Fingers From Heaven

Dr. Connie Tjaden, D.Ac., LMT
464 Route 25A
Miller Place, New York 11764
631-680-9458

No-Fault Registration Form

Patient Name: _____

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

Sex: _____SS#: _____ D.O.B._____

Telephone: (H) _____ (W) _____(C) _____

Email: _____

Emergency Contact/Relationship: _____ Phone: _____

No Fault Insurance Information

Name of Vehicle Ins. Company: _____

Address: _____ City: _____ State: _____Zip: _____

Name of Adjuster: _____ Phone: _____

Policy #: _____ Claim #: _____

Date of Accident: _____ E-Payor #: _____

Attorney Information:

Name: _____ Phone: _____

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

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No-Fault Registration Form

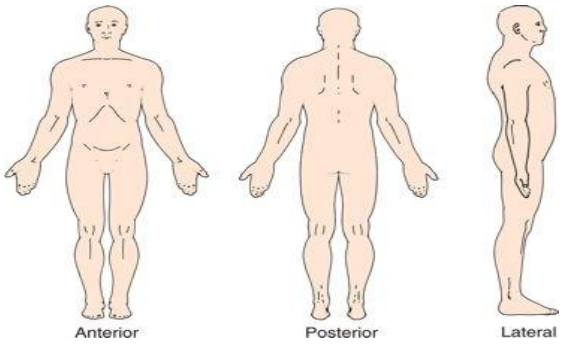
Name_____Age_____ Birthdate_____

Chief Complaint: _____

Date of injury or symptom onset: _____

Are you currently pregnant? _____

Please describe the injury or problem: _____



_____

Where is your pain? Please mark the drawing

Please indicate your pain level
0 = No pain 10 = Extreme pain

1. Right now 0 1 2 3 4 5 6 7 8 9 10
2. At best 0 1 2 3 4 5 6 7 8 9 10
3. At worst 0 1 2 3 4 5 6 7 8 9 10
4. What makes it better? _____
5. What makes it worse? _____

Circle the words which best describe your symptoms:

Dull/Ache	Shooting	Awareness	Sharp/Stabbing	Gnawing	Burning	Numbness
Throbbing	Heaviness	Weakness	Tightening/Constricting			

What diagnostic tests have you had for this condition? (X-ray, MRI, EMG, etc.)

Diagnostic test	Date	Results

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Consent Form

I, _____ understand that as part of my health care, **Fingers From Heaven,** will create, and maintain, health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as a:

• Mode of communication among the many health professionals who contribute to my care

• Source of information for applying my diagnosis information to my bill

• Basis for planning my care and treatment

• Means by which a third-party payer can verify that services reported were actually provided

• A tool for routine healthcare operations, such as assessing the quality and reviewing the competence of healthcare professionals

• Anonymous data may be used to track clinical progress to use for research purposes

I understand that I am entitled to a more complete description of this information, uses, and disclosures. I understand the organization reserves the right to change their notice and practices, prior to implementation, and will mail a copy of any revised notice to the address above that I've provided. I understand that I have the right to object to the use of health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed, to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also fully endorse responsibility for all fees related to my care. I understand that my insurance provider may or may not reimburse me for these services, and I will remain wholly responsible for payment.

I fully understand, and accept the terms of this consent.

Signature: _____ Date: _____

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NEW YORK STATE MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS
(FOR AN ACCIDENT OCCURRING AFTER 3/1/02)

I, _____ ("Assignor") hereby assign **Fingers From Heaven** ("Assignee") all
(Print Patient Name)

Rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault Statute) of the insurance law.

The assignee hereby certifies that, they have not received any payment from, or on behalf of the assignor, and shall not pursue payment directly from the Assignor, for services provided by said Assignee, for the injuries sustained, due to the motor vehicle accident, which occurred on _____, notwithstanding, any other agreement to the contrary.
(Print Accident Date)

This agreement may be revoked by the assignee when benefits are not payable, based upon the assignor's lack of coverage, and/or, violation of a policy condition, due to the actions, or conduct of the assignor.

ANY PERSON WHO KNOWINGLY, AND WITH INTENT, TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR COMMERCIAL INSURANCE, OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS, CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACTS MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES, OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES, WITH ANOTHER, TO MAKE A FALSE REPORT OF THE THEFTS, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE, TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES, OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY, NOT TO EXCEED FIVE THOUSAND DOLLARS, AND THE VALUE OF THE SUBJECT MOTOR VEHICLE, OR STATED CLAIM, FOR EACH VIOLATION.

_____ _____
(Print name of Patient) (Signature of Patient)

_____ _____
(Address of Patient) (Date of Signature)

_____ _____
(Signature of Provider)

_____ _____
(Date of Signature)

Provider**:** **Fingers From Heaven**
Dr. Connie Tjaden, D.Ac., LMT
464 Route 25A
Miller Place, New York 11764

NY Form NF-AOB (REV1/2004)

AUTHORIZATION

I further authorize release of Medical Records, and information to the provider listed on the NYS Form NF-AOB, it's representative, or assigns, and specifically waive, any privilege that may be associated therewith.

_____ _____
(Signature of Patient) **(Date)**

Fingers From Heaven

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LIEN

Date: _____

Patient: _____

DOA: _____

Attorney: _____

_____

_____

I, _____ authorize the above practitioner, **Dr. Connie Tjaden, D.Ac., LMT,** to furnish you, my attorney, with a full report of her examination, diagnosis, treatment, prognosis, etc., of myself, in regard to the accident in which I was involved. I hereby authorize and direct you, my attorney, to pay directly to said practitioner, such sum as may be due, and owing her for professional services rendered to me, both by reason of this accident, and by any other bills that are due her office, and to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect said practitioner. I hereby further give a lien on my case to said practitioner, against any and all proceeds of any settlement, judgment or verdict, which may be paid to you, my attorney or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly, and fully responsible, to said practitioner, for all professional bills submitted by her for services rendered me. This agreement is made solely for said practitioners' additional protection, and in consideration of her awaiting payment. I further understand that payment is not contingent of any settlement, judgment or verdict, by which I may eventually recover said fees.

_____

(Patient signature)

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

Date: _____ **Signed Attorney: _____**

(Attorney: please sign, date and return one copy to this office)