



Dr. Lawrence I. Barr

*Sports Injuries • Spine Surgery • Arthroscopy • Fracture Treatment
Industrial Injuries • Hand Surgery • General Orthopaedics*

FELLOWSHIP-TRAINED | BOARD-CERTIFIED
ORTHOPEDIC SPINE SURGEON | ORTHOPEDIC SURGEON

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TO ALL MOTOR VEHICLE ACCIDENT PATIENTS AND OTHER INJURIES WHERE A LAWYER/LITIGATION IS INVOLVED.

Please read carefully.

- We will work with you and your lawyer in getting your bills paid. If you have health insurance as secondary, we will bill them for your co-pays and deductibles. However, if a referral is required, this must be obtained prior to your visits. For motor vehicle cases, once the insurance has terminated your benefits, we will then bill your health insurance as primary. At that time, we will collect any co-pays or referrals for which you are responsible. However, we expect that all bill be paid, whether or not you or your lawyer has successfully pursued a lawsuit. This includes all deductibles, co-pays and any outstanding medical bills 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 everyday.

Motor Vehicle Cases

If our offices refers you for an MRI, bone scan and/or CT scan, it must be authorized through your motor vehicle insurance first. Once approval is received, it will be faxed to an MRI facility, and they will contact you for an appointment. Our office does not schedule patients for radiologic testing. If testing is denied, our office will contact you. X-rays do not require authorization. Out of NJ-state claims do not require authorization. The authorization process will take 7-14 business days from the date you were seen.

Motorcycle cases must use your health insurance.

I have read and understand the above:

Signature: _____ Date: _____

GARDEN STATE ORTHOPAEDICS
Patient Registration Form

Account #: _____ Date: _____ Referred by: Dr. _____

Attorney _____

Patient's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home phone#: _____ Other phone#: _____ cell work (please specify)

Referring Physician: _____ Address: _____ Phone# _____

City: _____ State: _____ Zip: _____

Family Physician: _____ Address: _____ Phone# _____

City: _____ State: _____ Zip: _____

Attorney: _____ Address: _____ Phone# _____

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 - If MVA, is your health insurance primary? YES NO

Work related

Medical

Other: please specify place of accident: _____

Primary Insurance Carrier: _____ Claim/policy number: _____

Address: _____ Policy Holder: _____

City: _____ State: _____ Zip: _____

Did you file an accident report? YES NO

Adjuster: _____ Phone# _____ Fax# _____

Secondary Insurance Carrier: _____ Subscriber: _____

Address: _____

City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____ 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 (harness lap belt both)

Was your car Moving or Stopped in traffic OR Stopped?

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

Were you hit or did you 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 Other _____

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 1 st Visit	Still treating with doctor?

What tests did you have done?	Where were they done?	On what body part(s)?
X-rays		
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

PLEASE CIRCLE ALL THAT APPLIES

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	YES	NO
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
^^^

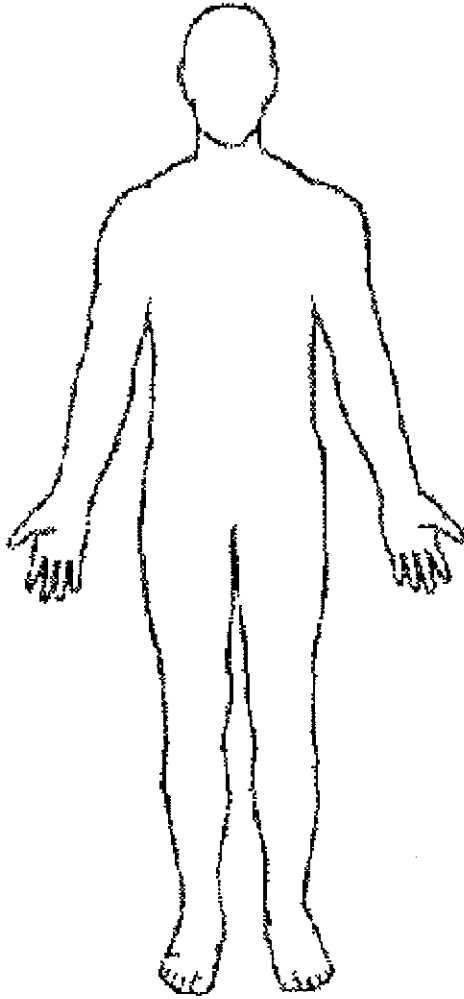
Numbness
===

Pins & Needles
ooo

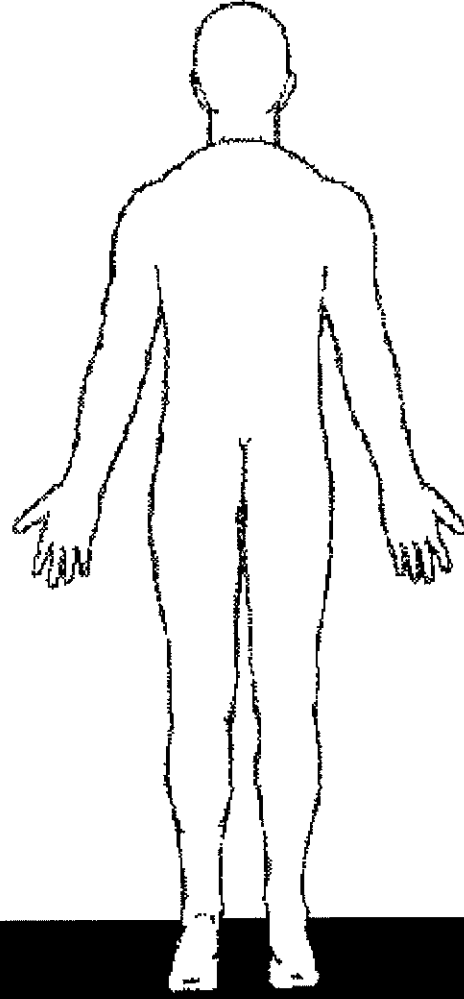
Burning
xxx

Stabbing
///

Other
...



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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*PLEASE SEND ALL CORRESPONDENCE
TO THE CHERRY HILL OFFICE

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, Lien and Authorization Insurance Benefits and Attorney

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 offices 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 fee's, 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: _____
(Patient or Guardian)

Date: _____



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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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Policy Number: _____ Claim #/Member ID #: _____
Patient's Name: _____ Medical Provider: Garden State Orthopaedics

Authorize and request my insurance company (hereafter referred to as the "Company") to pay directly to the above-named provider, the amount due under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associates with the provider's office.

_____ Date _____ Patient's Signature or Parent/Legal Guardian

I have read the information sent by the Company concerning the Decision Point Review plan, including any pre-certification requirements (collectively referred to hereafter as the "Plan") and, as a condition precedent to the Company's 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 from the Company concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, causal relationship to the injury and care plan and if necessary submit to Examinations Under Oath;
3. I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the Plan; I understand that I must have 3 or more dates of service before Arbitration will be submitted.
4. I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the Plan until there has been a final determination of the Internal Appeal Procedure of the dispute; and
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, I (we) will hold the patient harmless 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 Company does not provide coverage for any insured 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 Company has the right to reject this assignment of benefits.

Provider's Signature

1030 North Kings Hwy., Suite 200 • Cherry Hill, NJ 08034 • 856-616-2999 • FAX 856-616-1437

Billing inquiries: 856-616-2970 • FAX 856-616-1439

**New Jersey Application for Benefits
Personal Injury Protection**

Claim Number: _____

GARDEN STATE ORTHOPEDICS
1030 N KINGS HIGHWAY, SUITE 200
CHERRY HILL, NJ 08034

- Important:
- To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
 - You must also sign the authorizations, Affidavit and Notice attached.
 - 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 <input type="checkbox"/> / Female <input type="checkbox"/>	
List any aliases, maiden names or other names you use or have used in the past		Home Phone: () -	Cell 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 <input type="checkbox"/> No <input type="checkbox"/> Name of Insurance Company _____ Does anyone living in your residence own a vehicle? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Insurance Company _____ Do you have health insurance? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 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 <input type="checkbox"/> No <input type="checkbox"/>	Doctor's Name and Address			
If you were treated in a hospital, were you an In-patient? <input type="checkbox"/> Out-patient? <input type="checkbox"/>	Hospital's Name and Address			
Amount of Medical Bills to Date: \$ _____	Will you have more medical expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	At the time of your accident, were you in the course of your employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did you lose wages or salary as a result of your injury? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	If yes, amount: \$ _____ Per week _____ Per month _____
(1) Any Workers' Compensation Law?		
(2) Employees' Temporary Disability Benefit Statute?		
(3) Medicare?		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: _____

Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is reported to be extremely contagious. The state of medical knowledge is evolving, but the virus is believed to spread from person-to-person contact and/or by contact with contaminated surfaces and objects, and even possibly in the air. People reportedly can be infected and show no symptoms and therefore spread the disease. The exact methods of spread and contraction are unknown, and there is no known treatment, cure, or vaccine for COVID-19. Evidence has shown that COVID-19 can cause serious and potentially life-threatening illness and even death.

Garden State Orthopedics cannot prevent you from becoming exposed to, contracting, or spreading COVID-19 while utilizing Garden State Orthopedics services or premises. It is not possible to prevent against the presence of the disease. Therefore, if you choose to utilize services and/or enter onto Garden State Orthopedics premises you may be exposing yourself to and/or increasing your risk of contracting or spreading COVID-19.

ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19. I hereby choose to accept the risk of contracting COVID-19 in order to utilize Garden State Orthopedics services and enter Garden State Orthopedics premises. These services are of such value to me that I accept the risk of being exposed to, contracting, and/or spreading COVID-19 in order to utilize Garden State Orthopedics services and premises in person.

WAIVER OF LAWSUIT/LIABILITY: I hereby forever release and waive my right to bring suit against Garden State Orthopedics and its owners, officers, directors, managers, officials, trustees, agents, employees, or other representatives in connection with exposure, infection, and/or spread of COVID-19 related to utilizing Garden State Orthopedics services and premises. I understand that this waiver means I give up my right to bring any claims including for personal injuries, death, disease or property losses, or any other loss, including but not limited to claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

CHOICE OF LAW: I understand and agree that the law of the State of New Jersey will apply to this contract.

I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS RELEASE, AND FREELY AND KNOWINGLY ASSUME THE RISK AND WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE:

Signature: Date: _____

Name (printed): _____

I have the legal right to consent to and, by signing below, I hereby do consent to the terms and conditions of this release.

Signature : _____



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Patient Advisory and Acknowledgment

Receiving Medical Treatment During the COVID-19 Pandemic

Dear Patient:

While our medical practice complies with state health department and the Centers for Disease Control and Prevention (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees. Our staff, your surgeon, and your anesthesia personnel are symptom-free and to the best of their knowledge, have not been exposed to the virus.

Since this facility is a provider of healthcare services, persons (including other patients or staff) could be exposed or infected, with or without their knowledge. In order to reduce the risk of spreading COVID-19, we have employed reasonable precautions including pre-appointment screening of patients and daily screening of healthcare workers.

This information is provided to assist you in making an informed decision regarding the risks and benefits of your scheduled procedure during this time.

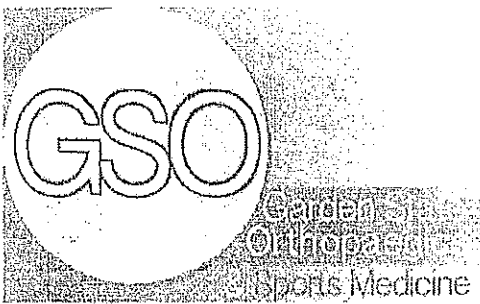
By signing below you are acknowledging your participation in the COVID-19 screening process, the truthfulness of your responses, and that you have discussed COVID-19 related risks with Garden State Orthopaedics or Dr. Lawrence Barr, D.O.

Thank you for choosing Garden State Orthopaedics.

Patient Printed Name: _____

Patient Signature: _____

Date: _____



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COVID-19 Screening Form

First point of contact should screen the patient/visitor/staff and check any boxes that apply:

- Patient has a fever (>100.4 visitor/patient >100.0 HCP) AND signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)
- Patient has had close contact with a laboratory confirmed COVID-19 patient within the last 14 days
- Patient has a fever (>100.4 visitor/patient >100.0 HCP) OR signs/symptoms of lower respiratory illness AND a history of travel from affected geographic regions within 14 days of symptom onset
- Patient does not meet any of the above criteria

Name _____ Phone _____ Date _____ Time _____