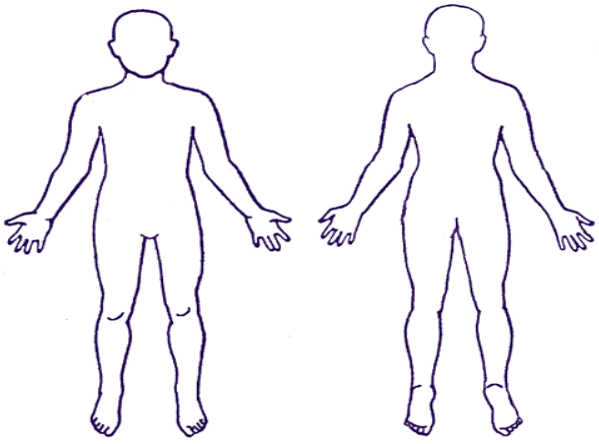
Family Chiropractic &
Spinal Health Care Center, LLC

INITIAL HEALTH STATUS

Patient Name: _____ Birth date: _____/_____/_____ Preferred Gender: M / F / Non-binary
Address_____ City _____State _____ Zip _____ Home Phone (___)_____Cell Phone (___)_____
S.S. #_____Marital Status: S M D W
E-Mail Address_____ Referred By:_____
Emergency Contact:_____ Emergency Phone (___)_____
Occupation _____ Employer _____Work Phone (____)_____
Primary Insurance Company_____ Subscriber S.S. #_____
Subscriber Name _____Subscriber Birth Date _____Self/ Spouse/Other_____
Subscriber ID # _____ Group # _____ Type Health Plan: PPO/POS/HMO
2nd Insurance Company_____Subscriber S.S. #_____Subscriber D.O.B._____
Primary Care Name_____Last Exam_____ PCP Phone (____)_____
OB/GYN Name_____Last Exam_____OB/GYN Phone(____)_____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS

Right



Right

Front

Back

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐Headache ☐Neck pain ☐Mid-back pain ☐Low Back pain
☐Other_____
Is This? ☐Work Injury ☐Auto Injury ☐N/A
Date Problem Began: _____ **How Problem Began:** Gradual / Sudden
_____

□ about a day ago □ several days ago □ about a week ago □ several weeks ago □ about a year ago
□ several years ago □ other:
Chief complaint (The level of Your WORST & BEST pain):

No Pain ~~0 1 2 3 4 5 6 7 8 9 10~~ – Unbearable Pain

Family Chiropractic &
Spinal Health Care Center, LLC

In the past week, on average how often have your symptoms been present?
(Intermittent) □ 0 – 25% □ 26 – 50% □ 51 – 75% □ 76 – 100% (Constant)

How frequently? □ intermittent □ occasional □ frequent □ constant

How severe? □ mild □ mild to moderate □ moderate □ moderate to severe □ severe

In the past week has your pain interfered with your daily activities (e.g., work, social activities, or household chores?

~~0 1 2 3 4 5 6 7 8 9 10~~

Select the type of pain that best describes your complaint:
□ achy □ numb ache □ shooting □ burning □ pounding □ stabbing □ dull
□ pulsating □ stinging □ sharp □ throbbing

Select each choice that applies to you:
Movement □ cramps □ inflexibility □ spasm □ stiffness □ prickly
Sensation □ crawling □ dead □ numb □ pins and needles □ tingling

Please indicate everything that makes you feel better, worse or aggravates your condition:

□usually better in the morning □ usually better during the day □ usually better at night

□ usually worse in the morning □ usually worse during the day □ usually worse at night

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? □No □Yes

Date(s) Taken _____ What areas were taken?

_____

Please check all of the following that apply to you:

□Recent fever □Prostate Problems □Diabetes □Menstrual Problems

□High Blood Pressure □Heart Disease □Urinary Problem □Lungs Disease

□□ □Stroke (date) _____

□Currently pregnant, # Weeks ____ □Corticosteroid Use (cortisone, prednisone, etc.)_____

□Abnormal Weight □Gain □Loss □Taking Birth Control Pills □Marked Morning Pain/Stiffness

□Dizziness/Fainting □Pain Unrelieved by Position or Rest □Numbness in Groin/Buttocks

□Nausea □Change in Bowel/Bladder □Pain at Night

□Cancer/Tumor (explain)_____ □Visual Disturbance

□Osteoporosis □Epilepsy/Seizures □Headaches

□Allergies _____ □Arthritis □Asthma

□Other Health Problems (explain)_____

□Surgeries_____Medications_____

_____

Family History: □Cancer □Diabetes □High Blood Pressure □Heart Problem/Stroke □Rheumatoid Arthritis

□Other_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature _____ Date _____

Family Chiropractic &
Spinal Health Care Center, LLC

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Family Chiropractic & Spinal Health Care Center LLC, Mohammed Abtahi AKA Moe Abtahi

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. **We are out of network with most insurance carriers**. You are responsible to know your policy. This physician may order procedures and tests during your visits that may not be covered by your insurance. Should your insurance company not reimburse those who provide these services, UNDERSTAND THAT YOU WILL BE RESPONSIBLE FOR PAYMENT. If this is of concern to you we recommend you contact your insurance company to confirm payment benefits.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected form me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 27 S. Franklin Tpk, Ramsey NJ. 07446. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____ _____

Printed Name of Patient Date

INFORMED CONSENT TO CHIROPRACTIC CARE

Family Chiropractic & Spinal Health Care Center
27 S. Franklin Tpk., Suite 302 Ramsey NJ Tel (201)995-9900 Fax (201)995-9901

Patient: Please discuss any questions or concerns with the Doctor before signing this consent.

Chiropractic Healthcare involves various techniques and modalities to achieve the best possible outcome for the patient. These include, but are not limited to the following:

1. Chiropractic Adjustment/Manipulation: A chiropractic therapeutic maneuver that utilizes controlled force, leverage, direction, amplitude, and velocity and which is directed at specific joints or anatomical regions. Chiropractors commonly use such procedures to influence joint and neurophysiologic function.

2. Electro-Therapy: A therapeutic treatment to aid in the relief of pain and promotion of soft tissue healing. Also causes stimulation of innervated muscle to cause contraction, which helps force fluid out of the lymphatic and interstitial tissues thereby reducing edema. Also helps stimulate the release of endorphins, which are the body's natural painkillers.

3. Myofascial Release Technique: Relaxes overactive muscles in and helps stretch chronically shortened muscles. Helps restore normal elasticity to the muscles, ligaments and tendons.

4. Manual Traction: Involves a force acting on a longitudinal axis to draw structures apart. Induces passive motion into the spine for the purpose of stretching spinal joints and increasing mobility.

5. Ultrasound: Sound vibrations penetrate the soft tissues deep in the body creating heat response. These vibrations and heat break down and disperse unhealthy calcium, adhesions and other hard tissue accumulations within the muscles, ligaments and tendons.

6. Microcurrent Therapy: Uses extremely small amounts of electrical current to help relieve pain and heal soft tissues of the body. Injury to the body disrupts its normal electrical activity. Microcurrent produces electrical signals like those naturally occurring when the body is repairing damaged tissues. By applying similar electrical currents, the healing process is enhanced.

7. Mobilization: Movement applied singularly or repetitively within or at the physiologic range of joint motion, without imparting a thrust or impulse, with the goal of restoring joint mobility.

It is common for chiropractic adjustments, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please do tell your treating chiropractic physician about it.

Chiropractic is a system of healthcare delivery, and, therefore, as with any healthcare delivery system cannot produce a cure for any symptom, disease or condition as a result of treatment at this facility. I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, and been informed of the risks and possible consequences involved with this treatment, and I understand that I will be given the opportunity to ask questions at every stage of my treatment. I also understand that there is always the possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named above.

I have had the opportunity to discuss with the doctor and/or the other office or clinic personnel the purpose and benefits of the chiropractic adjustments and other treatments outlined below.

Alternatives to treatment have been reviewed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that there are some risks to treatment. Risks include, but are

not limited to, fractures, disc injuries, strokes, dislocations and sprains. I understand that chiropractic is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results.

Family Chiropractic &
Spinal Health Care Center, LLC

.

I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. We are out of network with most insurance carriers. You are responsible to know your policy. I authorize Family Chiropractic and Spinal Health Care Center and its billing department to re appeal my insurance on my behalf for billing purposes.

I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment for my present condition and for any future condition(s) for which I seek treatment.

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The health care provider further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the health care professional changes as it relates to the patient's health benefits plan, the professional shall notify the patient promptly.

Acknowledgement of Receipt of Disclosures

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ Date _____

Signature

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ Date _____
Signature

PATIENT SIGNATURE:_____DATE:_____

PARENT/GUARDIAN SIGNATURE:_____DATE:_____
(If patient is a minor)

DOCTOR'S SIGNATURE:_____DATE:_____

Family Chiropractic &
Spinal Health Care Center, LLC

Patient Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. We are out of network with most insurance carriers. You are responsible to know your policy. In the event that we do accept assignment of benefits, we require a credit card with authorization, which we will hold, in the event of non-payment otherwise. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract. This physician may order procedures and tests during your visits that may not be covered by your insurance. Should your insurance company not reimburse those who provide these services, UNDERSTAND THAT YOU WILL BE RESPONSIBLE FOR PAYMENT. If this is of concern to you we recommend you contact your insurance company to confirm payment benefits.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

You hereby authorize insurance payment directly to our office. Should payment be sent to you, it is your responsibility to return the check to our office, within seven (7) days of receipt. Failure to do so will result in civil collection proceedings wherein you agree to pay our reasonable attorneys fees and costs for collection as well as potential criminal liability for theft and conversion of funds. You further assign your rights to benefits under your contract of insurance or other third party payment to **Family Chiropractic & Spinal Health Care Center** located at 27 S. Franklin turnpike, Ramsey NJ 07446, and its employees, agents and/or contractors, all benefits payable to you under you insurance policies and health benefits plans.

You hereby further provide **Family Chiropractic & Spinal Health Care Center** located at 27 S. Franklin turnpike, Ramsey NJ 07446 with a limited, irrevocable power of attorney to endorse any checks or other negotiable instruments made payable to you individually or jointly to you and **Family Chiropractic & Spinal Health Care Center**. This power expressly authorizes third parties including but not limited to commercial banking institutions to honor our endorsement on your behalf under this power of attorney and to accept deposit or cashing of any such negotiable instrument. This limited power of attorney shall be immediately effective and shall be durable in that it shall remain in full effect through any disability of the principal granting this power of attorney.

If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Canceling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THIS AGREEMENT.

_____

_____

Patient Name, (Printed) Witness:

_____ Date_____/_____/

_____

Signature

Family Chiropractic &
Spinal Health Care Center, LLC

DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Our Practice Participates With: ***Medicare***

Facilities Our Practice Is Associated with and Addresses: 1) 27 S. Franklin Turnpike Suite 302 Ramsey NJ 07446

If the patient's health plan is not listed above, the physician and/or facilities providing services do not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Licensed Assistant Healthcare Staff:

The following licensed healthcare professionals may perform assistant services on the patient based upon the treatment plan and needs of the patient:

1) NONE

Anesthesia, Radiology, Laboratory, Pathology Services:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

2) NONE

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may not participate with the patient's health insurance plan and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact the patient's health plan or administrator for further consultation on costs associated with these services.

Mandatory Disclosures:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan;

Patient initials: _____

2) I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request;

Patient initials: _____

3) I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided; Patient initials: _____

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of my in-network

copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Patient initials: _____

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Patient initials: _____

_____ Date_____/_____/_____

Signature

Revised 01/26/2022