Ricardo Lalama, DC
NEW PATIENT REGISTRATION PACKET

PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY **DATE:**

First Name: _____ Last Name: _____ Middle Initial: _____

DOB: _____ Age: _____ * Sex: Male ◯ Female * Social Security#: _____

Address: _____

HOUSE OR APT. NUMBER / STREET CITY STATE ZIP CODE

Home phone: _____ Mobile: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician's Name: _____ Phone: _____

Who may we thank for referring you? _____ Phone: _____

Occupation: _____ Marital Status: Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

PAYER/INSURANCE INFORMATION

Person responsible for this account/Subscriber: _____ Relationship to Patient: _____

Subscriber's DOB: _____ Type of Coverage: PPO ◯ Medicare ◯ Self Pay ◯ Other: _____

Primary Insurance Company: _____ ID: _____ Group#: _____

ACCIDENT/ INJURY INFORMATION

Is your Condition due to an accident? Yes ◯ No **Type of Injury:** Auto ◯ Work ◯ Slip&Fall ◯ Other:

Date of Accident: _____ Insurance Company: _____ Claim Number: _____

Attorney's Name: _____ Phone: _____

Adjuster/Case worker's name: _____ Phone: _____

Was there a police report filed? Yes ◯ No (If yes, present a copy with your auto insurance declaration page.)

Describe how the accident/injury occurred? _____

Which hospital did you go to? _____

Did you have any other accidents or injuries before this one? If yes, when? _____

Employer's Name: _____ Address: _____

PATIENT CONDITION

Which part of the body is the reason for your visit today? _____

When did this current episode of pain/problem begin? _____

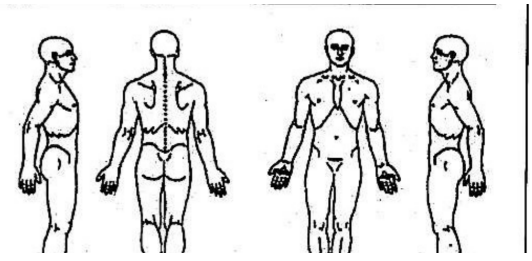
Did your problem begin: suddenly or ◯ gradually?

Please indicate the location of pain on the diagram. →

What is your pain level today?

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

0 1 2 3 4 5 6 7 8 9 10



Thank you for trusting us with your care!

Ricardo Lalama, DC

Newark, Jersey City, Woodbridge

NEW PATIENT REGISTRATION PACKET

PATIENT & FAMILY HISTORY

Height: _____ Weight: _____ LBS Handedness: ◯Left ◯Right

Allergies: _____

Are you taking any medications? ◯Yes ◯No If yes, please list: _____

Are you currently pregnant? ◯Yes ◯No

Pharmacy's Name: _____ Location/City: _____

RxID#: _____ RxBIN: _____ RxGroup: _____ RxPCN: _____

Medical Illness/ Problems

Please indicate if you or any family member had or is currently having any issues with the following illnesses:
Write: **S** for Self o**F** for Family member.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Others: _____
- ☐ Hypothyroid
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid /Lupus/ Gout or other Connective tissue disorder
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Head Injury

Surgical History

✓ Check if you had any of the following surgeries:

- ☐ Cardiac Bypass Surgery
- ☐ Tonsillectomy
- ☐ Gallbladder surgery
- ☐ Appendectomy
- ☐ C-Section
- ☐ Hysterectomy
- ☐ Joint surgery: _____
- ☐ Spine: _____
- ☐ Other: _____

REVIEW OF SYSTEMS AND SOCIAL HABITS

- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Weight Loss
- ☐ Excessive Fatigue
- ☐ Stiffness in Joints
- ☐ Joint Swelling/Warmth
- ☐ Unusual Rashes
- ☐ Easy Bruising
- ☐ Chest pain/Tightness
- ☐ Trouble Breathing
- ☐ Swollen Ankles/Legs
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Numbness/Tingling
- ☐ Anxiety/Depression
- ☐ Difficulty Sleeping
- ☐ Headaches
- ☐ Loss of Bowel Control
- ☐ Black or Bloody Stools
- ☐ Urinary Incontinence
- ☐ Menstrual Problems
- ☐ Memory Problems
- ☐ Dizziness
- ☐ Other: _____

Are you a smoker? ◯Yes ◯No If yes, how many packs per day? _____ Since: _____

Do you consume alcohol? ◯Yes ◯No Drinks per day: _____ Drinks per week: _____

Ricardo Lalama, DC

NEW PATIENT REGISTRATION PACKET

ASSIGNMENT, RELEASE AND ACKNOWLEDGEMENT

I, the undersigned, certify that for I (or my dependent) have insurance coverage with the above listed company and assign directly to the providers of The Center for Joint and Spine Relief all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure payment of benefits and related to my direct care to my insurance company, attorney, school or any treating specialist. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party	Date	Signature of Patient	Date

MEDICATION POLICY

Medication prescriptions or refills will not be called in on weeknights, Fridays, weekends or holidays under any circumstances. It is your responsibility to monitor the amount of medication you have. Therefore, you cannot expect the physicians to call in refills on the same day of your request. You must allow the doctors at least 2 days to call in your refill of your current medication.

Signature of Responsible Party	Date	Signature of Patient	Date

PLEASE READ AND SIGN. PLEASE BE ADVISED THAT IF YOUR INSURANCE COMPANY DOES NOT PAY YOU WILL BE RESPONSIBLE FOR YOUR BILL.

1. Patients with no insurance: payment is expected at the time of service. A specific payment plan acceptable between you and billing office may be arranged.

2. Patients with insurance: Your co-payment is an amount, which is not covered by your insurance and is not always and exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility.

3. If a patients account balance remains unpaid for more than 120 days, and no response has been made to our office billing department, the patient's account may be turned over to our attorney for collection.

INSURANCE POLICY

We extend to our patients, the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expenses. Please also note the following:

1. Since we do not own your insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.

2. It is the goal of this office to provide you with the finest quality care available. If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

PLEASE SIGN BELOW

- I have reviewed and am aware of the payment policies of Ricardo Lalama, DC.
- I authorize my insurance company to make payment for my unpaid balance directly to:

Ricardo Lalama, DC

Signature of Responsible Party	Date	Signature of Patient	Date

OUT OF NETWORK

I HAVE BEEN MADE FULLY AWARE THAT Ricardo Lalama, DC AND THEIR PROVIDERS DO NOT PARTICIPATE WITH MY INSURANCE. I AGREE THAT I WILL BE HELD RESPONSIBLE FOR ANY AND ALL REMAINING BALANCES THAT MY INSURANCE WILL NOT PAY.

Signature of Responsible Party	Date	Signature of Patient	Date

"Ricardo Lalama, DC"

Ricardo Lalama, DC

NEW PATIENT REGISTRATION PACKET

Authorization to Use or Disclose Protected Health Information

Patient Name:

Address:

Date of Birth: Date of Request:

As required by the Privacy Regulations, Ricardo Lalama, DC, may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Patient Health Information authorized to be disclosed:

For the specific purpose of (describe in detail)

Effective dates for this authorization: through

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

- ,

Signature of Responsible Party Date Authorized Signature of Facility

ASSIGNMENT, LIEN, AUTHORIZATION OF

Thank you for trusting us with your care!

Ricardo Lalama, DC

Newark, Jersey City, Woodbridge
NEW PATIENT REGISTRATION PACKET
INSURANCE BENEFITS AND POWER OF ATTORNEY

Name of Patient:

Date of Accident:

I hereby authorize and direct any insurance company and/or my attorney to pay directly to Ricardo Lalama, DC such sums as may be due and owing this office for services rendered to me, both by reason of accident or illness and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office.

I hereby assign all of my interest and rights to PIP benefits, which shall include, but not be limited to the right to file a PIP suit or seek arbitration for PIP benefits relative to treatment by said Office. I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against any insurance carrier that may be liable for payment of PIP benefits, and authorize this Office to compromise, settle or otherwise resolve said claim or cause of action as they see fit. Further, in the event that the within assignment is not consented to by an insurer or in any other manner is held invalid by any party, arbitrator or any other person, I hereby give this Office the power of attorney to bring any arbitration proceeding or suit in my name on my behalf as if I had filed such action myself. I further agree to fully cooperate with regard to prosecuting such action or proceeding.

I understand that I remain personally responsible for the total amount due the Office for services, subject to New Jersey Law. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize this office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization, so long as the request is submitted in writing. I agree that the above-mentioned Office is hereby given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bill. I further authorize any insurance company and any other physicians who have treated me for this accident to provide this Office with any documentation needed by this office with regard to the payment of my bills.

This Office agrees that it will as a condition of this assignment: follow all legally valid provisions of the insurer's Decision Point Review plan, hold the insured harmless for penalty co-payments properly imposed by the insurer based upon this Office's failure to follow the legally valid requirements of the Insurer's Decision Point Review Plan and that as a condition of this assignment this Office agrees to submit disputes to Alternative Dispute Resolution pursuant to N.J.A.C. 11:3-5. Nothing contained in the preceding sentence shall in any manner be deemed to be a waiver of this Office's right to contest the legal validity of any provision of the insurer's policy or Decision Point Review Plan or the insurer's application of the policy or Plan to your claim or to contest the imposition of penalty co-payments that this Office disputes.

,

Signature of Responsible Party Date

Witness:

Provider's Signature

Ricardo Lalama, DC

PATIENT QUESTIONNAIRE FOR NARRATIVE REPORTS

1. Did you have any other accidents, injuries prior to the current one? Another car accident, slip and fall? Anything that you had a lawyer for? Yes: No: If yes, when: _____ and what was it?

_____

2. Did you have any other prior incidents? Please list them if more than two

,

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3. How did it affect your life? Can you perform all your work duties compared to your ability prior to the current accident? If no, describe how so:

Do you have any hobbies?

Can you continue them after the accident?

4. What is your occupation?
5. What are your tasks at work?
6. Do you have any difficulty performing them?

7. Do you have children? Any activities you cannot do without experiencing pain?

Nov /2024 JM

Ricardo Lalama, DC

PATIENT QUESTIONNAIRE FOR NARRATIVE REPORTS

Please provide any additional information, you can think of that may be relevant, for us to be able to complete your case summary for your attorney at the end of your case:

New Jersey Application for Benefits
Personal Injury Protection

Name
Address 1
Address 2
Address 3

Important: 1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Date | **Type of Claim** | **Date of Accident** | **Claim Number**

Your Name

Gender M ◯ F ◯

Phone Nos.: Home

Business

Your Address (No. & Street, City/Town, State & Zip Code)

Social Security No. (if none, enter 'none')

Date of Birth

Your Address (No. & Street, City/Town, State & Zip Code)

Date of Accident | **Time of Accident** AM◯ PM◯ | **Place of Accident (Street, City/Town & State)**

Brief Description of Accident

Do you or any member of your household own a vehicle? **Yes** ◯ **No** ◯

Name of Insurance Company

Were you the driver of the vehicle? Yes◯ No◯
Were you a passenger in the vehicle? Yes◯ No◯
Were you a pedestrian? Yes◯ No◯
Were you a member of vehicle owner's household? Yes◯ No◯

Do you have health insurance? Yes ◯ No ◯

Name of Insurance Company

As a result of this accident were you injured? Yes ◯ No ◯

If your answer is "Yes", complete the remainder of this form. If "No", sign here and return this form to us.

Date:

Describe your Injury:

Were you treated by a doctor? Yes ◯ No ◯

Doctor's Name and Address

If you were treated in a hospital, were you an

In-patient? Yes ◯ No ◯

Out-patient? Yes ◯ No ◯

Hospital's Name and Address

Amount of Medical Bills to Date:
$

Will you have more medical expenses? Yes ◯ No ◯

At the time of your accident, were you in the course of your employment? Yes ◯ No ◯

Your lost wages: Date disability from work began:

What is your average weekly wage or salary?
$

Did you lose wages or salary as a result of your injury? Yes ◯ No ◯

If yes, amount lost to date: $

Date you returned to work

Have you received or are you eligible for benefits under:

(1) Any Workers' Compensation Law? Yes ◯ No ◯
(2) Employees' Temporary Disability Benefit Statute? Yes ◯ No ◯
(3) Medicare? Yes ◯ No ◯

If yes, amount: $
Per week ◯ Per month ◯

If you are a Medicare beneficiary, enter your Health Number (HICN)

List names and addresses of your employer and other employers for one year prior to accident date and give occupation

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ◯ No ◯ **If your answer is "Yes", explain on reverse side.**

Signature: **Date:**

Do Not Detach
Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance the Personal Injury Protection Benefits Law.

Signature: **Date:**

Do Not Detach
Authorization for Wage Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

New Jersey Application for Benefits
Personal Injury Protection

As a result of your injury, have you had any other expenses?

If your answer is "Yes", explain here: