Appointment & Cancellation Policies

Regularly scheduled treatment appointments represent an agreement between you and your doctor. A particular time slot will be reserved for you. You are expected to regularly attend scheduled appointments.

Reasons for absences are to be limited to only serious illness, hospitalizations, emergencies, critical family situations, vacations, and holidays. **We require cancellations to be made at least 24 hrs prior to your scheduled appointment**. All cancellations made with less than 24 hours notice (for any other reason than illness) of the treated patient are subject to a cancellation fee ($75 for a single appointment, $150 for double appointments). Please be advised that the visit cannot be billed to your insurance company. If you wake up feeling sick, please **text message us at (973) 251-6569** as early as possible, allowing the office staff time to schedule another appointment within your slot. Please feel free to **text message 24 hours a day 7 days a week.**

When it is necessary to cancel an appointment, we encourage you to reschedule it whenever possible, to ensure consistency of your treatment and maximize therapeutic gain. If there are excessive cancellations, we reserve the right to put treatment on hold.

You will receive an advance cancellation notice from your doctor's here due to the occasional professional endeavors, family situations, or annual vacations. Barring any unforeseen circumstances, you will be notified by 8:00 a.m. if your doctor must cancel your present-day appointment due to illness or an emergency. For inclement weather updates, please be sure to check our Website, Social Media, or Text Message the office. If nothing is indicated, our sessions are being held as scheduled.

It is our intention at All ProHealth to stay on schedule however, there may be times when you have to wait for 5 - 10 minutes due to unforeseen circumstances. If a doctor is behind schedule, you will always be seen for the allotted time of your scheduled appointment.

Thank you for your understanding of our appointment and cancellation policies. If you have any questions, please do not hesitate to inquire with our staff for further clarification.

I have thoroughly read the appointment and cancellation policies of All Pro Health and I understand and sign in agreement to this policy.

_____

Print Name

_____ _____

Signature of Patient or Guardian **Date**

Informed Consent for Chiropractic & Physical Therapy Treatment

I hereby consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination testing and diagnostic X-rays on me (or on the patient named below for whom I am legally responsible) which are recommended by the doctor of Chiropractics named below and/or other licensed doctors of Chiropractics who now or in the future render treatments to me while employed by and/or associated with All Pro Health, LLC.

I hereby also consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by/or under contract with All Pro Health, LLC.

I understand that, as with any healthcare procedure, there are certain complications which may arise during treatments. Those complications include but are not limited to fractures, disc injuries, disc dislocations, muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. I do not expect the doctor to be able to anticipate all risks and complications during my treatment, and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts known, is(are) in my best interest.

I have had the opportunity to discuss with the doctor(s) named below, and/or the office personnel, the nature, purposes, and risks of Chiropractic adjustments and other recommended procedures. I understand the results are not a guarantee of permanent relief.

I have read, or have had read to me, the above explanation of Chiropractic adjustments and related treatments. By signing below I state that I have weighed the risks involved in undergoing treatment and have, myself, decided that it is in my interest to undergo any treatment that may be recommended. I intend this consent form to cover the entire course of treatment of my present condition(s) and for any future condition through which I seek treatment.

Name & Address of Facility
All Pro Health, LLC.
381 Walnut Street
Livingston, NJ 07039

Name(s) of Doctor(s)
Todd E. Schragen DC, CCSP
Salvatore Colangelo, DPT

_____ _____
Print Patient Name **Date**

_____
Signature of Patient or Guardian

Media Consent Form

I, _____,
(**Print patient name and if under the age of 18, Print name of consenting parent / guardian**)

grant All Pro Health, LLC (All Pro) permission to record my personal image, likenesses, and voice by photography, video recording, audio recording, or by any other medium (of recordings). I acknowledge and agree that All Pro owns the recordings and may use, modify, display, and or distribute these recordings, whether edited or in full, in connection with it's business. I further consent to All Pro'ss use of my name together with the recordings and acknowledge that I will not receive any compensation for the use of these recordings.

I give this consent voluntarily and hereby release All Pro, its members, officers, directors, employees, and agents from liability for any and all claims arising out of the recordings.

Print name: _____

Signature: _____

Date: _____

If under 18 years of age, a parent or legal guardian must complete the following:

Print Name of Parent / Guardian: _____

Signature of Parent / Guardian: _____

Date: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have received a copy of All Pro Health's Notice of Privacy Practices.

_____

Patient Name

_____

Signature of Patient / Guardian / Legal Representative

_____

Date