORMATION

You are authorized to release any information you deem necessary and appropriate concerning my condition, to any insurance carrier, attorney or adjuster, in order to process any claim for reimbursement of charges incurred at your facility by me.

AUTHORITY TO PAY DOCTOR

I authorize the direct payment to you, of any sum I now or hereafter may owe you, be either my carrier or my attorney, out of the proceeds of any settlement of my case, or for which my insurance carrier has been billed, or otherwise obligated to make payment either to me or to you, based in whole or in part on the charges made for your services.

IRREVOCABLE ASSIGNMENT

I authorize you to compromise, settle or otherwise resolve said claim as you see fit. I further agree that the foregoing assignment shall be binding until you are paid in full and will be irrevocable for such period. I further agree to grant you my full and complete permission to endorse any check from my carrier, payable to me, with a facsimile of my signature.

PATIENT RESPONSIBLE FOR BALANCE

I understand that I am personally liable for any amount owed after reasonable efforts have been made to collect from any carrier so obligated.

Date: _____ Signed: _____

FORT LEE HEALTH CENTER, INC.

Dr. Robert M. Monahan, D.C.

1067 Palisade Avenue, Fort Lee, NJ 07024

Patient Privacy Policy & Procedure Statement

(HIPAA)

Dear Patient:

Fort Lee Health Center, Inc. maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent, to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical records and access history by signing a letter for release of your medical information. The cost for copies and of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 201-886-8184.

Fort Lee Health Center, Inc. reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulations and guidelines.

THANK YOU FOR CHOOSING FORT LEE HEALTH CENTER, INC. FOR YOUR HEALTHCARE!!

Signature:_____ Date:_____

VERIFICATION OF INSURANCE COVERAGE

****** THIS OFFICE IS NOT RESPONSIBLE TO VERIFY BENEFITS ******

Please contact your insurance company to obtain your chiropractic benefits and coverage.

Date:_____

Name of Insured:_____

Name of Patient:_____

Insurance Company Policy #:_____Group #:_____

Insurance Company:_____

Address:_____

Insured's Employer:_____

This is to verify coverage, as stated in our telephone conversation of _____

When I spoke to _____ Coverage was stated, as follows:

Amount of deductible:_____

Individual:_____ Family:_____

Has the deductible been met?:_____

Co-insurance responsibility:_____

Co-payment responsibility:_____

Maximum number of visits allowed per year_____

Contract Year or Calendar Year?_____

Reference Number for the call:_____

Date:_____ Signature:_____

DOCTOR'S LIEN

To: Attorney/ Insurance Carrier

_____
_____
_____

Doctor

Dr. Robert M. Monahan, D.C.
Fort Lee Health Center
1067 Palisade Avenue
Fort Lee, New Jersey 07024
P 201-886-8184 / F 201-886-8483

RE: Patient records and doctor's lien

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, claim, judgment, or verdict as a result of said accident/illness, and authorize 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.

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.

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.

Date: _____ Authorized signature: _____

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