ADVANCED BACK AND NECK CARE
227 MADISON AVENUE
LUMBERTON, NJ 08048
6092617562

C0VID-19 Screening Form and office protocol for patients

Please answer the following questions by circling YES or NO

NO YES Have you bad a cough, shortness of breath, difficulty breathing, fever (temp 100.5 Fahrenheit or greater) chills, unexplained repeated shaking with chills, muscle pain, unexplained headache, sore throat or new onset loss of taste or smell in the last 14 days?

NO YES Have you had close, unprotected, contact with a suspected or laboratory-confirmed COVID-19 individual in the last 14 days?

NO YES Have had a laboratory confirmed or suspected diagnosis of COVID-19 in the past 14 days?

NO YES Have you or someone you had close contact with traveled to other states where COVID-19 cases have been spiking, internationally or been on a cruise in the last 14 days?

- New patients are encouraged to fill out paperwork in their vehicles if possible.
- Mouth and Nose coverings are mandatory for admission
- Guests/family of patients are encouraged to stay in their vehicles if possible.
- Upon entry please sanitize, have your temperature taken by staff and wash your hands. If you choose to wear gloves please put them on upon entry to lessen the likelihood of contaminants
- All staff and patients are encouraged to wash hands frequently
- Signs are posted on the ceiling to ensure social distancing

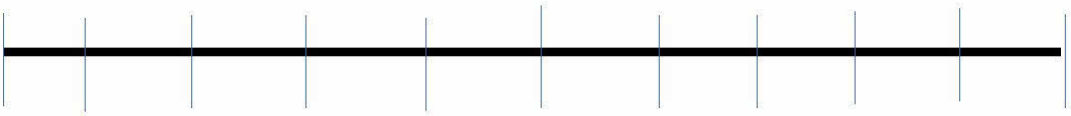
name_____ signature_____date___/___/____

ADVANCED BACK AND NECK CARE
OUTCOME

PATIENTS NAME: _____ **DATE:**_____

PAIN

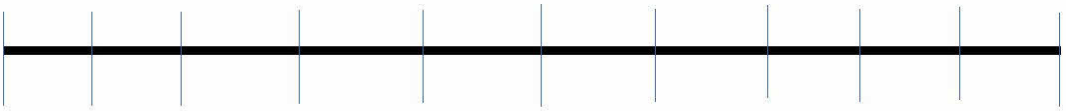
On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain, place an "X" on the scale below to rate your current level of pain.



No pain 0 | mild pain 2 | moderate pain 4 | severe pain 6 | very severe pain 8 | worst possible pain 10

MOTION

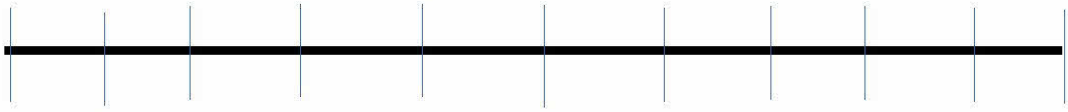
On a scale of 0 to 10, with 0 being normal and 10 being unable to, place an "X" on the scale below for your current ability to perform simple movements (reaching overhead, making a fist,bending over, ect...).



no limitation 0 | mild limitation 2 | moderate limitation 4 | severe limitation 6 | very severe limitation 8 | unable to perform 10

FUNCTION

On a scale of 0 to 10,with 0 being able to perform your entire normal daily activities, and 10 being that you are unable to perform any of your normal daily activities, place an "X" on the scale below your current ability to perform your normal daily activites.



no limitation 0 | mild limitation 2 | moderate limitation 4 | severe limitation 6 | very severe limitation 8 | unable to perform 10

PATIENT INFORMATION

LAST NAME:_____ **FIRST NAME:**_____

SOCIAL SECURITY #:____-____-_____ **EMAIL:**_____

_____

ADDRESS **CITY** **STATE** **ZIP**

HOME #:_____ **MOBILE #:**_____ **OTHER#:**_____

EMPLOYER'S NAME:_____

_____

EMPLOYER'S ADDRESS **CITY** **STATE** **ZIP**

DESCRIBE YOUR JOB DUTIES:

DATE OF BIRTH:_____-_____-_____ **SEX:** M[ ] F[ ]

MARITAL STATUS:_____ **SPOUSE NAME:**_____

PRIMARY INSURANCE COMPANY/PHONE#:

_____

POLICY #/ID#/WCB#:_____

POLICY HOLDER/PCP:_____

CLAIM #:_____

SECONDARY INSURANCE/PHONE#:

_____

POLICY#/ID#:_____

POLICY HOLDER/PCP:_____

CLAIM#:_____

Briefly describe your injuries and how they happened:_____

_____

_____

DATE OF ACCIDENT/ONSET OF SYMPTOMS:_____

ATTORNEY/PHONE # :_____

LIEN NF WC MM(_____) MC **COPAYS: [ ] BALANCE BILLED [ ] PAY DAILY (check one)**

Assignment of Insurance Benefits

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO ***ADVANCED BACK AND NECK CARE P.C.*** I HEREBY ASSIGN TO ***ADVANCED BACK AND NECK CARE P.C.*** ALL RIGHTS, PRIVELEGES, AND REMEDIES WHICH I AM ENTITLED UNDER THE STATE INSURANCE LAW. ANY PAYMENT PURSUANT TO THIS ASSIGNMENT SHALL NOT EXCEED THE HEALTH CARE PROVIDER'S PERMISSIBLE CHARGES.

_____

SIGNATURE (IF MINOR, PARENT/GUARDIAN)

AUTHORIZATION FOR THE RELEASE OF HEALTH SERVICE AND TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT INCLUDING THE HISTORY OBTAINED, XRAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

_____

SIGNATURE (IF MINOR, PARENT/GUARDIAN)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

_____/_____/_____

TODAY'S DATE

NOTICE OF DOCTOR'S LIEN

I do hereby authorize **Advanced Back and Neck Care PC**. to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc, of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and is consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Date:_____ Patient's Signature:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date: _____ Attorney's Signature: _____

(Please date, sign and return one copy to doctor's office. Keep one copy for your records)

Date Of Accident: _____

NAME: _____

Patient Disclosure Consent

The HIPAA privacy rules give individuals the right to request a restriction of uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications be made via alternative means such as sending information to the individuals place of employment instead of their home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply).

Home telephone: (_____) - _____ - _____

- ☐ Allowed to leave a detailed message
- ☐ Leave a message with a callback number only.

Work telephone: (_____) - _____ - _____

- ☐ Allowed to leave a detailed message
- ☐ Leave a message with a callback number only.

Cell phone number: (_____) - _____ - _____

- ☐ Allowed to leave a detailed message
- ☐ Leave a message with a callback number only.

Emergency Contact

Name: _____ Relationship:_____

Number: (_____)-_____-_____

- ☐ Allowed to leave a detailed message.
- ☐ Leave a message with a callback number only.

PRIVACY RULES REQUIRE US TO TAKE REASONABLE STEPS TO LIMIT THE USE OR DISCLOSURE OF YOUR INFORMATION TO THE MINIMUM NECESSARY TO ACCOMPLISH THE INTENDED PURPOSE. USES AND DISCLOSURES ARE PERMITTED WITHOUT PRIOR CONSENT AN EMERGENCY. MY SIGNATURE ALSO IMPLIES I RECEIVED THE GENERAL OFFICE PRIVACY GUIDELINES.

SIGNATURE PRINT NAME DATE

Advanced Back and Neck Care PC

227 Madison Avenue, Lumberton NJ 08048
609-261-7562
abnc227@outlook.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Upon request, we will give you a copy of your records within 15 days of the request. State board and HIPAA Rules allow us to charge a reasonable fee for these records (1$ per page). If you would like a copy of your records in electronic format, we recommend that you purchase an encrypted thumb drive.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

HIPAA Privacy Officer, Dr. Xerxes Oshidar
609-261-7562
abnc227@outlook.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorization

I hereby authorized the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or care provider, the released of information may no longer be protected by federal privacy regulations.

Patient name: _____ DOB: _____

Persons/Organizations providing the information:

_____
_____
_____
_____
_____

Persons/organizations receiving the information:

ADVANCED BACK AND NECK CARE
Xerxes Oshidar D.C
227 Madison Ave
Lumberton, NJ 08048
PH: 609-261-7562 FX: 609-228-7411

Specific description of information (including date(s)): ER DOCUMENTS/RADIOLOGY

Section B: Must be completed only if a health care provider has requested the authorization

1- The health plan or care provider must complete the following:
A- What is the purpose of the use or disclosure? _____
_____
_

B- Will the health plan or care provider requesting the authorization received financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes____ No **_X_**

2- The patient or the patient's representative must read and initial the following statement:
a- I understand that my health care and the payment for my health care will not be affected if I do not sign this form .
Initials: _____

b- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initials: _____

Section C: Must be completed for all authorization

The patient or the patient's representative must read and initial the following statement:
1- I understand that this authorization will expired on __01_/__01_/__2022___ (DD/MM/YYYY) Initials: _____
2- I understand that I will revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation. Initials: _____

_____ _____
Signature of patient or patient's representative Date
(form MUST be completed before signing)
Printed name of patient's representative: _____
Relationship to the patient; _____

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ***

You may not use this form to release information for treatment or payment except when the information to be released is CHIROPRACTIC notes or certain research information