ADVANCED HEALTH CENTER, P.C.
Angel M. Carrion, D.C. & Lisa D. Noto, D.C.
335-A Main Street Hackensack, NJ 07601

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

DATE _____/_____/_____

PATIENT INFORMATION:

FIRST NAME: _____

LAST NAME:_____

Sex: □M □F Marital Status: □ Single □ Married

DOB: _____/_____/_____ □ Widowed □ Divorced

SS#: _____-_____-_____

ADDRESS: _____ APT#: _____ CITY: _____

STATE: _____ ZIP CODE: _____ EMAIL: _____

HOME #: (_____) _____ CELL #: (_____) _____

EMERGENCY CONTACT: _____ RELATION: _____ PH: (_____) _____

EMPLOYMENT STATUS: □ Unemployed □ Part-time □ Full-time □ Retired

EMPLOYER: _____OCCUPATION: _____

WORK ADDRESS: _____ STATE: ____ ZIP: _____ PH:(_____) _____ EXT_____

HOW DID YOU HEAR ABOUT US? _____ DATE SYMPTOMS BEGAN: _____/_____/_____

PRIMARY PHYSICIAN: _____ PHONE #: (_____) _____ LAST VISIT: _____

FILL OUT BELOW ONLY IF YOU ARE NOT THE PRIMARY ON YOUR INSURANCE

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ INSURED'S DOB: _____/_____/_____

INSURED'S SSN: _____/_____/_____ RELATIONSHIP TO INSURED: □ SELF □ SPOUSE □ CHILD □ OTHER

SUBSCRIBER ID #: _____ GROUP #: _____

CITY:_____ STATE: _____ ZIPCODE: _____ PH:(_____) _____

AUTHORIZATIONS:

1. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

2. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

3. I have read and received a copy of the Financial Policy. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's signature _____ Date_____

Guardian's signature _____ Date _____

ADVANCED HEALTH CENTER, PC
335-A MAIN STREET, HACKENSACK, NJ 07601
201-489-3400 FAX 201-489-3411

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic - Angel Carrion, DC and /or Lisa Noto-Carrion, DC and/or any other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup Doctor of Chiropractic in this office.

I have had the opportunity to discuss with the treating Doctor of Chiropractic, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ Increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of arterial dissections (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: Will consist of specific Chiropractic Adjustments in addition to any other recommended modality as deemed medically necessary by the treating Chiropractor to include but not limited to Myofascial Release, Ischemic Compression, Extremity adjustments, Basic Exercises for strengthening and stretching of muscles, tendons and ligaments of the spine and extremities, Electrical stimulation, Ultrasound and Laser Therapy. Recommendation may also include nutritional supplements to help maintain a healthy body and orthotics for improved balance, foundational stability and structural correction of the feet and lower kinetic chain.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
Print name

_____
Signature of patient

_____
Date signed

To be completed by the patient's representative:

_____
Print name of patient

_____
Print name of patient's representative

_____
Signature of patient's representative

as:_____
Relationship/authority of patient's representative

_____
Date signed

To be completed by doctor or staff:

_____ _____
Witness to patient's signature Date

_____ _____
Translated by Date

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Patient Authorization for appointment reminders and scheduling related matters as well as chiropractic care, related services and/or related health products and information.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments and re-evaluations or other appointment related issues, as well as to advise you about health-related meetings, workshops, products and information.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality health care. If you choose not to authorize this information use, your decision will have no adverse effect on your care from the date of this notice or on your relationship with our staff.

Your signature indicates your authorization of this activity.

_____	_____	_____
Name (Print)	**Signature**	**Date**

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

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335A MAIN STREET, HACKENSACK, NJ 07601

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at **Advanced Health Center, P.C.,** we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.
- If you are not home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or require to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your personal health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy, or amend your health-related information should be in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the change. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice our privacy practices or any aspect to our privacy activities you should contact Dr's Angel & Lisa Carrion.

If you would like further information about our privacy policies and practices, please contact Dr's Angel & Lisa Carrion.

This notice is effective as of the date of your signature below. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____	_____	_____
Name (printed)	***Signature***	***Date***

If you are a minor, or if you are being represented by another party

_____	_____	_____
Personal Rep. (Print)	***Personal Rep. Signature***	***Date***

_____

Description of authority to act on behalf of the patient.

ADVANCED HEALTH CENTER, PC
335A MAIN STREET, HACKENSACK, NJ 07601
OFFICE POLICY

We believe that a clear definition of our office policies will allow both you the patient and us the doctor to concentrate on the big issue – **RECLAIMING AND MAINTAINING YOUR HEALTH.**

APPOINTMENT POLICY

Multiple appointments have been given for your convenience, to minimize waiting and to facilitate incorporating these appointments into your daily routine.

Regardless of how many appointments are scheduled for you each week, please note that it is the frequency of visits that counts and not the days.

Therefore, if you are unable to keep an appointment for any reason, we require that you call immediately to reschedule your visit at **(201) 489-3400**. It is your obligation to make up a missed appointment within **7 days** of any cancellation.

We attempt to honor all appointments at the scheduled time. If you are late you may have to wait for the next available appointment. Please note that the Doctor at times may have an emergency situation with a patient which requires more of her/his time. If there are any questions, speak with the Doctor during your visit time.

FINANCIAL POLICY

1. **Patients with no insurance:**

   All payments are expected at the time of service or at the end of each week. Patient balances may not exceed $150.00 at any time unless other agreements have been made, or professional care may be terminated.

2. **Patients with insurance:**

a. **In-network** – This means that our Doctors are providers with your insurance company. All co-payments are expected at the time services are rendered. Deductibles and all co-insurance payments will be billed to you the patient at the time this office receives an Explanation of Benefits from your insurance company explaining your responsibility.

b. **Out of network** - This means that our Doctors are not providers with your insurance company. Deductibles and co-insurance payments are due at the time services are rendered. Also deductibles and all co-insurance payments will be billed to you the patient at the time this office receives an Explanation of Benefits from your insurance company explaining your responsibility.

INSURANCE POLICY

It is the policy of this office to extend to our patients the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of–pocket expense and allows you to place your family under chiropractic care.

1. The **privilege** of insurance assignment begins when your insurance forms are received by our office.

2. All deductibles payments MUST be made prior to insurance submittal.

3. Our office will qualify your insurance coverage in an effort t help you determine exactly what chiropractic coverage is available to you under your policy. This information must be confirmed by you the patient and does not reflect any guaranteed accuracy.

4. All co-payments are payable when service is rendered or at the end of each week. (Co-payment is that part of our service that is not paid for by your insurance). A $150.00 co-payment balance must not be exceeded by any patient.

5. This office does not file for or accept co-payment for **secondary** insurance carriers, but will be happy to assist you in collecting from the secondary carrier.

6. Since we **do not own your policy** and since from time to time we experience difficulty in collecting from your insurance company and since insurance assignment is a privilege it may be terminated at any time. Of course, we will give you ample notice and ask that you act in your own behalf with your **insurance company.**

7. All patient's whose visitation schedule is once per month or longer will no longer be eligible for insurance assignment. Charges for services rendered will again be due as they are rendered or at the end of each week. We will continue to assist you in collecting from your insurance company.

8. This office **does not** promise that an insurance company will pay for the usual and customary charges of this office nor will this office enter into any dispute with an insurance company over reimbursement or the amount of reimbursement.

9. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately due and payable in full by you, regardless of any claims submitted.

10. When making a health care decision it is important to remember that you the patient are ultimately financially responsible for any services rendered.

11. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care or any of our policies, please let us know. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

Signature:_____ **Date:**_____

Print Name:_____