ADVANCED DIAGNOSTIC IMAGING OF NJ

34 Route 17 North, Paramus NJ 07652 Tel.: (201) 368- 2005 Fax: (201) 368-1431

PATIENT'S NAME _____ DATE _____

ADDRESS_____

CITY_____ STATE_____ ZIP _____

HOME PH #_____ CELL #_____ WORK PH#_____

EMAIL: _____

DATE OF BIRTH: _____/_____/_____ SS# _____-_____-_____ ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐MARRIED ☐SINGLE ☐WIDOW ☐DIVORCED ARE YOU PREGNANT? ☐ YES ☐ NO

EMERGENCY CONTACT _____PH#_____

REF. DOCTOR_____PH#_____

LAWYER_____PH#_____

☐CAR ACCIDENT ☐WORKER'S COMP ☐ SLIP & FALL ☐ MED. INSURANCE

PATIENT WAS:
☐PASSENGER ☐DRIVER ☐PEDESTRIAN ☐BICYCLIST ☐MOTORCYCLIST ☐_____

HAVE YOU EVER BEEN A PATIENT IN THIS FACILITY? ☐YES ☐NO WHEN?_____

WHAT IS YOUR **PRIMARY INSURANCE** _____

☐AUTO INS. CARRIER ☐WORKER'S COMP ☐MED. INSURANCE ☐ _____

ADDRESS: _____ PHONE# _____

POLICY#_____ GROUP# _____CLAIM#_____

COVERAGE _____DEDUCTIBLE_____ CO-PAYMENT MET _____ OUT OF NEWORK _____
PRE-CERT ☐Y ☐ N _____ AUTHORIZATION # _____UNTIL_____

INSURED: _____ DOB: _____ SS # _____

ADDRESS_____RELATION TO PT _____

WHAT IS YOUR **SECONDARY INSURANCE** _____

☐AUTO INS. CARRIER ☐WORKER'S COMP ☐MED. INSURANCE ☐ _____

ADDRESS: _____ PHONE# _____

POLICY#_____ GROUP# _____CLAIM#_____

COVERAGE _____DEDUCTIBLE_____ CO-PAYMENT MET _____ OUT OF NEWORK _____

PRE-CERT ☐Y ☐ N _____ AUTHORIZATION # _____ EXPIRE_____

INSURED: _____ DOB: _____ SS # _____

ADDRESS_____RELATION TO PT_____

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QUESTIONARY - PREGUNTAS A CONTESTAR

NAME (*NOMBRE)*_____DOB(*/FECHA DE NACIMIENTO)*_____

1. PLEASE CHECK THE SYMPTOMS THAT APPLIES TO YOU(*POR FAVOR MARCAR LOS SINTOMAS QUE USTED TIENE)*

- ☐ HEADACHE*/DOLOR DE CABEZA*
- ☐ VISSION LOSS/*PERDIDA DE VISION*
- ☐ DIZZINESS/ *MAREOS*
- ☐ NUMBNESS/*ADORMECIMIENTOS*
- ☐ RINGING IN EARS/*ZUMBIDO EN OIDOS*
- ☐ ARM PAIN ☐RT☐/LT/ *DOLOR-BRAZOS* ☐*DER*☐*IZQ*
- ☐ LEG PAIN ☐RT☐LT/*DOLOR-PIERNAS* ☐*DER*☐*IZQ*
- ☐ KNEE PAIN ☐RT☐LT/ *RODILLA-DOLOR* ☐*DER*☐*IZQ*
- ☐ LOWER BACK PAIN/*DOLOR DE ESPALDA BAJA*
- ☐ UPPER BACK PAIN/ *DOLOR DE ESPALDA ALTA*
- ☐ NECK PAIN/*DOLOR DE CUELLO*
- ☐ ABDOMINAL PAIN/*DOLOR ABDOMINAL*
- ☐ FOOT PAIN ☐RT ☐LT /*DOLOR-PIES* ☐ *DER*☐*IZQ*
- ☐ SHOULDER PAIN ☐RT☐LT/*DOLOR-HOMBROS*☐*DER*☐*IZQ*

2. HOW LONG HAVE YOU HAD ABOVE SYMPTOMS(*HACE CUANTO TIEMPO TIENE LOS SINTOMAS MENCIONADOS)* _____

3. IS THIS RESULT OF ANY INJURY AND/OR ACCIDENT ☐YES ☐NO (*ES ESTE EL RESULTADO DE ALGUNA CAIDA, GOLPE O ACCIDENTE)* ☐SI ☐NO

4. HAVE YOU HAD PRIOR IMAGING STUDIES OF THE BODY PART BEING EXAMINED TODAY ☐YES ☐NO *(HA TENIDO ALGUN STUDIO DE RESONANCIA MAGNETICA (MRI) ANTERIORMENTE DE LA PARTE DE SU CUERPO QUE VA A SER EXAMINADA HOY)* ☐SI ☐NO.

5. HAVE YOU EVER HAD ANY PREVIOUS SURGERIES ON THE PART OF THE BODY THAT RESULTED IN HAVING METAL IN IT ☐YES ☐NO, IF YES, PLEASE DESCRIBE IT.(*HA TENIDO ALGUNA CIRUGIA PREVIA EN LA PARTE DE SU CUERPO A SER EXAMINADA HOY Y QUE HAYA RESULTADO CON UN METAL PERMANENTE* ☐SI ☐NO, *SI DIJO QUE SI, POR FAVOR DESCRIBA)*
   _____

6. HAVE YOU EVER DONE ANY WELDING, GRINDING OR CUTTING OF METAL ☐YES ☐NO
   IF YES, PLEASE DESCRIBE IT (*HA HECHO TRABAJO DE SOLDAR, MOLDEAR O CORTAR METALES* ☐SI ☐NO *SI DIJO QUE SI, POR FAVOR DESCRIBA:*
   _____ _____

7. IS THERE ANY POSSIBILITY OF METAL IN YOUR EYES? ☐YES ☐NO
   HAY ALGUNA POSIBILIDAD DE TENER METALES EN SUS OJOS? ☐SI ☐NO
8. HAVE YOU EVER HAD OR DO YOU HAVE CANCER NOW? ☐YES ☐NO
   HA TENIDO O TIENE CANCER? ☐SI ☐NO
9. DO YOU HAVE ANY KIDNEY DISEASE? ☐YES ☐NO
   HA TENIDO O TIENE ALGUNA ENFERMEDAD RENAL? ☐SI ☐NO
10. WOMEN: IS THERE ANY CHANCE THAT YOU ARE PREGNANT? ☐YES ☐NO
    MUJERES: HAY ALGUNA POSIBILIDAD DE EMBARAZO? ☐SI ☐NO
11. WOMEN: ARE YOU BREASTFEEDING? ☐YES ☐NO
    MUJERES: ESTA DANDO DE LACTAR? ☐SI ☐NO

WEIGHT: _____ALLERGIES: _____

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

_____

WITNESS SIGNATURE **NAME** **DATE**

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CAUTION: THE FOLLOWING ITEMS CAN PRESENT A HEALTH HAZARD OR MAY BE FATAL TO THE PATIENT EXPOSED TO THE MAGNETIC FIELD!

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

☐ CARDIAC PACEMAKER OR CARDIAC MONITOR ☐ BRAIN ANEURYSM CLIPS
☐ SURGICAL RODS, PINS, CLIPS, STENTS, FILTERS ☐ ELECTRONIC PUMPS/IMPLANTS
☐ THERMO REGULATOR DISORDER ☐ NEUROSTIMULATOR (TENS UNIT)
☐ PENILE IMPLANT ☐ PERMANENT EYE LINER TATTOO
☐ INNER EAR PROSTHESIS OR COCHLEAR IMPLANT ☐ ORTHOPEDIC IMPLANTS: _____
☐ METAL MESH ☐ PREGNANT/POSSIBLY PREGNANT
☐ DENTURES/DENTAL PROSTHESIS ☐ HAVE YOU EVER HAD EXPOSURE TO METAL FRAGMENTS
☐ HAVE YOU EVER BEEN A MACHINIST, WELDER OR METAL WORKER?
☐ HAVE YOU EVER HAD A PIECE OF METAL FLUSHED OR REMOVED FROM YOUR EYES?

☐ **HAVE YOU EVER HAD ANY OF THE FOLLOWING ITEMS IN OR AROUND YOUR EYES?**

A. BULLETS ☐ YES ☐ NO B. BB'S ☐ YES ☐ NO C. PELLETS ☐ YES ☐ NO
D. METAL ☐ YES ☐ NO E. SHRAPNEL ☐ YES ☐ NO F. FRAGMENTS ☐ YES ☐ NO

☐ **ARE YOU ON DIALYSIS? ☐ YES ☐ NO**

THE FOLLOWING MAKE AND MODEL MUST BE INCLUDED

IUD	MAKE: _____	MODEL: _____
ARTIFICIAL HEART VALVE	MAKE: _____	MODEL: _____
SHUNTS	MAKE: _____	MODEL: _____
VENACAVA FILTER	MAKE: _____	MODEL: _____
OTHER METALLIC IMPLANTS	MAKE: _____	MODEL: _____

SURGICAL HISTORY

SPINAL SURGERY _____ DATE: _____

ORTHOPEDIC SURGERY _____ DATE: _____

OTHER SURGERY _____ DATE: _____

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE (PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE DATE

_____

WITNESS SIGNATURE NAME DATE

I _____ was explained for a second time by the Technician that any electronic devices are not permitted in the testing area. Any damage caused to the devices will be the patient's responsibility.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE (PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE DATE

_____

TECHNICIAN SIGNATURE NAME DATE

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CONSENT TO PROVIDE TESTING AND TO RELEASE INFORMATION

1. I HEREBY AUTHORIZE ADI OF NJ AND ITS ASSOCIATES TO PROVIDE TESTING AND/OR EXAMINATION. THE NATURE AND PURPOSE OF THE TESTS AND /OR THE EXAMINATION HAS BEEN EXPLAINED TO ME AND I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS. I ACKNOWLEDGE THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULTS TO BE OBTAINED.

2. IN THE EVENT OF ACCIDENTAL EXPOSURE FROM MY BODY FLUIDS, I FURTHER CONSENT TO THE DRAWING OF BLOOD AND TESTING FOR SYPHILIS, THE HEPATITIS B AND HUMAN IMMUNODEFICIENCY VIRUSES IF ANY INDIVIDUAL AT ADVANCE DIAGNOSTIC IMAGING IS EXPOSED. THE RESULTS OF THESE TESTS WILL REMAIN STRICTLY CONFIDENTIAL EXCEPT AS SPECIFIED BY LAW.

3. ANY INFORMATION PERTINENT TO MY CASE IN THE COURSE OF MY EXAMINATION OR TESTING MAY BE RELEASED TO MY PHYSICIAN, INSURANCE COMPANY, ADJUSTER, OR ATTORNEY IF APPLICABLE IN THIS CASE.

VERIFICATION OF REVIEW OF PATIENT BILL OF RIGHTS

4. I CERTIFY THAT I HAVE BEEN OFFERED/GIVEN A COPY OF THE PATIENT BILL OF RIGHTS FOR MY REVIEW AND ANY QUESTIONS THAT I MAY HAVE HAD REGARDING THEM HAS BEEN ANSWERED TO MY SATISFACTION.

ADVANCED DIRECTIVE – LIVING WILL AND DO NOT RESUSCITATE

5. DUE TO THE AMBULATORY NATURE OF YOUR TESTING AND THIS FACILITY, WE WILL **NOT HONOR " DO NOT RESUSCITATE OR ADVANCED DIRECTIVE"** ORDERS FOR THE SHORT TIME YOU ARE HERE AS A PATIENT. IN SIGNING THIS FORM YOU HAVE AGREED TO THE POSTPONEMENT OF YOU DIRECTIVES UNTIL YOU LEAVE THIS FACILITY. INFORMATION ON ADVANCED DIRECTIVES/LIVING WILLS IS AVAILABLE UPON REQUEST.

I CERTIFY THAT I HAVE READ THIS DOCUMENT IN ITS ENTIRETY AND COMPLETELY UNDERSTAND ALL THE ABOVE STATEMENTS. ANY QUESTIONS THAT I MAY HAVE HAD REGARDING THEM HAVE BEEN ANSWERED TO MY SATISFACTION.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT,,IF I SO CHOOSE.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES TODAY, BUT ACKNOWLEDGMENT COULD NOT BE OBTAINED BECAUSE:

☐PATIENT /REPRESENTATIVE REFUSED TO SIGN ☐COMMUNICATION BARRIERS PROHIBITED FROM OBTAINING IT
☐EMERGENCY SITUATION PREVENTED US FROM OBTAINING IT AT THIS TIME (WILL ATTEMPT AGAIN AT A LATER TIME)

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MEDICAL RECORDS RELEASE FORM

I, _____ AUTHORIZE AND REQUEST ADI OF NJ TO RELEASE MY COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT.

FROM _____ TO_____

TO: _____

DOCTOR'S OFFICE OR HOSPITAL

_____

ADDRESS

SIGNATURE _____ NAME_____ DATE_____

ADDRESS_____

WITNESS SIGNATURE _____ NAME _____

MEDICAL RECORDS RELEASE FORM

I, _____ HEREBY AUTHORIZE AND REQUEST

_____

DOCTOR'S OFFICE OR HOSPITAL

_____

ADDRESS

TO RELEASE MY COMPLETE MEDICAL RECORDS IN YOUR POSSESSION CONCERNING MY ILLNESS AND/OR TREATMENT

FROM _____ TO_____

TO: ADVANCED DIAGNOSTIC IMAGING OF NJ INC, 34 ROUTE 17 NORTH PARAMUS NJ 07652

SIGNATURE _____ NAME_____ DATE_____

ADDRESS_____

WITNESS SIGNATURE _____ NAME _____

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ASSIGNMENT OF BENEFITS

PATIENT'S NAME:_____

I **irrevocably** assign to Advanced Diagnostic Imaging Of New Jersey , Inc., my medical provider, all my rights and benefits under my insurance contract for payments services rendered to me.

I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Advanced Diagnostic Imaging of New Jersey, Inc. to be released to Advanced Diagnostic Imaging of New Jersey, Inc.

I irrevocably authorize Advanced Diagnostic Imaging of New Jersey, Inc. to file Insurance claims on my behalf for services rendered to me as a result of this automobile accident and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP/health care carrier. I irrevocably direct that all such payments go directly to Advanced Diagnostic Imaging of New Jersey , Inc., my medical provider.

I irrevocably authorize Advanced Diagnostic Imaging of New Jersey, Inc. to act on my behalf . I **consent** to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the benefit denial process set forth in the NJ Administrative Code and report any suspected violations of proper claims practices to the proper regulatory authorities.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this **limited power of attorney** and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

_____

WITNESS SIGNATURE **NAME** **DATE**

Any services that are not covered by your insurance is your responsibility and will be due and payable upon receipt or a billing statement. If correct insurance information or referral is not presented at the time of service, you are responsible for the full amount of charges incurred. If you do not have medical insurance, financial arrangements will be made.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

_____

WITNESS SIGNATURE **NAME** **DATE**

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FINANCIAL AGREEMENT

I, _____, hereby agree to the following, as a condition of receiving treatment at ADI OF NJ INC,

1 ADI OF NJ INC, as a courtesy to its patients, participates with certain insurance companies and managed health care programs. If I am a member of one of these plans, ADI OF NJ INC, will submit an insurance claim on my behalf.

2 Any medical services which are not covered by my insurance (including denials of payments based upon incorrect, misleading, or incomplete information provided by me), are my responsibility, and payment in full will be due and payable by me upon receipt of a billing statement.

3 If my insurance covers only a portion of ADI OF NJ INC's charges for medical services, and/or pays ADI OF NJ INC, less than its full charges, I am responsible for the difference between ADI OF NJ INC,'s customary fee and any partial or incomplete payments made by my insurance company. Payment in full will be due and payable by me upon receipt of a billing statement.

4 In addition, if I provide to ADI OF NJ INC, incorrect, misleading, or incomplete information which results in an insurance company, government agency or other entity conducting an audit, investigation, litigation, recoupment effort, arbitration or other proceeding against ADI OF NJ INC, or relating to ADI OF NJ INC's charges and/or services, I agree to take full personal responsibility for my actions, and I agree to indemnify and hold ADI OF NJ INC, harmless, including, without limitation, reimbursing ADI OF NJ INC, for all damages, penalties, costs and expenses (including attorneys' fee) Incurred by or assessed against ADI OF NJ INC, in all such matters.

5 If I do have group or individual medical insurance, payment for all medical services is due at the time of my visit. If needed, I will contact ADI OF NJ INC's ADMINISTRATOR to set up a payment plan based on my financial condition.

6 Cash and/or personal check are the only accepted methods of payment by ADI OF NJ INC, for professional services. I agree that ADI OF NJ INC, will add a service fee of up to $25.00 for all returned checks.

7 All balances due to ADI OF NJ INC, that remain delinquent after 120 days, may be referred by ADI OF NJ INC, to a collection agency. Once an account is turned over to the collection agency, I will have to settle the debt with the agency. If a balance remains unpaid, ADI OF NJ INC, may elect to no longer provide medical services to me. If this happens, I will be notified that I have 30 days to find alternative medical care. During that 30 day period, ADI OF NJ INC will only treat me on an emergency basis.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

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WITNESS SIGNATURE **NAME** **DATE**

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LETTER OF PROTECTION - (L.O.P.)

TO: ATTORNEY: _____

_____

_____

_____

RE: PATIENT RECORDS AND ATTORNEY'S LIEN.

- I DO HEREBY AUTHORIZE THE ABOVE FACILITY TO FURNISH YOU, MY ATTORNEY/INSURANCE CARRIER, WITH A FULL REPORT OF MY EXAMINATION AND DIAGNOSIS OF MYSELF IN REGARD TO MY ACCIDENT/ILLNESS WHICH OCCURRED/BEGAN ON _____
- I HEREBY GIVE A LIEN TO SAID FACILITY 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 FACILITY SUCH SUMS AS MAY BE DUE AND OWING THEM FOR SERVICE RENDERED ME, AND TO WITHHOLD SUCH SUMS FROM SUCH SETTLEMENT, CLAIM, JUDGMENT, OR VERDICT AS MAY BE NECESSARY TO PROTECT SAID FACILITY ADEQUATELY.
- I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO SAID FACILITY FOR ALL MEDICAL BILLS SUBMITTED BY THEM FOR SERVICE RENDERED ME, AND THAT THIS AGREEMENT IS MADE SOLELY FOR SAID FACILITY'S ADDITIONAL PROTECTION AND 'IN CONSIDERATION OF THEIR 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.
- I FULLY UNDERSTAND THAT THIS FACILITY DOES NOT PARTICIPATE IN ANY MEDICAL NETWORKS WITH REDUCE FEE.
- I AGREE TO PROMPTLY NOTIFY SAID DIAGNOSTIC FACILITY OF ANY CHANGE OR ADDITION OF ATTORNEY(S) USED BY ME IN CONNECTION WITH THIS ACCIDENT AND I INSTRUCT MY ATTORNEY TO DO THE SAME AND TO PROMPTLY DELIVER OF COPY OF THIS LIEN TO ANY SUCH SUBSTITUTED OR ADDED ATTORNEY(S).
- PLEASE ACKNOWLEDGE THIS LETTER BY SIGNING BELOW AND RETURNING TO THE DIAGNOSTIC FACILITY. I HAVE BEEN ADVISED THAT IF MY ATTORNEY DOES NOT WISH TO COOPERATE IN PROTECTING THE DIAGNOSTIC FACILITY'S INTEREST, THE DIAGNOSTIC FACILITY WILL NOT AWAIT PAYMENT BUT MAY DECLARE THE ENTIRE BALANCE DUE AND PAYABLE.

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____

(PRINT) PATIENT'S NAME OR LEGAL REPRESENTATIVE (IF APPLICABLE) **RELATIONSHIP TO PATIENT (IF APPLICABLE)**

_____

WITNESS SIGNATURE **NAME** **DATE**

THE UNDERSIGNED, BEING ATTORNEY OF RECORD OR AUTHORIZED REPRESENTATIVE OF INSURANCE CARRIER FOR THE ABOVE 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 TO ADEQUATELY PROTECT AND FULLY COMPENSATE SAID DIAGNOSTIC FACILITY ABOVE NAMED. ATTORNEY FURTHER AGREES THAT IN THE EVENT THIS LIEN IS LITIGATED THAT THE PREVAILING PAIL WILL BE AWARDED ATTORNEY FEES AND COSTS.

ATTORNEY'S SIGNATURE. _____ DATE _____

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AFFIDAVIT OF NO OTHER SOURCES OF INSURANCE

1. I currently reside at _____ and have done so since _____.
2. My home phone number is _____.
3. My date of birth is _____.
4. My Social Security number or ITIN number is_____.
5. My Gender is ☐Male ☐ Female
6. Medicare beneficiary
   a. _____ I **am not** a Medicare beneficiary
   b. _____ I **am** a Medicare beneficiary and my Health Insurance Claim Number ("HICN") is _____.

7. My driver's license information is: State _____ Number _____.
   On _____, the date the accident occurred:

   a. I resided at _____.
   b. Other residents of my household on the date the accident occurred were:
      i. Name _____DOB_____
         Driver's License # _____State _____
         Their relationship to you_____

      ii. Name _____DOB_____
         Driver's License # _____State _____
         Their relationship to you_____

      iii. Name _____DOB_____
         Driver's License # _____State_____
         Their relationship to you_____

CHECK ALL THAT APPLY BELOW:

☐On _____, the date the accident occurred, I was not a resident of a household wherein any resident was the registered owner of a motor vehicle covered by a policy issued by an insurance company in the state of NJ.

☐On _____, the date the accident occurred, I was not insured by **any** medical insurance carrier for coverage of medical services.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

SIGNATURE _____ NAME_____ DATE_____

ADDRESS_____

WITNESS SIGNATURE _____ NAME _____