

Absolute Chiropractic
Family Care of Woodbridge

Patient Information

Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Age: _____ Sex: F ___ M ___ Height: _____ Weight: _____
Home Phone: _____ Cell Phone: _____
Email: _____ Occupation: _____
Emergency Contact: _____ Phone Number: _____
Relation to Patient: _____

Insurance Information

Primary Ins: _____ Member ID: _____
Subscriber: _____ Subscriber DOB: _____
Relation to Patient: _____

Secondary Ins: _____ Member ID: _____
Subscriber: _____ Subscriber DOB: _____
Relation to Patient: _____

Current Health Condition

Reason for Visit: _____
Previous Chiropractic Tx: YES / NO If yes, who, when? _____
When Did Condition Begin? _____
Has Condition Occurred before? YES / NO If yes, when? _____
Previous Tx for Condition? YES / NO If yes, who, when? _____
Is Condition A: __ Home Injury __ Work Injury __ Auto Injury __ Slip & Fall
If other, please explain: _____
Current Medications: _____

Extra Info: _____

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



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Past Medical History

Please check any of the following that you have had:

- Arthritis Cancer Chicken Pox Diabetes Eczema Epilepsy Flu Covid
 Heart Disease Mental Disorders Pneumonia Thyroid Issues Back Pain Measles
 Mumps Pleurisy Polio Rheumatic Fever Tuberculosis High Blood Pressure Stroke

Not Listed: _____

Past Fractures: _____

Past Surgeries & Dates: _____

ALL Allergies: _____

Please check any of the following that you are currently experiencing.

Musculoskeletal: Arm Pain Clicking Jaw/Difficulty Chewing Difficulty Walking
 Joint Pain/Stiffness Leg/Ankle Pain Low Back Pain Mid Back Pain Neck Pain 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

For Women: 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

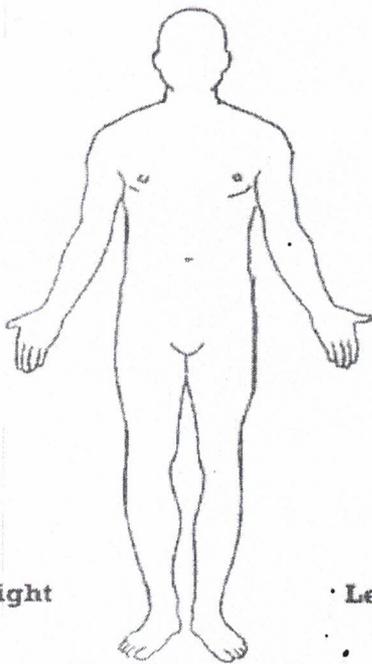
Not Listed: _____

Do You Smoke: YES / NO If yes, how many packs per day? _____

History of Drug Use? YES / NO Number of Alcoholic Drinks Per Day: _____

No Pain Low Moderate Intense Unbearable
0 1 2 3 4 5 6 7 8 9 10

Indicate the location and type of your pain



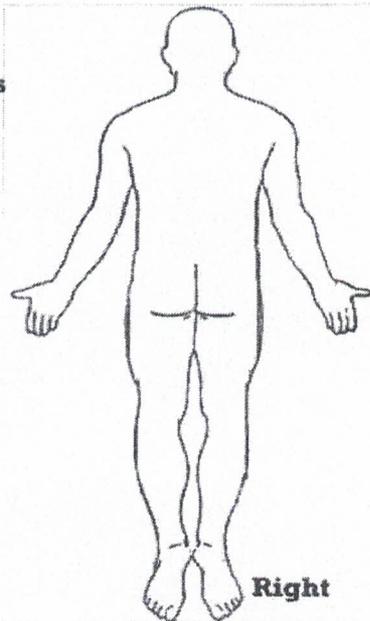
Right

Left

Front

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XXXXXX
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Keys
Pins & Needles
Burning
Stabbing
Numbness
Aching

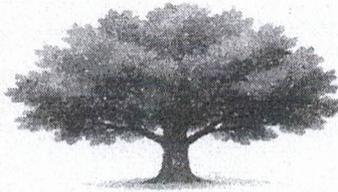


Left

Right

Back

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



Absolute Chiropractic
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Informed Consent Document

Patient Name: _____

The nature of the chiropractic adjustment.

The primary treatment used by Doctors of Chiropractic is spinal manipulation therapy. I will use that procedure to treat you. I may use my hands or mechanical instruments on your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you've experienced when you "crack" your knuckles. You may also feel a sense of movement.

Analysis / Examination / Treatment

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

- Spinal Manipulation 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: _____

The risks inherent in chiropractic treatment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation & therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains & separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading or contributing to serious complications including stroke. Some patients will feel some stiffness & 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 a result from some underlying weakness of the bone, which we check for during your initial examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research & 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 & remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.



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Informed Consent Document cont'd

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 & 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's postponed.

Consent to Treatment of Minor

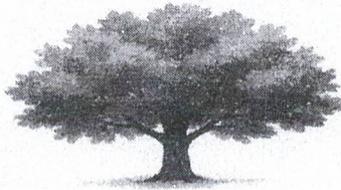
I hereby request and authorize "**Absolute Chiropractic Family Care of Woodbridge**" to perform diagnostic tests and render chiropractic treatment to my minor child:_____. This authorization extends to all other doctors and office staff and is intended to include radiographic examination at the Doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare services for the minor child named above. (If applicable) Under the terms & 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 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 the office and have had my questions answered to my satisfaction. By signing below, I confirm that I have weighed the risks involved in undergoing treatment and have decided it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby consent to that treatment.

Patient/Guardian Signature & Date:_____ Dr. Signature & Date:_____



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Direct Assignment of Benefits & Rights

Provider: Dr. Laura Funk Patient: _____ Date: _____

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

1. **RELEASE OF INFORMATION:** I authorize the release of my medical information related to my condition to any insurance company, attorney, or claims adjuster as necessary to process & facilitate the payment of benefits for services provided at your facility. I assign all rights to receive payment for these services directly to your facility.

2. **RIGHT TO RECEIVE PAYMENT:** I give my full and permanent permission for my chiropractor to receive direct payment from my attorney or any insurance company that owes me money related to my care.

3. **ASSIGNMENT OF RIGHT TO SUE:** If any insurance company or attorney who is supposed to pay me for your services refuses to do so when you request it, I permanently assign to you the right to take legal action against them on my behalf. I also understand that I am responsible for paying any amount you are unable to collect from the insurance or attorney.

4. **RIGHT TO LEIN:** I give my chiropractor a permanent right to place a lien on any claims I have against a third party whose negligence may have caused my injury, including their insurance, for the full amount of my treatment. I also give clear and permanent instructions to my attorney to pay your office in full for services related to my injury before giving any settlement, judgment, or other proceeds to me. My attorney or representative must pay your office first, and they are not allowed to reduce your bill in any way. I agree to pay the full amount for all services you provided.

5. **RIGHT FOR INFORMATION:** I give permanent permission for my attorney, insurance company, or anyone involved in my case or care to share financial information with you. This includes details about proposed settlements or verdicts, payments, amounts owed, liens, bills, and balances—whether from other providers or legal representatives. I also instruct all parties to provide full financial details related to all parts of my case, including third-party claims, uninsured motorist, and underinsured motorist coverage.

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

7. **I understand that I am receiving (or will receive) healthcare services**, and that the provider is willing to wait for payment—as long as there is a reasonable chance the bill will be paid through insurance or from a settlement. However, if either: (a) there is no insurance that is required to pay, or the insurance company refuses to honor the assignment or protect the provider's rights, or (b) I have a liability claim but my attorney will not agree to protect the provider's interests, or I do not have an attorney, then I agree to pay for all services immediately and keep my account current. In any case, I promise to pay the full balance no later than 10 days after my case is settled—or within 3 months of my last treatment date—whichever comes first.

8. If payment for any services under this agreement becomes overdue, the patient (or the patient's guardian) agrees to pay all costs related to collecting the debt. This includes court fees, attorney's fees, fees for serving legal papers, and any other reasonable expenses involved in getting the payment.

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



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Hardship Agreement

To Whom It May Concern:

By signing below, I am requesting that if my financial situation changes and I cannot afford the usual fees, my doctor reduce the fees so that I am able to continue receiving chiropractic care.

I understand that any special fee arrangement made to help me is confidential and different from the standard fees at this office.

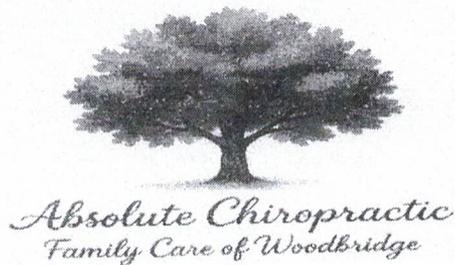
If my insurance requires full payment of deductibles or co-pays, I agree it is my responsibility to inform my insurance company that, due to financial hardship, I am making only partial payments.

Print Patient Name

Signature

Doctor Signature

Date



245 Main St. Woodbridge, NJ 07095

Privacy Policy

We may share your private health information (PHI) if required by a court order or if you are involved in a lawsuit or similar legal matter. We may also release your PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the case.

We may use or share your private health information (PHI) as needed for workers' compensation claims or similar programs that provide benefits for work-related injuries or illnesses.

We may use a sign-in sheet at the front desk and may call your name when it's time to see the doctor. We may also contact you by mail or phone at your home to remind you about appointments or to share information about treatment options. Unless you tell us not to, we may send appointment reminder postcards and leave messages on your voicemail or with someone who answers your phone.

You may ask us to contact you in a specific, confidential way. Your request must be in writing and clearly explained. While we are not required to accept your request, if we do agree, we will follow it—unless the law requires otherwise, there is an emergency, or the information is needed to treat you.

Rights that you have:

You have the right to ask us to limit how your private health information is used or shared, as described above.

You have the right to look at and get copies of your medical records. We may charge a fee to cover the cost of copying and mailing your records.

You have the right to ask us to correct or update your medical records. Your request must be in writing and include a reason for the change. We will let you know if we approve or deny your request. If we deny it, we will also inform you of your rights regarding that decision.

You have the right to ask for a list of certain times we have shared your private health information (PHI). This does not include disclosures made for treatment, payment, or healthcare operations, ones you authorized in writing, or those allowed or required by law under 45 CFR 164.502—such as for emergencies, national security, or to law enforcement or correctional facilities.

You have the right to get a paper copy of this notice. To request one, please contact our office manager.

If you believe your privacy rights have been violated, you have the right to file a complaint with our office or with the **Secretary of the U.S. Department of Health and Human Services**. Complaints must be in writing and sent to our office at the address listed above. You will not be punished or penalized for filing a complaint.

This privacy policy may change as needed. Any updates will take effect when a new version is released, and patients can request a copy of the updated policy.

Please sign and date below to confirm that you have read and agree to the terms of this privacy policy.

Print Patient Name

Signature

Date