REGISTRATION

Patient _____ Date_____
Last Name First

Street Address_____City / State / Zip_____

Sex: M F Age_____ Birthdate_____ Phone_____

How were you referred to our office?_____

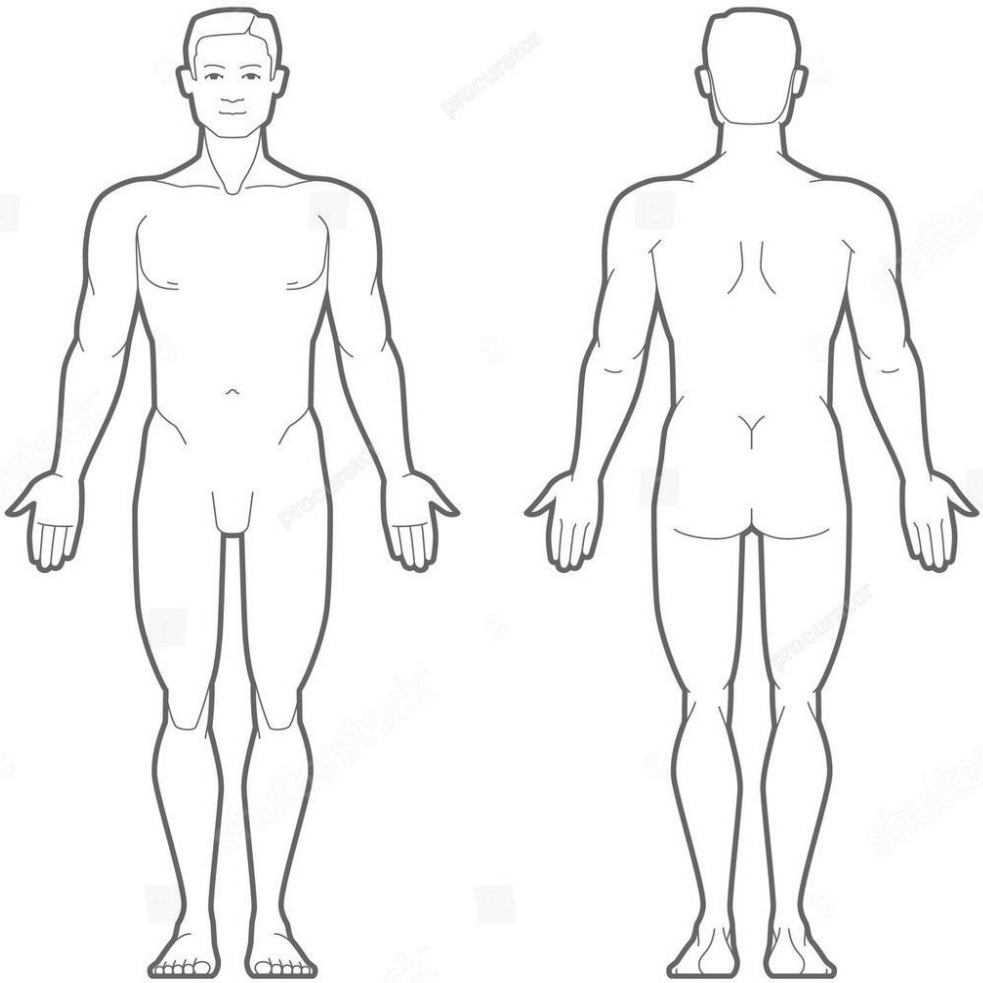
E-mail_____

I give John Carlucci, D.C. permission to examine and treat me today.

_____

Signature

Please draw on the diagram where you are suffering from pain or other symptoms:



Medical History:

Please list your medications: _____

_____

Do you have any allergies?_____

Do you smoke, consume alcohol or drugs?_____

Have you suffered from any medical conditions in the past?_____

_____

Do you currently suffer from any medical conditions?_____

_____

Were you ever treated for an injury in the past?_____

Have you ever been hospitalized or had surgery?_____

_____

Are your parents / siblings alive?_____

Do your parents or siblings suffer from any medical conditions?_____

Do you experience any of the following:

Fever or chills?_____

Weakness or fatigue?_____

Vision or hearing problems?_____

Skin rash or bruising?_____

Blue, red, white skin color or coldness in hands or feet?_____

Chest pain, pressure, racing heart?_____

Excessive thirst or urination?_____

Urinary burning, bleeding or pus?_____

Sweating, chills?_____

Weakness or clumsiness in the hands?_____

Trouble walking, balance?_____

Digestive problems, stomach pain, blood in stool?_____

Recent weight loss or gain?_____

Do you have a pacemaker or other implant?_____

Other problem:_____

_____

Health Insurance:

Company: _____ **Policy number:** _____

If this is for an auto injury, please provide:

Auto insurance company:

_____

Claim number: _____

Policy number: _____

Medical adjuster's name and phone number:_____

_____

Attorney's name, address, phone number:

_____

_____

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

Patient or legal Guardian: _____

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You, John F. Carlucci, D.C., my Chiropractic Provider, are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc. as necessary as it relates to the care being provided by my chiropractic doctor.

3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.

4. ASSIGNMENT OF RIGHT TO SUE: In the event any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me. I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you.

6. I waive the Statute of Limitations regarding my doctor's right to recover from me directly.

7. I hereby acknowledge that I am receiving (or about to receive) health care services from John Carlucci, D.C. (Doctor) and am advised that he is willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor or make other provisions for the protection of the interest of the Doctor; or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor or if I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor will be made on a current basis and my account paid in full immediately. I understand that the Doctor may or may not file PIP appeals and agree to pay any balance due regardless of the outcome of said appeals. I understand that the daily fee for my care with the Doctor is that specified by the State of New Jersey Department of Banking and Insurance Automobile Medical Fee Schedule and instruct my attorney to fully reimburse the Doctor for any amounts due to him from any aforementioned settlement in accordance with that Fee Schedule. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

8. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all Court costs, attorney's fees, service of process fees and any additional reasonable costs incurred in order to collect or that are associated with collecting monies due on the patient's account.

Dated: Day_____ Month _____ Year _____

_____ _____

Patient signature Witness