COVID-19 INFORMED CONSENT TO TREAT

understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me n making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____
Name	_____	Name	_____
Date	_____	Date	_____

Witness Signature	_____
Name:	_____
Date:	_____

Absolute
Chiropractic & Massage

Patient Intake Form

Date: _____

Personal Information

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Sex: ____ M ____ F Social Security #: _____

Email: _____ Circle One: Single Married Widowed Divorced Separated

Business Employer: _____ Occupation: _____

Business Phone: _____ Who Referred You to the Office: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance Information

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

Responsible Party: _____ Responsible Party DOB: _____

Relationship to Insured: _____ Insured's Address: _____

Secondary Insurance Company: _____ ID #: _____ Group #: _____

Responsible Party: _____ Responsible Party DOB: _____

Relationship to Insured: _____ Insured's Address: _____

For Auto, Work, or Slip and Fall Injuries:

Name of Insurance Company: _____ Policy #: _____

Claim #: _____ Claim Adjuster & Phone #: _____

Current Health Condition

Reason for visit: _____

Other Doctors seen for this condition: Yes No Who? _____

When did this condition begin: _____ Has this condition occurred before? Yes No

Is your condition: ___ Work Injury ___ Auto Accident Injury ___Home Injury ___Slip & Fall ___ Other

If other please explain: _____

Previous Chiropractic Treatment? Yes No If yes, who? _____

Current Medications? Yes No If yes, please list: _____

_____

Additional Information (optional): _____

_____

Patient Signature & Date: _____ **Dr. Signature & Date:** _____

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Past Medical History - Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases that you have had:

___ Arthritis
___ Cancer
___ Chicken Pox
___ Diabetes
___ Eczema
___ Epilepsy
___ Flu/Influenza
___ Heart Disease
___ Mental Disorders
___ Pneumonia
___ Thyroid Problems
___ Lumbago
___ Measles
___ Mumps
___ Pleurisy
___ Polio
___ Rheumatic Fever
___ Tuberculosis
___ High Blood Pressure
___ Stroke
___ Other _____

List any past fractures: _____

Any Surgeries? Yes No

List any past surgeries & dates: _____

_____

Any Allergies? Yes No If yes, to what? _____

Review of Systems: Check any of the following that you are experiencing currently.

Musculo-skeletal: ___ Low Back Pain ___ Mid Back Pain ___ Neck Pain ___ Arm Pain ___ Leg/Ankle Pain ___ General Stiffness ___ Joint Pain/Stiffness ___ Difficulty Walking ___ Clicking Jaw/Difficulty Chewing ___ Swelling

Nervous System: ___ Nervous/Anxiety ___ Numbness ___ Paralysis ___ Dizziness ___Forgetfulness ___Headaches ___ Confusion ___ Depression ___ Fainting ___ Convulsions ___ Stress ___ Cold/Tingling Extremities

Gastrointestinal: ___ Poor/Excessive Appetite ___ Excessive Thirst ___ Frequent Nausea ___ Vomiting ___ Diarrhea ___ Constipation ___ Hemorrhoids ___ Liver Problems ___ Heartburn ___ Gall Bladder Problems ___Overweight ___ Abdominal Cramps ___Colitis ___ Gas/Bloating After Meals ___ Black/Bloody Stool

Cardiovascular/Respiratory: ___ Chest Pain ___ Shortness of Breath ___ High/Low Blood Pressure ___Stroke ___ Heart Problems ___ Lung Problems/Congestion ___ Varicose Veins ___ Ankle Swelling

Ears, Eyes, Nose, Throat: ___ Blurred Vision ___ Double Vision ___ Sore Throat ___ Ear Aches ___ Cough ___ Yellow Eyes ___ Hearing Difficulty ___Runny Nose

Genitourinary: ___ Painful/Excessive Urination ___Discolored Urine ___ Bladder problems

Skin: ___ Rashes ___Dry Skin ___Psoriasis ___ Itching

Lymphatic: ___ Enlarged/Painful Lymph Nodes

Hematologic: ___ Anemia ___Bruising ___Bleeding

Constitutional: ___ Weight Loss ___ Fever ___ Chills ___Weakness ___ Fatigue

Sexual: ___ Menstrual Irregularity ___ Menstrual Cramps ___Vaginal Pain/Infection ___ Breast Pain/Lumps ___Prostate/Sexual Dysfunction

For Females: Are you pregnant? Yes No Date of Last Period: _____

Patient Signature & Date: _____ **Dr. Signature & Date:** _____

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Social/Family Medical History (M=Mother F=Father S=Sibling)

___ Heart Disease ___ Stroke ___ Circulatory Disorder ___ Blood Pressure ___ Diabetes

___ Other _____

Do you smoke? Yes No # Packs Per Day? _____

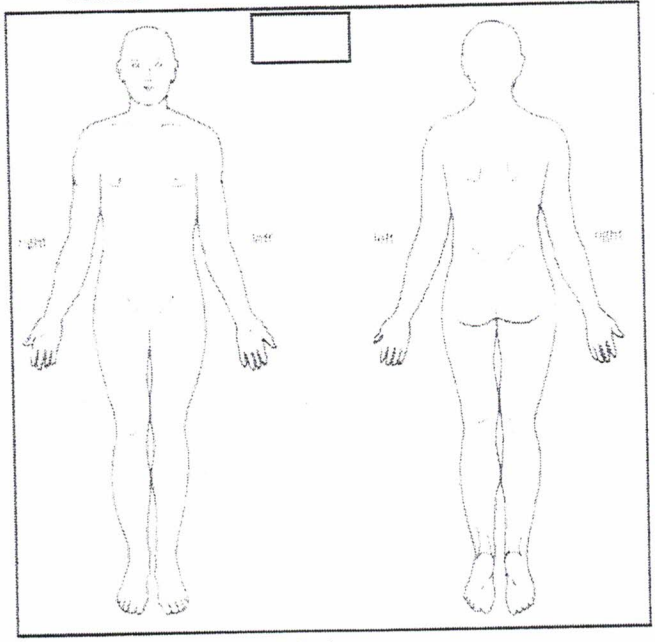
History of Drug Use? Yes No

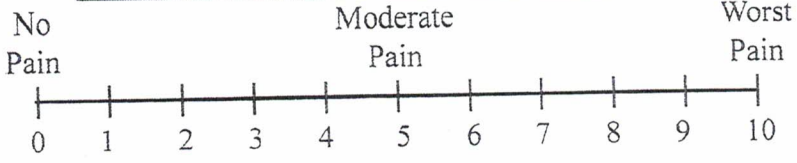
Alcoholic Consumption # off drinks per day _____

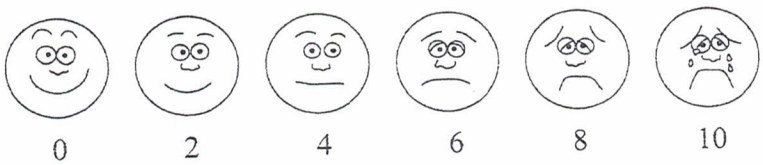
PAIN DIAGRAM

Mark areas of *PAIN* that you have on the diagram using **SHADING**

Mark areas of *TINGLING or PINS AND NEEDLES* with **CROSSES**







Patient Signature & Date: _____ **Dr. Signature & Date:** _____

Absolute Chiropractic & Massage
245 Main Street
Woodbridge, NJ 07095
(732) 874-5109

Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy ___ palpation ___ vital signs
___ range of motion testing ___ orthopedic testing ___ basic neurological testing
___ muscle strength testing ___ postural analysis testing
___ ultrasound ___ hot/cold therapy ___ EMS
___ radiographic studies
___ Other (please explain)

_____

_____

Patient should initial each procedure they are consenting to.

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care: however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

continued on next page

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize (*insert your name*) to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(insert your name)* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)

Absolute Chiropractic & Massage
245 Main St.
Woodbridge, NJ 07095
(732) 874-5109

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

PROVIDER: **PATIENT:** **Date:**

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

1. RELEASE OF INFORMATION: You 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 authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc., 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 the 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.
5. RIGHT TO LIEN: 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. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries from any proceeds or settlements, claims, or judgment regarding said injuries. My legal counsel or any representative is to pay the doctor/clinic prior to distributing and proceeds to me, and I instruct said legal counsel or representative not to attempt to reduce by means of negotiation my doctor's bill for services that have been provided to me for the accident/injury/illness which I have agreed to pay in full.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payments, or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorist, and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my Doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are 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(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full immediately. 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.
9. 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 reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.

Patient Signature_____

Dated Signature ___ day of _____ 20 __ Witness Signature _____

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Chiropractic & Massage

Hardship Agreement

To Whom It May Concern:

By my signature below I am requesting that my doctor reduce normal and customary fees charged as to allow me to receive chiropractic care. My financial circumstances are such that is I were to pay customary fees charged I would be forced (due to economic reasons) to not receive care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement would be different than that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-payments, I agree that it is my responsibility to notify my insurance carrier that due to economical hardship I am only making partial payment.

_____

Signature of Patient

_____

Print Patient's Name

_____

Witness

_____

Date

ABSOLUTE CHIROPRACTIC & MASSAGE

245 Main Street Woodbridge, NJ 07095 **PHONE: 732-874-5109 • FAX: 732-874-5109**

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk, and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor, and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment, or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and

Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____

Absolute
Chiropractic & Massage

Office Cancellation and No-Show Policy

It is expected that patients provide 24 hours' notice when cancelling an appointment. There is no fee to cancel an appointment with at least 24 hours' notice. If a chiropractic, massage, or acupuncture appointment is cancelled with less than 24 hours' notice a fee cancellation fee may be assessed at the discretion of the office manager. Below is the list of fees:

Chiropractic/Acupuncture Treatment Cancellation Fee: $25

Chiropractic/Acupuncture No-Show Fee: $50

Massage Therapy Cancellation/No-Show Fee: $15

Massage Therapy Policy

Massage Therapy Fee: $15 for a 15-minute time slot (includes preparation and clean-up time)

Patient must be on time for the appointment.

Patient must follow their chiropractic treatment plan to receive massage therapy in our office.

By signing below, you agree that you have read and understand the above policies.

Name: _____ Date: _____

Patient Signature: _____