

Who referred you to this office? _____ Date: ___/___/___

Who is your primary care doctor? _____ DOB: ___/___/___

Name: _____ Age: _____ Sex: M or F Height: ___' ___ Weight: _____

Race:
___ American Indian/Alaska Native
___ Asian
___ Native Hawaiian/Pacific Islander
___ Black/African American
___ White
___ Hispanic
___ Other
___ Refuse to Answer

Ethnicity:
___ Hispanic/Latino
___ Non Hispanic/Latino
___ Refuse to Answer

Marital Status:
___ Single ___ Divorced
___ Married ___ Separated
___ Widowed ___ Common Law

Email Address: _____

Home Address: _____ Town/State: _____ Zip Code: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell: (____) _____ - _____

Employer: _____ SSN: _____ - _____ - _____

Primary Medical Insurance: _____ ID#: _____

Secondary Medical Insurance: _____ ID#: _____

Spouse Name: _____ Spouse Employer: _____

In case of an emergency: _____ Phone: (____) _____ - _____

If patient is minor, list responsible relative/guardian: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell: (____) _____ - _____

Is this visit related to an accident or work injury? _____ Motor Vehicle Accident _____ Worker's Comp _____

Is there litigation related to this injury? _____ Attorney's Name/Phone: _____

Insurance Company: _____ Claim #: _____ Adjuster: _____

Insurance Company Address: _____ Phone: (____) _____ - _____

Do you have an Advance Directive (Living Will)? _____ Name of Surrogate: _____

Medical History

Do you take any medications? Yes__ No__ (Please list your medications, dosage, and schedule)

Do you take:
Aspirin Yes__ No__
Birth Control Yes__ No__
Herbal Supplements Yes__ No__

Do you have any allergies or adverse reaction to medication or anesthesia? (Please list)

Please list prior hospitalizations or surgery including reason for hospitalization and dates:

Have you received the Flu vaccine: Please circle Y/N- Month/Year received _____

Have you received the Pneumonia vaccine: Please circle Y/N- Month/Year received _____

Have you received a colonoscopy? Please circle Y/N-Month/Year received _____ Results _____

Female patients only:

Date of last PAP Smear _____ Results _____

Date of last Mammogram _____ Results _____

Do you or your family members (children, siblings, parents or grandparents) have the following medical conditions:

	You	Family		You	Family
Bad reaction to anesthesia			Thyroid disease		
Stroke			Elevated cholesterol		
TIA (mini stroke)			Ulcers		
Bleeding in brain			Diverticulosis/diverticulitis		
Aneurysm in brain			Hepatitis		
Seizures			Aortic aneurysm		
Heart attack			Peripheral vascular disease		
Angina			AIDS/HIV		
Heart disease			Muscle disease		
Heart failure			Rheumatoid arthritis		
Mitral valve prolapse			Osteoarthritis		
High blood pressure			Osteopenia		
Asthma			Osteoporosis		
Emphysema			Urinary infection		
Tuberculosis			Kidney insufficiency/failure		
Cancer (type _____)			Bleeding tendency		
Diabetes			Depression		
Anemia			Psychiatric illness		
Sickle cell			Migraines		

Please list any other medical problems you have that are not listed above:

Do you have any of the following symptoms? [Check all that apply]

<input type="checkbox"/> Memory Loss <input type="checkbox"/> Visual change or loss <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Shortness of breath at rest <input type="checkbox"/> Shortness of breath w/ activity <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing blood <input type="checkbox"/> Abnormal bruising or bleeding <input type="checkbox"/> Fever or chills <input type="checkbox"/> Abnormal weight loss <input type="checkbox"/> Heartburn	<input type="checkbox"/> Persistent nausea/vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in bowels <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Painful urination	<input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Rash or skin lesions <input type="checkbox"/> Jaundice <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety/stress <input type="checkbox"/> Heat/cold intolerance <input type="checkbox"/> Abnormal thirst
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Has a family member ever had an adverse reaction to anesthesia or medication? If yes, explain. Yes___ No___

Do you smoke? Yes___ No___ If yes, how long? _____ How much? _____ Did you ever smoke? Yes___ No___

If you used to smoke, when did you quit? _____ How much did you smoke? _____ How long did you smoke? _____

Do you drink alcohol? Regularly___ Occasionally___ Never___ Daily intake of alcohol: Wine___ Beer___ Liquor___

Do you use any recreational drugs now? Yes___ No___ In the past? Yes___ No___ Any intravenous drugs? Yes___ No___

Do you exercise regularly? Yes___ No___ How many times per week? _____

North Jersey Spine Group

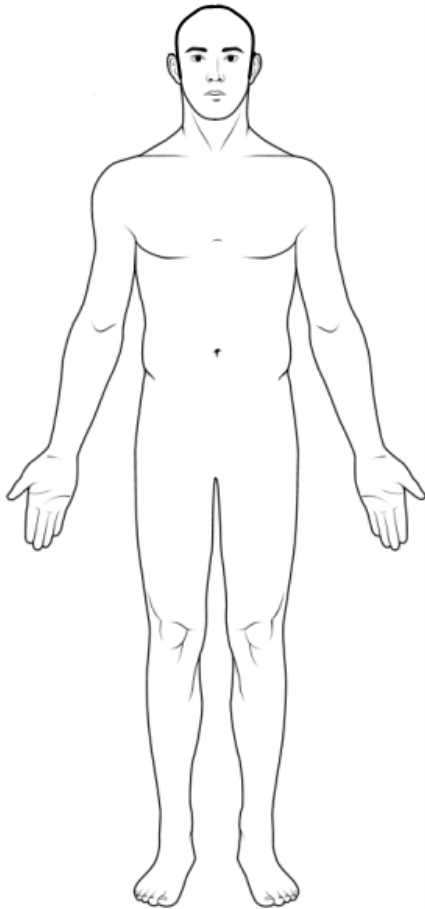
Name: _____

Date: _____

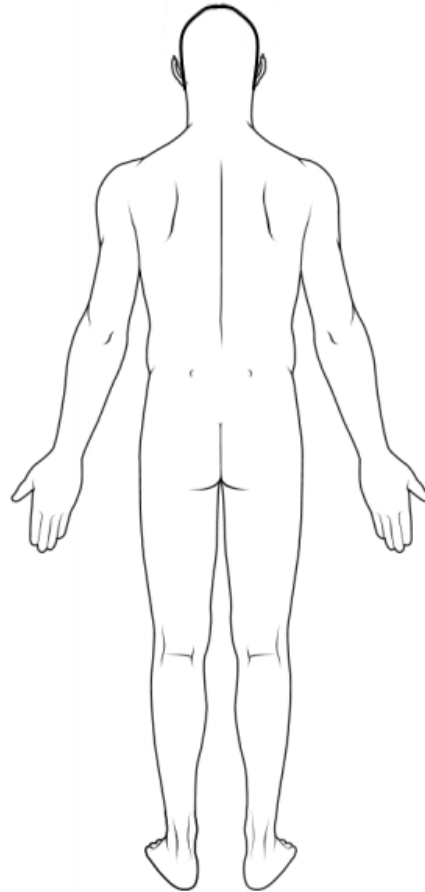
Draw your pain on the diagram shown. Use the corresponding symbols to show the type of pain you feel.

- Stabbing Pain** **////**
- Burning Pain** **OOO**
- Aching Pain** **XXX**
- Pins & Needles** **VVV**
- Numbness** **===**

FRONT



BACK



Circle your pain level on a scale of 1 to 10, with 10 being unbearable pain



Patient Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment. Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. In the event that we do accept assignment of benefits, we require a credit card with authorization, which we will hold, in the event of non-payment otherwise. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

You hereby authorize insurance payment directly to North Jersey Spine Group ("NJSJG"). Should payment be sent to you, it is your responsibility to return check to NJSJG, within seven (7) collection proceedings wherein you agree to pay our reasonable attorney fees and costs for collection as well as potential criminal liability for theft and conversion of funds.

You assign your rights to benefits under your contract of insurance or third party payment to NJSJG, and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plan. If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Cancelling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THE AGREEMENT.

Patient Name

Witness

Signature

___/___/___
Date

Consent for Minor

I grant the physicians associated with the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

Signature

___/___/___
Date

Relationship to patient

Notice of Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

Signature

___/___/___
Date

If not signed by the patient, please indicate the relationship between the signee and the patient:



PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _____ (print last name), _____ (print first name), hereby acknowledge and understand that even with the best training, skill experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and health outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office; as in any bad health outcome resulting from my failure to follow the advice of my doctors.

Signature

____/____/____
Date



PHARMACY INFORMATION FORM

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Signature: _____ Date: ____/____/____



OUT OF NETWORK PROVIDER WAIVER FORM

I, _____, have been advised that Dr. Raab, Dr. Skovrlj, Dr. Sundstrom, Dr. Haber are not in-network providers for my insurance plan, therefore, services provided to me and billed by North Jersey Spine Group will be considered out of network services. Under this acknowledgement, I understand that my insurance carrier may deny payment if I do not have out of network benefits or am subject to an out of network deductible. I agree to pay any outstanding balance if my insurance company denies any claim submitted by North Jersey Spine Group

Patient Name

Patient Signature

___/___/___
Date

AUTHORIZATION FOR PAYMENT WHEN PATIENT RECEIVES CHECK

Date: ___/___/___

Patient Name: _____

Insurance Company: _____ ID#: _____

Based on our experience with your insurance company, NJSG's payment for services rendered to you may be sent directly to you (the patient) instead of us. If you receive any type of correspondence from the above named insurance company for services rendered in this office, please bring the information to us within 10 days.

STATEMENT OF AGREEMENT:

I, _____, hereby agree to endorse any checks received by me from the above named insurance company for services rendered in this office or I will deposit the check and immediately reimburse this office within 10 days.

Patient or Guardian Signature

___/___/___
Date



PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities, and your insurance company. This personal information includes items such as your name, address, phone number, date of birth, social security number, employer, health history, insurance policy and coverage, and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress, and any test results or films.

How your information is used

The personal and health information gathered may be used and disclose with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state, or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Safeguarding your personal and health information

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your person and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your person or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.



OUR PAIN MEDICATION POLICY

In the course of your treatment, you may receive pain medications. However, all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics.

Consequently, all patients need to make arrangements to obtain any necessary prescription refills prior to the weekend. We will not provide pain prescriptions or refills during the weekend, which begins each Friday at 12 noon and end the following Monday at 8:30am.

The goal of our spine center is to help patients become less dependent on pain medications. Consequently, our policy is to NOT provide prescription refills by phone. Therefore, you may need to see the physician or the physician assistant to make these arrangements. Please call at least two days prior to your last dose. This will assure the most prompt response to your request. Do not wait until the day your medication runs out. Our clinical staff needs sufficient time to review the request for your refill.

USE ONE PHARMACY

Using the same pharmacy helps assure that the pharmacy will stock your medication for refills and that the pharmacy will know that you have a legitimate need for pain medication. It is in your best interest to use only ONE pharmacy for refills of your pain medication.

PROTECT YOUR MEDICATION FROM LOSS

You are personally responsible for the safekeeping of your medication. Please do not sell, trade, or give it away. If your medication is damaged, stolen, or lost, you must notify us right away.

Please do not seek pain medication from any other doctor unless approved by our clinical staff. Let us know if at any time another doctor prescribes medication for you.

The above restrictions apply a variety of prescription drugs, including, but not limited to:

1. Narcotics (*Vicodin, Percocet, Oxycontin, Codeine*)
2. Non-Steroidal Anti-Inflammatory Drugs, "NSAIDS" (*Motrin, Celebrex, Naprosyn*)
3. Non-Narcotic and Other Pain Medication (*Ultram, Darvocet*)
4. Muscle Relaxants (*Flexeril, Soma*)



North Jersey Spine Group's Pain Agreement

The purpose of this agreement is to prevent misunderstandings about your medical treatment and the medications you may be prescribed for pain management. It is important to understand that there are various medical interventions available to treat your pain and your doctor may prescribe medications or recommend other options available to treat your condition instead of or in addition to the use of pain medications. The physicians at North Jersey Spine Group are under no obligation to prescribe pain medications to you. Many of these medications have serious side effects and can be harmful if not taken properly. There may be times that a North Jersey Spine Group healthcare provider may contact your other treating physicians and/or pharmacy to clarify questions regarding your healthcare.

Below are various descriptive terms used in this agreement:

Opioid = a group of chemically related medications with strong pain relieving, narcotic qualities that also possess sedating qualities that may reduce suffering, fear and panic associated with pain through action on the brain and central nervous system.

Benzodiazepine = a class of medications with calming, sedating qualities frequently used to treat anxiety, tension and fear.

Other related drugs = for the purpose of this agreement, "other related drugs" include muscle relaxants, membrane stabilizing medications and other nonnarcotic pain relieving medications. These medications may cause altered mental status, sedation, occasionally dangerous withdrawal effects when stopped abruptly and may have medication interactions similar to or different from opioids or benzodiazepines.

Controlled substance = for the purpose of this agreement, a controlled substance will apply to opioids, benzodiazepines or other related medications as described above.

Informed Consent:

There are various risks associated with the use of opioids, benzodiazepines and other related medications that are important for you to be aware of:

Physical Dependence - the abrupt discontinuation of controlled substances which could lead to withdrawal symptoms including but not limited to chills, hot flashes, nausea/vomiting, muscle aches/joint pains, abdominal cramping, diarrhea, anxiety, hypertensive crisis, cardiac arrest or other cardiac dysfunction, seizures and death.

Psychological Dependence and Addiction – the use of these medications may lead to a behavior focused on the obtaining and misuse of controlled substances.

Tolerance – the need to increase an opioid dose over time to maintain a similar level of pain relief.

Overdose - may lead to low blood pressure, respiratory arrest and death.

Mental Changes - these classes of medications may cause confusion, sedation, drowsiness, problems with coordination and changes in thinking ability. This may make it unsafe to drive a motor vehicle, operate hazardous equipment and machinery or perform dangerous activities. Other side effects may include but are not limited to the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression and loss of sexual drive with testicular atrophy (in males).

There are other non-pharmacologic treatments available to treat your pain which could be used as an alternative to pain medications. These may include: physical therapy, acupuncture, chiropractic care, injection therapy and surgery.

Patient Printed Name: _____

Patient Signature: _____

Today's Date: _____

Pain Agreement:

By placing your initials along the line at each numbered statement, you acknowledge that you have read, understood and will comply with each statement:

- 1) _____ I understand that this agreement is essential to create guidelines for the trust and confidence necessary to develop a responsible doctor/patient relationship when taking pain medications. If this trust is compromised, my continued treatment with pain medications may be discontinued and I may be dismissed from North Jersey Spine Group.
- 2) _____ I understand that controlled substances may be prescribed by my physician only if it is believed that this treatment may have a medically reasonable chance of improving my quality of life, including participation in work and social activities.
- 3) _____ If my physician finds that treatment with controlled substances is not providing an adequate therapeutic benefit, or if addiction, rapid loss of effect, or significant side effects develop, I agree to have my medications tapered as directed.
- 4) _____ I understand the possible adverse effects and dependencies associated with opioids as outlined on the Risks section of this agreement.
- 5) _____ I will not present to the practice for early controlled substance refills. I understand that early pain medication refills are not provided. Furthermore, I understand that medication renewals are at the discretion of the treating physician and will be prescribed at office appointments only.
- 6) _____ I understand that controlled substance refill prescriptions will only be provided at the time of a scheduled office visit and the medications will not be prescribed after office hours or weekends. The North Jersey Spine Group medication refill hours are 9 AM to 4 PM Monday through Friday.
- 7) _____ I understand that pain medication prescriptions will not be mailed to me.
- 8) _____ I understand that I should not drive a motor vehicle, operate heavy machinery or perform any other activity of responsibility while I am taking pain medications as these medications may make me sleepy, alter my judgment and ability to think clearly.
- 9) _____ I will notify North Jersey Spine Group immediately of any adverse effects with my prescribed pain medications.
- 10) _____ I understand that controlled substances and other drugs may potentially harm an unborn child or a breast fed infant, and I will notify my North Jersey Spine Group physician if I am or plan to become pregnant. Furthermore, I will use appropriate measures to safeguard and prevent pregnancy during the course of my treatment with pain medication.
- 11) _____ I will have all imaging studies, lab tests and diagnostic procedures as well as referrals to additional subspecialists as advised by my North Jersey Spine Group physician.
- 12) _____ **I will only use one pharmacy to fill my pain medication prescriptions.** Under extenuating circumstances when an alternative pharmacy must fill my prescriptions, I will notify North Jersey Spine Group of this change.

My Pharmacy is: _____

Address: _____

Telephone #: _____

- 13) _____ I agree to seek psychiatric treatment, psychotherapy and/or psychological treatment if my North Jersey Spine Group physician feels it's necessary.
- 14) _____ I agree to have all my pain medications managed solely by my North Jersey Spine Group physician. **I will not obtain any controlled medications, including pain medications, stimulants, or anti-**

anxiety medications from any other doctor without first obtaining the consent of my treating physician at North Jersey Spine Group.

- 15) _____ **I will take my pain medications as prescribed and will never adjust the dosage or frequency of the medications without the direction and consent of a North Jersey Spine Group physician.**
- 16) _____ If, while under treatment with controlled substances, a substance abuse problem is suspected, I agree to evaluation and treatment of this problem as directed by my North Jersey Spine Group physician.
- 17) _____ I will never share, sell, exchange or misuse my pain medications for any reason.
- 18) _____ I currently am not and will not be involved in the sale, illegal possession, diversion or transport of controlled substances like narcotics, sleeping pills or nerve pills.
- 19) _____ **I will safeguard my pain medication from loss, theft or damage; and I understand that lost or stolen medications will not be replaced.**
- 20) _____ I agree to bring my unused pain medications to every office visit for random pill count to assess compliance with my medical treatment.
- 21) _____ I do not currently have any substance abuse problems (drugs and/or alcohol) and I agree that I will not use any illegal substances, including marijuana, nor will I misuse or self-prescribe/medicate with legal controlled substances.
- 22) _____ I will refrain from drinking alcohol, as alcohol can enhance the side effects of my pain medication, potentially causing over sedation, slowed breathing and respiratory depression, which could lead to coma or death.
- 23) _____ I agree to drug screening tests while under treatment at North Jersey Spine Group. I will submit to blood, urine, or salivary testing as requested by my doctor to determine my compliance with my treatment program. Refusal to participate in this testing may result in immediate termination of treatment with pain medications and possible discharge from North Jersey Spine Group. Positive tests for any illegal substances or opioids not prescribed by North Jersey Spine Group will result in dismissal from the practice.
- 24) _____ I understand that abusive behavior or harassment towards North Jersey Spine Group's staff will not be tolerated and may result in dismissal from the practice.
- 25) _____ I authorize North Jersey Spine Group and my pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care physician or local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- 26) _____ I understand that if I do not follow this agreement, I may be dismissed from North Jersey Spine Group at their discretion.

Patient Printed Name: _____

Patient Signed Name: _____

Today's Date: _____

ASSIGNMENT OF BENEFITS & AUTHORIZATION
TO PURSUE APPEAL &/OR LITIGATION OF HEALTH CARE BENEFITS

_____ [Patient Name]
_____ [Insurer]
_____ [Claim#]

In consideration of the professional services rendered by North Jersey Spine Group, and its affiliated health care providers, ("Health Care Providers"), I, hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect and appeal and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to Health Care Providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claims, pursuant to my rights under state and/or federal law including but not limited to federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).
2. The authorization of Health Care Providers to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully-funded or self-funded.
3. The authorization of Health Care Providers to initiate, prosecute, and resolve any and all appeals and/or arbitrations and/or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigation matters in state or federal court including but not limited to claims under the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).
4. The authorization of Health Care Providers to obtain and/or disclose any Private Health Information as contemplated by HIPPA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPPA authorization in this regard.
5. The authorization of Health Care Providers to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, the federal Department of Labor as it relates to ERISA plans, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to Health Care Providers to which I might be entitled under the above-captioned claim.
7. The assignment of all my rights under my insurance contract to North Jersey Spine Group, including all my rights governed by the statutes and regulations of the Employee Retirement Income Security Act (ERISA), including, without any limitation whatsoever, my rights to "recover benefits" under ERISA Section 502(a)(1)(B), my rights to recover civil statutory penalties under ERISA Sections 502(c)(1)(B); and my rights to pursue breach of fiduciary claims under ERISA Sections 502(a)(2) and 502(a)(3).

PATIENT:

By: _____

Dated: _____

WITNESS:

By: _____

Dated: _____



CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary. This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [] (or [x]) and signing below, agree to:

- [] representation by North Jersey Spine Group in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.
[] release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: [] I am the Patient [] I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.



New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care - Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329

OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807
You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

I hereby revoke my consent to representation by North Jersey Spine Group and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties

Signature: _____ Ins. ID# _____ Date: _____

Relationship to Patient: [] I am the Patient [] I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

Referral Source

Patient Name: _____

Date: _____

How did you hear about our practice? Please place a check mark in the appropriate field and fill in all applicable information.

<input type="checkbox"/> Physician Referral	Name of referring physician: _____
<input type="checkbox"/> Case Manager	Name of case manager: _____ Company: _____
<input type="checkbox"/> Newspaper	Wayne Today __ Passaic Valley Today __ Argus __ Suburban Trends __ Town News __ Hawthorn Gazette __ Ridgewood Village Gazette __ Glen Rock Gazette __ Town Journal __ Suburban News __
<input type="checkbox"/> Magazine	<input type="checkbox"/> 201 <input type="checkbox"/> Wayne <input type="checkbox"/> NJ Monthly
<input type="checkbox"/> Health Fair/Seminar presentation/Event	Name of Event: _____ Location: _____
<input type="checkbox"/> Previous Patient of NJSG	Name of previous NJSG patient: _____
<input type="checkbox"/> NJSG Website	
<input type="checkbox"/> Internet Search	Search words used: _____
<input type="checkbox"/> Occupational Health Nurse	Name of Occupational Health Nurse: _____
<input type="checkbox"/> Initially seen at a Hospital/facility (e.g. seen at Chilton Emergency room department)	Hospital or Facility Name: _____
<input type="checkbox"/> Valley Medical Group	Location: _____ Physician's Name: _____
<input type="checkbox"/> Get + Well Urgent Care	
<input type="checkbox"/> Other	Please Specify: _____



AUTHORIZATION FOR DIRECT PAYEMENT, AUTHORIZATION TO RELEASE INSURANCE INFORMATION AND REQUEST FOR PIP PAYOUT LOG

Automobile Claim Insurance Carrier: _____

Claim Number: _____

Date of Loss/Accident: _____

I direct my automobile claim insurance carrier to provide North Jersey Spine Group, LLC. any coverage information, documents, PIP payout sheet/PIP log, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath, independent medical evaluations and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefit.

PATIENT'S NAME (PRINT)

DATE

SIGNATURE

DATE OF BIRTH