New Jersey Spine Center
Phone: (973) 635-0800
Fax: (973) 635-6254

PATIENT INFORMATION

Name: ______________________________________ Date of Birth: ________________________

Address: ____________________________________ Social Security #: ___________________

____ Driver's License #: ___________________________________

Home Phone: _________________________________ Marital Status: ☐Married ☐Single ☐Divorced

Business Phone: _______________________________ Referring Physician: ___________________________________

Mobile Phone: _________________________________ Address: ____

PATIENT'S EMPLOYMENT Primary Physician: ____________________________________

☐Employed ☐Retired ☐Unemployed ☐Other Address: ____

IF UNDER 18 YEARS OF AGE
PLEASE PROVIDE GUARANTOR INFORMATION

Employer: _______________________________________

Address: ____ Name____

Injury related to: ☐ Employment ☐ Auto Accident Address: ____

Claim Number:____________ Date of Injury: ____________ Phone: _______________________________________

Nurse Case Manager: ___________________________ Relationship to Patient:___________ Date of Birth: ____________

Phone: ___________________________________ Social Security #: ___________________________________

PRIMARY INSURANCE ☐Same as patient ☐ Same as Guarantor

☐ Other: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child Policy Holder: ______________________________

Insurance Company: ______________________________ Insured Phone:______________________________

Insured ID: ____________________________ Social Security #: ____________________

Policy Group Number: ____________________ Date of Birth_________________________

SECONDARY INSURANCE ☐ Same as Patient ☐ Same as Guarantor

☐ Other: Relationship to Patient: ☐ Self ☐ Spouse ☐ Child Policy Holder: ______________________________

Insurance Company: ______________________________ Insured Phone:______________________________

Insured ID: ____________________________ Social Security #: ____________________

Policy Group Number: ____________________ Date of Birth_________________________

☐ **Dr. Dorsky** ☐ **Dr. Rieger** ☐ **Dr. Schoeb** ☐ **Dr. Lipp** ☐ **Dr. Allen**

Appointment in: ☐ **Chatham** ☐**Millburn** ☐**Bayonne** ☐ **Sparta** ☐ **Newark Airport**

www.njspinecenter.com

New Jersey Spine Center

Name:____________________ **Age:**______ **Date of Birth**______ **Height** ______ **Weight**______

Referring physician name and address and/or referral source: ______________________________

____

Is this related to an accident? ☐ Auto ☐ Work **Date of Incident:** __________________

Occupation: ____________________ **Are you working:** ☐Yes ☐No **Date Last Worked** __________

Main complaints in order of importance:

____

____

Type of Injury?

____

____

Prior Studies: ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Myelogram ☐ EMG/NCV ☐ Bone Scan ☐ Discography

Other ____________________

Allergies to Medication – List all:

____

____

Allergies to shellfish or contrast dye? ☐Yes ☐No

Other:________________________

Surgery:

	Type	Year
1	____________	______
2	____________	______
3	____________	______

Rate your pain from 1 to 10 ______ (1 mild – 10 severe) **Baseline** ______ **Worst** ______

Medical History:

☐ Heart Disease ☐ Stroke
☐ Hypertension ☐ Seizures
☐ Cancer ☐ Depression
☐ Asthma ☐ Hepatitis Type ______
☐ Diabetes ☐ HIV/AIDS
Other________________

Other Medical Complaints:

☐ Vision ☐ Ears/Nose/Throat
☐ Blackouts/Fainting ☐ Bleeding/Clotting
☐ Balance/Dizziness ☐ Digestion
☐ Bladder Dysfunction ☐ Bowel Dysfunction
☐ Numbness/Tingling ☐ Psychiatric History
☐ Menopause (female) ☐ Lungs
☐ Headaches Other __________

Please check if you:

Smoke: Packs per day________ Quit: When__________ Alcohol: How often______________

Current Medications:

1. ________________ 2.________________ 3. ________________

4. ________________ 5. ________________ 6. ________________

I certify that all of the above is accurate, complete, and without fabrication or suppression.

Signature ____________________________ Reviewed by ____________________

NEW JERSEY SPINE CENTER

CONSENT

I hereby consent to the use of my otherwise protected health information for the purpose of my ongoing treatment, New Jersey Spine Center's operations, and to secure for reimbursement services.

ASSIGNMENT OF BENEFITS

I hereby instruct and direct ______________________________ to pay by check made payable to:
(Your insurance company)

New Jersey Spine Center
40 Main Street
Chatham, NJ 07928

benefits allowable according to my plan for services rendered. I authorize a representative of New Jersey Spine Center to initiate a complaint to the insurance commissioner for any reason on my behalf.

I have received a copy of NJSC financial policy and will make the appropriate payment for today's services. I understand that if my account is not paid directly by my insurance company I am responsible for the full amount. I acknowledge the fact that my insurance policy may exclude certain services that may be medically necessary and that I could be responsible for payment of such services. I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional collection fee of the greater of $50.00 or twenty percent (20%) of the balance of my account. I acknowledge there will be a returned check fee of $35.00 assessed for each item not honored by my bank. A photocopy of this assignment shall be considered as valid as the original.

PLEASE READ AND INITIAL THE FOLLOWING

- Should you decide to schedule a surgical procedure, please be aware that there is a great deal of time and effort put forth making these arrangements. The practice may impose a $300.00 cancellation fee for any surgical procedure that is canceled or postponed by the patient. ____________ **INITIALS**

- **HORIZON PATIENTS:** The authorization process for surgical procedures has become arduous. It involves multiple calls with an inordinate amount of time on hold, and, frequently, the need to have our surgeons speak to the medical directors. As a result we regret that we have to impose a $25.00 administrative fee to help defray some of these expenses. ____________ **INITIALS**

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our Notice and ask questions about our privacy practices. The terms of this notice may change. Upon request, a copy of our revised notice will be made available to you.

By signing this form, you acknowledge that you have read and agree to the consent and assignment of benefits, and received our Notice of Privacy Practices.

______________________________ ______________________________
Print Patient Name Signature of Patient/Guardian

____
Today's Date

New Jersey Spine Center
Financial Policy

Please read carefully. We are available to answer any questions you may have.

HMO and Other Managed Care Plans

In the even that your insurance contract requires a referral, it is you responsibility to provide this before or at the time of your appointment. If you do not have a referral you may pay for today's visit or reschedule for another time.

Medicare

New Jersey Spine Center is participating with Medicare. You are responsible for your annual deductible. After this is satisfied you are responsible for 20% of the allowable fee. Please provide secondary insurance information for wrap around benefits.

Workers Compensation

If this visit is related to a work injury, your claims adjuster or nurse case manager must preauthorize our services. You may choose to see our physicians without this authorization but will be expected to pay at the time of service. You may provide insurance information in order to secure reimbursement from your personal health carrier.

Personal Injury Protection (Auto)

If this visit is related to a motor vehicle accident, your claim adjuster or nurse case manager must authorize our services. During the first ten days immediately following your accident you may see the physician of your choice. After that time all treatment must be authorized. Without this authorization you will be expected to pay our fee at the time of service. With prior approval you are responsible for your deductible and 20% of the PIP fee. Please provide health insurance information to secure reimbursement for this difference.

Preferred Provider Organizations

New Jersey Spine Center participated with many PPO Organizations. Patients are responsible for the copay or coinsurance amount at the time of service. A current list of plans with whom we participate is posted in the waiting room.

All Others

If we are not participating with your current insurance plan, payment is expected at the time of service. Payment arrangements can be made in advance for future appointments and surgical procedures. Our billing staff is available to make comfortable payment arrangements. Please call (973) 635-6403 to speak with one of our patient account representatives.

NEW JERSEY SPINE CENTER
40 Main Street
Chatham, NJ 07928
(973) 635-0800

Steven G. Dorsky, M.D.
Matthew I. Lipp, M.D.

Kenneth J. Rieger, M.D
Kara D. Allen, D.O.

Patient's Name: ______________________ Medicare # (HICN)/Other Ins. I.D. # ____________

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare/your insurance will not pay for the item(s) or service(s) that are described below. Medicare/your insurance does not pay for all of your health care costs. Medicare/your insurance only pays for covered items and services when Medicare/your insurance rules are met. The fact that Medicare/your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare/your insurance probably will not pay for....**

Items of Service: Include but are not limited to the following: Services exceeding Medicare or other insurance maximum allowable benefits; services provided by an assistant surgeon or physician assistant, durable medical equipment, EMG or fluoroscopy services, other miscellaneous items.

Because: Not a covered service or considered maintenance or non-therapeutic.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, **you should read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare/your insurance probably won't pay.
- Ask us how much these items or services will cost you **(Estimated cost: $_________),** in case you have to pay for them yourself.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN AND DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that my insurance company will not decide whether to pay unless I receive these items or services. Please submit my claim to my insurance. I understand that you may bill me for items or services and that I may have to pay the bill while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out-of-pocket or through any other insurance that I have. I understand I can appeal my insurance company's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to my insurance and that I will not be able to appeal your opinion that my insurance won't pay.

_______________ ____

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare/your insurance, your health information on this form may be shared with Medicare/your insurance. Your health information, which Medicare/your insurance sees, will be kept confidentially by Medicare/your insurance.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (May 2006)

IMPORTANT NOTICE PLEASE READ

PRESCRIPTION RENEWAL POLICY

New Jersey Spine Center accepts calls for prescription renewals during normal business hours only. We cannot renew medications during the evening or on weekends when your chart is unavailable.

Please be sure to monitor your medications. All renewal requests should be made two (2) days in advance and called in before 10:00 a.m. Messages left after 10:00 a.m. will be addressed at the end of the next business day. You should call your pharmacy to confirm that your renewal is ready for pick-up.

We have a phone line dedicated to prescription renewals. Call our main phone number (973) 635-0800. When the auto-attendant answers, you should dial extension 50. Follow the instructions carefully. Be assured that all messages are addressed.

WE REQUIRE 24 HOURS NOTICE IF YOU INTEND TO PICK UP YOUR X-RAY'S OR MRI'S.

Thank you for your cooperation.

NEW JERSEY SPINE CENTER
NOTICE OF PRIVACY PRACTICES
Effective: April 14, 2003

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. If you have any questions about this notice please contact our office.

This Notice of Privacy Practices advises you about the way we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information. We are required to abide by the terms of this notice and may change the terms at any time. Upon your request, we will provide you with any revision made to this notice.

Uses and Disclosures of Protected Health Information: Your protected health information (PHI) may be used and disclosed for your ongoing treatment, our ongoing healthcare operations or to secure payment for services.

Treatment: The provision, coordination or management of healthcare and related services among providers or with a third party.

Healthcare Operations: Necessary disclosures to run our practice and monitor quality of care including staff performance, evaluation of practice enhancements, and staff education.

Payment: Necessary disclosure to secure reimbursement from you, your insurance company, or other third party payer for services rendered. In addition, PHI may be disclosed to obtain prior approval from your insurance company to assure payment for services yet to be rendered.

Appointment Confirmation: We will continue our practice of telephone confirmation of all appointments.

Individuals Involved in Your Ongoing Care: Upon your verbal authorization, we will disclose information about you to your designated caregivers, other family members, or other individuals.

Case Management for Workers' Compensation/PIP/Disability: We may release PHI for your workers' compensation, auto related or other liability claim, or your claim for disability benefits or similar program that provides benefits for injuries or illnesses. This may include claims adjusters, nurse case managers, and may be telephonic.

As Required by Law: We will disclose medical information about you when required to do so by federal, state or local law. This may include activities by the government to monitor the healthcare system and compliance with civil rights laws, audits, inspection and licensure. We may disclose PHI for matters involving public health risks including disease exposure, child abuse or neglect, or other domestic abuse, neglect or violence. If you are involved in a lawsuit, we may disclose PHI in response to a subpoena or other court order. PHI may be disclosed to other legal authority pursuant to law enforcement.

Other Uses and Disclosures of Your PHI: Other disclosures of your PHI will be made only upon your written authorization and **payment of the allowable fee.** You may obtain an authorization from our office. You may revoke this authorization, at any time, in writing. You understand that we are unable to take back any disclosures that have already been made with your prior permission.

Methods of Disclosure: We will respond to your requests by mailing copies of your records via US Postal Service. We will not disclose any PHI through e-mail. Under limited circumstances, at our discretion, your medical records may be faxed.

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Your Rights Regarding Your Protected Health Information

Right to Inspect: You have the right to inspect a copy of your PHI, including medical and billing information, which is used to make decisions about you. You must submit your request in writing. We may charge a fee, as permitted by state law, for the costs of copying and mailing. We will not fax your medical information to you. We may deny your request under limited circumstances.

Right to Amend: If you feel the medical information we have is incorrect or incomplete, you may ask us to amend it. We will provide an amendment form, which you must complete. You must provide a reason that supports your request. In the absence of a reason, we will deny your request.

Rights to an Accounting of Disclosure: We will keep an accounting of all disclosures we made about you. You may request this list in writing and must state a time period no longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction on the medical information we disclose for treatment, payment, operations, or your caregivers and other involved persons. *We are not required to agree with your request.* We will comply with your request unless the information is needed for emergency treatment. Your request for limitations must be made in writing and must include what information you want limited and to whom you want these limits to apply.

Changes to this Notice: We reserve the right to change this notice and apply the changes to information we already have about you or may receive in the future. We will post a copy of the current notice in the office. The effective date will appear in the upper right hand corner. We will offer you a copy of the current notice.

Complaints: If you believe that your rights have been violated, you may file a complaint with our office. Your complaints must be made in writing and addressed to Sharon Hayden, New Jersey Spine Center, 40 Main Street, Chatham, NJ 07928. No complaints will be acknowledged by phone.