GARDEN STATE ORTHOPAEDICS

Patient Registration Form

Account #: ______________ Date: ____________________ Referred by: Dr. ___________________________

Attorney__________________________________

Patient Name: ____

Address:____

City:____________________________________ State:_________ Zip:___________

Email: ____

Home phone #:______________________ Other phone#:_________________________ ☐ cell ☐ work (please specify)

Referring Physician_________________________ Address ____________________________ Phone Number________________

City__________________________ State __________ Zip _________________

Family Physician ___________________________ Address ____________________________ Phone Number________________

City__________________________ State __________ Zip _________________

Attorney __________________________________ Address ____________________________ Phone Number________________

City__________________________ State __________ Zip _________________

Sex: _______ Date of Birth: _____________________ Age: ________ SSN: ______-_____-__________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed

Employer Name: ____________________________________ Phone: _____________________________

Address: ____ Occupation: _________________________

City :____ State: _____________ Zip: _______________________

TYPE OF ACCIDENT

Date of accident: _______________________

☐ Motor Vehicle Accident – Is your health insurance primary? Yes No

☐ Work related

☐ Medical

☐ Other: please specify place of accident: ______________________________

INSURANCE INFORMATION

Primary Insurance Carrier: _____________________________ Claim/policy number: _______________________

Address: ____ Policy Holder: ______________________________

City: ____ State: _________ Zip:_______________________

Adjuster: __________________________________ Phone #: _______________________ Fax #: ___________________

Did you file an accident report? Yes No

Secondary Insurance Carrier: ________________________________ Policy #: __________________________________

Address: ____ City: ______________________ State: _______ Zip: _________

Relationship to subscriber: _________________________

REASON FOR VISIT:

☐ Medical ☐ Accident related

If accident, state cause: ☐ Auto accident ☐ Auto accident work related ☐ At work ☐ At home
☐ Fall on another's property ☐ At school ☐ Other ________________________

Date of accident: __________________________ Did you go to a hospital/ER? ☐ YES ☐ NO

If yes, where? ____________________________ Were you taken by ambulance? ☐ YES ☐ NO

Were x-ray-rays taken? ☐ YES ☐ NO If yes, of what body part(s)? _________________________

ACCIDENT INFORMATION

Where did this accident/injury take place? ____

How did it happen? ____

What body parts were injured during the accident? ____

What was your position sitting in the vehicle?

☐ Driver ☐ Front passenger ☐ Rear right ☐ Rear left ☐ Other___________________

Were you wearing a seat belt? ☐ YES ☐ NO

Was your car ☐ Moving ☐ Stopped in traffic ☐ Stopped?

If moving, what was your approximately speed at the time of impact? ___________mph

Were you ☐ hit ☐ hit another vehicle?

If you were hit, where? ☐ rear ended ☐ back driver's side ☐ back passenger's side ☐ head on
☐ front driver's side ☐ front passenger's side ☐ other______________________

If you were the driver, did you have both hands on the steering wheel? ☐ YES ☐ NO

If you were the passenger, did you brace with your hands on impact? ☐ YES ☐ NO

Did any part of your body come in contact with any part of the vehicle? ☐ YES ☐ NO

If yes, describe: ____

Describe your body movement at the time of impact: ____

____

How many vehicles were involved in the accident? ______________

Did you lose consciousness? ☐ YES ☐ NO If yes, for how long? ____________________________________

Since the accident/injury, do you have trouble with the following? (please check all that are appropriate)

☐ physical exercise ☐ bending ☐ crawling ☐ sitting ☐ stiffness ☐ driving
☐ walking ☐ standing ☐ lifting ☐ kneeling ☐ climbing stairs
☐ sleeping ☐ overhead work ☐ getting up in the morning

Since the accident/injury, what are you having trouble doing (include sports, problems at work, household chores, etc.)?____

Due to your injuries, what are your current symptoms? ____

☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Fainting ☐ Nervousness

Do you have pain in your: ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Mid back
☐ Low back ☐ R shoulder ☐ L shoulder ☐ R arm ☐ L arm ☐ R hand
☐ L hand ☐ R wrist ☐ L wrist ☐ R leg ☐ L leg ☐ R knee ☐ L knee ☐ R foot
☐ L foot ☐ R ankle ☐ L ankle

Are there any complaints of numbness or tingling? ________________

How frequent is your pain? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

What makes the pain worse? ____

What makes the pain better? ____

Did you seek treatment with a doctor after the hospital? ☐ YES ☐ NO

Name of Doctor	Specialty	Date of 1st visit	Still treating Yes or No

What test did you have done?	Location of test	What body part(s)
X-ray		
MRI		
CT Scan		
EMG		

Did you have any physical therapy treatment? ☐ YES ☐ NO If yes, where? ______________________________

Did you have any chiropractic treatment? ☐ YES ☐ NO If yes, where? ______________________________

When did you start treatment? ________________ Are you currently going? ☐ YES ☐ NO

What type(s) of treatment have you received? ☐ Hot packs ☐ Electric stimulation ☐ Exercise

☐ Ultrasound ☐ Traction ☐ Ice ☐ Manipulation

☐ Other____

How often do you or did you go? ____________________ How long did you go? ____________________

Has it been helpful? ☐ YES ☐ NO

Have you missed any work due to the accident? ☐ YES ☐ NO If yes, how long? ____________________

MEDICAL HISTORY

Height__________ Weight__________ ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Have you had any prior motor vehicle accidents or significant injuries? ☐ YES ☐ NO If yes, when? __________

What areas of the body were involved in any PRIOR accident? ______________________________

Were these injuries resolved prior to your current injuries? ☐ YES ☐ NO

If no, what complaints remained? ____

Are you still treating for these injuries? ☐ YES ☐ NO

List any fractures/sprains: ____

List any surgeries: ____

Current medical problems: ☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Epilepsy/seizure disorder
☐ Heart attack ☐ Migraines ☐ Stroke ☐ Cardiac disease ☐ Ulcers ☐ Cancer
☐ Anemia ☐ Thyroid disease ☐ Other____________________

List current medications: ____

Are you allergic to any medications? ☐ YES ☐ NO

If yes, please list medications: ____________________________________

EMPLOYMENT HISTORY (if work-related)

When the accident/injury occurred, did you have a job? ☐ YES ☐ NO

Job title: ______________________________

Job description: ______________________________ ☐ Full time ☐ Part time__________hrs/wk

Job duties: Lifting/carrying______________lbs. Sitting____________________hrs/wk

Standing________________hrs/wk Walking__________________hrs/wk

Did you miss time from work due to accident/injury? ☐ YES ☐ NO Date first missed work: ____________

If yes, how much time? __________________ days/months Date returned to work: ______________

Employer for work comp claim at time of injury: ________________________________

Hours worked weekly: _______________________ Years at job: __________

Are you actively working now? ☐ YES ☐ NO

If yes: ☐ same job (same duties) ☐ same job (different duties) ☐ new job ☐ side jobs

☐ Any work restrictions? ____

☐ List duties____

Employment history (last five years):

Employer's Name	Job Description	Years Worked

SOCIAL HISTORY:

Do you use tobacco? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

How many packs of cigarettes per day? _________

How many drinks per day? __________

How many years have you smoked? ____________

If you quit, when? ___________________

FAMILY HISTORY:

Have any family members had the following:

☐ diabetes, who? _______________________

☐ cancer, who? _____________________

☐ heart disease, who? ___________________

☐ arthritis, who? _____________________

☐ other disease(s), who? ______________________________________

PATIENT'S SIGNATURE: ____

TODAY'S DATE: ____

PATIENT NAME: ______________________________________ DATE: ______________________

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS

Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses or contacts	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problem or rhinitis	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitation	YES	NO
Shortness of breath with walking or lying flat	YES	NO
Swelling of feet, ankles or hands	YES	NO

RESPIRATORY

Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change in bowel movements	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movement or constipation	YES	NO
Rectal bleeding or blood in stool	YES	NO
Abdominal pain or heartburn	YES	NO
Peptic ulcer (stomach or duodenal)	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression/Insomnia	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty walking	YES	NO

INTEGUMENTARY (Skin, Breast)

Rash or itching	YES	NO
Changes in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Skin becoming dryer	YES	NO
Change in hat or glove size	YES	NO

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO
Enlarged glands	YES	NO

GENITOURINARY

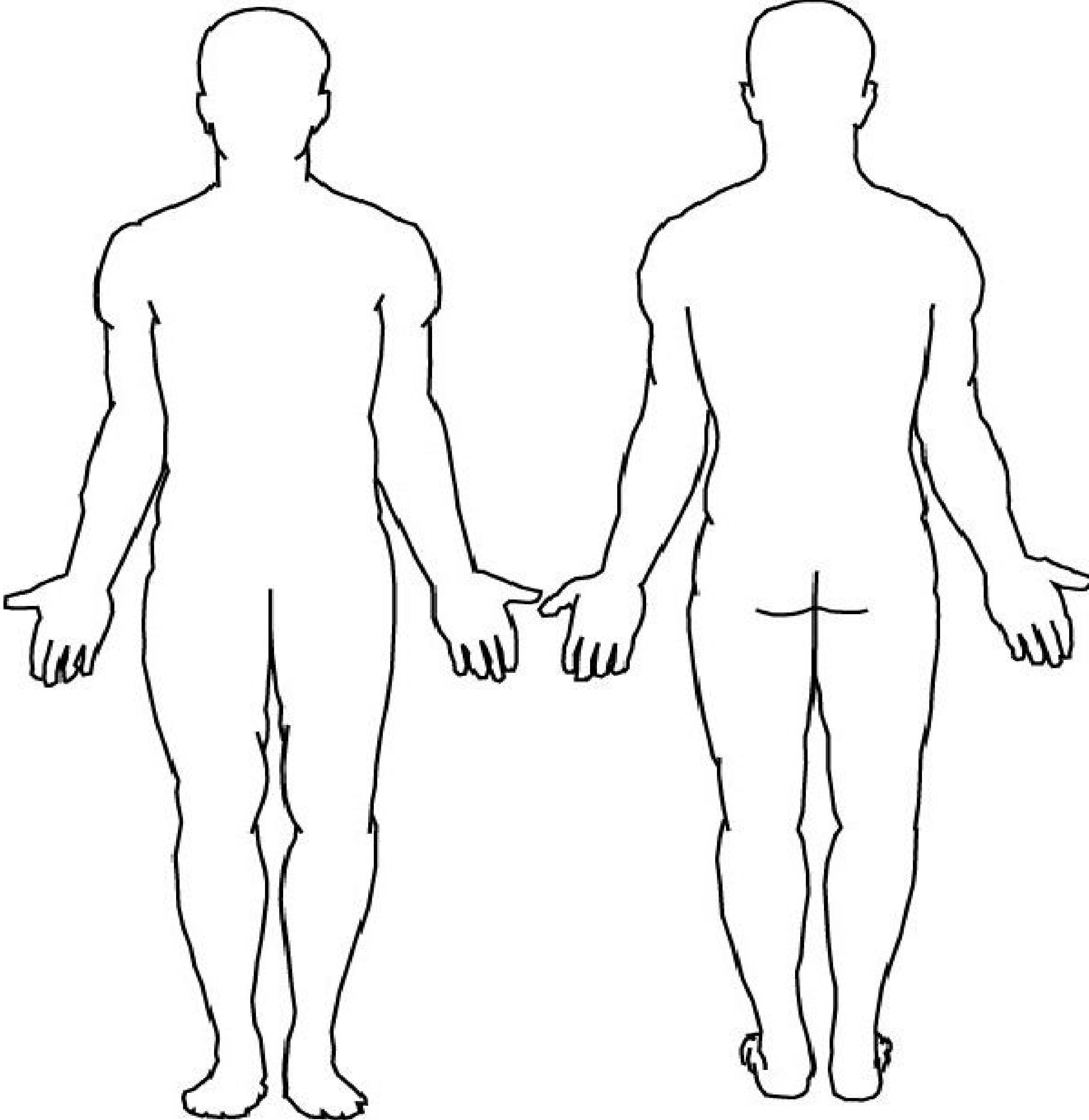
Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force/strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male - testicular pain	YES	NO
Female - pain with periods	YES	NO
Female - irregular periods	YES	NO
Female - vaginal discharge	YES	NO
Female - number of pregnancies	#_______	
Female - number of miscarriages	#_______	
Female - date of last pap smear	_________	

PAIN DRAWING

Using the symbols giving below, mark the area(s) on your body where you feel the described sensations.   Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	. . .

FRONT **BACK**



Pain in the arm(s) compared to the neck: ☐ worse ☐ same ☐ less
Pain in the leg(s) compared to the back: ☐ worse ☐ same ☐ less

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Consent for Treatment
The undersigned hereby consents to any medical services rendered to the patient by the physicians, employees and contracted healthcare providers of Garden State Orthopaedics.

Authorization to Release Information
The undersigned authorizes Garden State Orthopaedics (GSO) to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to GSO that may be required to assist GSO in patient's diagnosis and/or treatment.

Assignment of Insurance Benefits
As a convenience to our patients, Garden State Orthopaedics will bill your insurance carrier directly. I hereby assign, transfer, and set over to GSO all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining precertification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA Privacy Policy
The undersigned acknowledges that he/she received a copy of GSO's notice of privacy policy as required by HIPAA.

Financial Responsibility
The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all and any unpaid portion of the bill incurred. The bill may include this office's administrative fees, such as no-show fees and fees for filling out disability forms. I further understand the unpaid section of the bill may be insurance deductibles, coinsurance, co-payments, or the entire bill if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duty authorized representative of the patient and accepts and consents to the above terms.

____ ____________________

Signature of patient/authorized representative Date

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Assignment of Benefits

Policy#: ______________________________ Claim #: ______________________________________

Patient's Name: ______________________________ Medical Provider: Garden State Orthopaedics

I Authorize and request my insurance company to pay directly to Garden State Orthopaedics and Sports Medicine, the amount due under the terms of the above referenced policy pertaining to the medical care rendered by Garaden State Orthopaedics. provider's office.

____ ______________________

Sign Date

I have read the information sent by my insurance carrier concerning the Decision Point Review plan, including any pre-certification requirements and, as a condition precedent to the insurance carrier acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office to the following:

1. I (we) have complied and will comply with all the procedures identified within the plan.
2. I (we) will comply with all requests for additional information form the insurance carrier concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, casual relationship to the injury and care plan and if necessary, submit to Examination Under Oath.
3. I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the plan.
4. I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the plan until there is a final determination of the internal Appeal Procedure of the dispute.
5. In the event that I (we) fail to comply with the requirements of the plan, and such failure results in the imposition of a co-payment penalty, we will not hold the patient responsible for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the plan.

The Insurance Carrier does not provide coverage for any insure or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident/injury or loss for which coverage or benefits are sought.

I (we) understand that the insurance carrier has the right to reject this assignment of benefits.

L. Barr

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HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: ____

Signature: ____

Date: ____

PLEASE NOTE THAT IF YOU WOULD LIKE TO READ AND/OR NEED A COPY OF HIPAA NOTICE OF PRIVACY PRACTICES PLEASE SEE THE FRONT DESK RECEPTIONIST

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Financial Agreement

I hereby authorize and direct you, my insurance company, and or my attorney to pay directly to Garden State Orthopaedics such sums as may be due and owing this office for services rendered me both by reason of accident, or illness and by reason of any other bills that are due the office, and to withhold such sums from any disability benefits, medical payment benefits. No fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of benefits form to the extent of the office's services provided.

In the event my insurance company refuses to make such payments upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this office to compromise, settle or otherwise resolve said claim or cause of action they see fit.

I understand that I am financially responsible to Garden State Orthopaedics for the total amount due and/or for any amount not covered by my insurance for their services, or in the event of no recovery upon settlement. I further understand and agree that this assignment, lien and authorization does not constitute any consideration of the office to await payment and they may demand payments from me upon rendering services at their option.

In the event your account with Garden State Orthopaedics is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court costs will be added to your total amount.

I authorize Garden State Orthopaedics to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien and authorization and I understand that Garden State Orthopaedics will be using my social security number as identification. I agree that the above-mentioned office be given the power of attorney and to endorse/sign my name on any and all checks for payment of services rendered.

I certify that the information provided to Garden State Orthopaedics regarding the injuries I sustained in my accident is honest and truthful.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE LISTED ITEMS IN THESE PARAGRAPHS.

Signed: ______________________________ Date: ____________________

(Patient or Guardian)

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: ______________________

GARDEN STATE ORTHOPAEDICS
1030 NORTH KINGS HIGHWAY
SUITE 200
CHERRY HILL NJ 08034

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)

Gender: Male / Female

List any aliases, maiden names or other names you use or have used in the past

Home Phone: ( ) -

Cell Phone: ( ) -

Work Phone: ( ) -

Your Address (No. & Street, City/Municipality, State, County & Zip Code

Date of Birth

Social Security No. (if none, enter "none")

Your Previous Address (If you lived at the above address for less than 2 years from the accident date)

Email:

Date of Accident

Time of Accident
AM PM

Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes No
Name of Insurance Company ____
Does anyone living in your residence own a vehicle? Yes No
Name of Insurance Company ____
Do you have health insurance? Yes No
Name of Insurance Company ____

	Yes	No
Were you the driver of the vehicle?		
Were you a passenger in the vehicle?		
Were you a pedestrian?		
Were you a member of vehicle owner's household?		

As a result of this accident were you injured? Yes X No If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: ____ Date: ______________________

Describe your injury: ____

Were you treated by a doctor? Yes No

Doctor's Name and Address

If you were treated in a hospital, were you an In-patient? Out-patient?

Hospital's Name and Address

Amount of Medical Bills to Date: $______________

Will you have more medical expenses? Yes No

At the time of your accident, were you in the course of your employment? Yes No

Did you lose wages or salary as a result of your injury? Yes No
If yes, amount loss to date: $ ________.______

What is your average weekly wage or salary? $_______________

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under: Yes No
(1) Any Workers' Compensation Law?
(2) Employees' Temporary Disability Benefit Statute?
(3) Medicare?

If yes, amount: $____________ Per week Per month

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) ______________________________

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes No If your answer is "Yes", explain on reverse side.

Signature: ____ Date: ______________________

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization, I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Signature: ____ Date: ______________________

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PIP Payout Ledger and Automobile Insurance Declaration Page Authorization Form

Dear Patients:

You have indicated to us that you were involved in a motor vehicle accident. As a courtesy to you we will file for benefits under your Personal Injury Protection Coverage (PIP) so that we may be reimbursed for the treatment you receive. On occasion, in certain situations, we may need to know your policy limits and what is available on your claim for billing purposes. Please sign the following page granting us permission to obtain this information.

- ✓ I hereby authorize Garden State Orthopaedics to contact my insurance company to request and obtain the Declaration Page of my auto policy.
- ✓ I hereby authorize Garden State Orthopaedics to contact my insurance company to request and obtain the PIP Payout Ledger.

Automobile Insurance Company

Insurance Company Name: ____

Claim Number: ____

Policy Number: ______________________ Date of Accident: __________________

I, ________________________________, authorize Garden State Orthopaedics to obtain The PIP Payout Ledger and the Declaration Page to my auto policy.

____

SIGN DATE

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<u>IF YOUR VISIT TODAY INVOLES AN ATTORNEY FOR A MOTOR VEHICLE ACCIDENT, OR A PERSONAL INJURY CASE, PLEASE READ AND SIGN BELOW.</u>

- We will work with you and you attorney in getting your medical bills paid. If you have health insurance as a secondary coverage, we will bill them for your co-pays and deductibles. However, if a referral is required, this **must be obtained before your visit**. For motor vehicle cases, once your insurance has exhausted, we will then bill your health insurance as primary. At that time, we will collect any co-pays or deductibles for which you are responsible. However, when treatment concludes, we expect that all bills be paid in full regardless of the outcome of your case. This includes all deductibles, co-pays and any outstanding balances not covered or paid for by your insurance company or legal settlement.
- Medications will only be filled during business hours.
- All cellular devices must be turned off in the examining rooms.
- Eating and drinking are not allowed in the examining rooms
- **Disability papers must be pre-paid.** $15 per form. Forms are not filled out every day.
- Motorcycle cases must use health insurance.

Radiology for Motor Vehicle Cases

- If our office refers you for an MRI, bone scan, CT scan and/or Xray, it must be authorized through your motor vehicle insurance first. Once approval is received, it will be sent to a radiological facility, and they will contact you for an appointment. <u>Our office does not schedule patients for radiologic testing</u>. If testing is denied, our office will contact you. The authorization process will take 7-14 business days from the date you were seen.

I have read and understand the above:

Signature____ Date:_____________________________

Revised 5/18/2021

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COVID-19 Screening Form

Please circle "yes" or "no" to the following questions.

YES	NO	Have you had a cough, shortness of breath, difficulty breathing, fever (temp 100 or greater), chills, repeated shaking with chills, muscle pain, headache, sore throat or new onset loss of taste or smell in the last 14 days?
YES	NO	Have you had close unprotected contact with a suspected or laboratory confirmed COVID-19 individual in the last 14 days?
YES	NO	Have you had a laboratory confirmed or suspected diagnosis of COVID-19 in the past 14 days?
YES	NO	Have you or someone you know had close contact with someone who traveled to others states or out of the country?

- All patients' temperatures will be taken upon arrival.
- All patients' assistants and visitors must wear a face mask or face covering all the time at the facility.
- All drivers, family members, friends, and assistants must stay in their vehicles.
- All patients and assistants must maintain a social distance at the facility.
- Please wash your hands with soap and water after handing this form back to our staff.
- Please wash your hands with soap and water before leaving this office.

To the best of my knowledge my above answers are correct and accurate. By signing this form, I agree to comply with the above rules and recommendations.

____ ____________________

Signature Date

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COVID-19 Liability Waiver Form

I acknowledge:

- the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
- Garden State Orthopaedics has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
- Garden State Orthopaedics cannot guarantee that I will not become infected with the Coronavirus/Covid-19.
- that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others.
- that I am voluntarily seeking services provided by Garden State Orthopaedics and that I am increasing my risk to exposure to the Coronavirus/COVID-19.
- that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

- I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
- I have not traveled internationally within the last 14 days.
- I have not traveled to a highly impacted area within the United States of America in the last 14 days.
- I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
- I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Garden State Orthopaedics harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of Garden State Orthopaedics, or that may otherwise arise in any way in connection with any services received from Garden State Orthopaedics. I understand that this release discharges Garden State Orthopaedics from any liability or claim that I, my heirs, or any personal representatives may have against them with respect to any bodily injury, illness, medical treatment, or death or property damage that may arise from, or in connection to, any services received from Garden State Orthopaedics.

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Patient signature Date