PROGRESSIVE SPINE & ORTHOPAEDICS

PERSONAL INFORMATION :

LAST NAME: _____ FIRST NAME: _____

PHONE #:_____ CELL PHONE#:_____

ADDRESS:_____

TOWN/CITY :_____ ZIP CODE:_____

EMERGENCY CONTACT:_____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

MARITAL STATUS : _____ MALE/FEMALE: _____

E-MAIL ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____

NAME OF PHARMACY: _____ PHARMACY PHONE #:_____

EMPLOYMENT STATUS:_____

EMPLOYER'S ADDRESS:_____

EMPLOYER'S PHONE NUMBER:_____

HOW DID YOU HEAR ABOUT US?

_____

INSURANCE INFORMATION :

NAME OF INSURANCE:_____

INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

POLICY NUMBER:_____

GROUP NUMBER:_____

INSURANCE ADDRESS:_____

SECONDARY INSURANCE:_____

INSURED'S NAME:_____

INSURED'S DATE OF BIRTH:_____ RELATIONSHIP TO PATIENT:_____

POLICY NUMBER:_____

GROUP NUMBER:_____

INSURANCE ADDRESS:_____

WORKER'S COMPENSATION/ MOTOR VEHICLE ACCIDENT:

NAME OF INSURANCE:_____

CLAIM NUMBER:_____

DATE OF ACCIDENT:_____

INSURANCE ADDRESS:_____

ADJUSTOR/ NURSE CASE MANAGER'S NAME:_____

PHONE NUMBER:_____ EXT: _____

ATTORNEY'S INFORMATION:

ATTORNEY'S NAME:-_____

ADDRESS:_____

PHONE NUMBER:_____

MEDICAL HISTORY/ PERSONAL INFORMATION:

PLEASE CIRCLE ANY KNOWN MEDICAL CONDITION:

HYPERTENSION	LIVER DISEASE
HEART DISEASE	DIABETES
ASTHMA	ANEMIA
GERD	OTHER:_____

ARE YOU CURRENTLY TAKING ANY MEDICATION?_____

DO YOU HAVE ANY KNOWN DRUG ALLERGIES?_____

PLEASE LIST ANY PRIOR SURGERY:_____

DO YOU SMOKE?_____ DO YOU DRINK ALCOHOL?_____

DO YOU USE ANY RECREATIONAL DRUGS?_____

HOW MANY CHILDREN DO YOU HAVE ?_____

ARE YOU RIGHT HANDED OR LEFT HANDED?_____

DESCRIPTION OF INJURY/ACCIDENT:

WHAT BODY PART DID YOU HURT?_____

WHEN DID THE PAIN START TO OCCUR?_____

BRIEF DESCRIPTION OF THE INJURY: _____

_____

_____

ARE YOU EXPERIENCING PAIN IN EITHER OF YOUR ARMS?_____

ARE YOU EXPERIENCING PAIN IN EITHER OF YOUR LEGS?_____

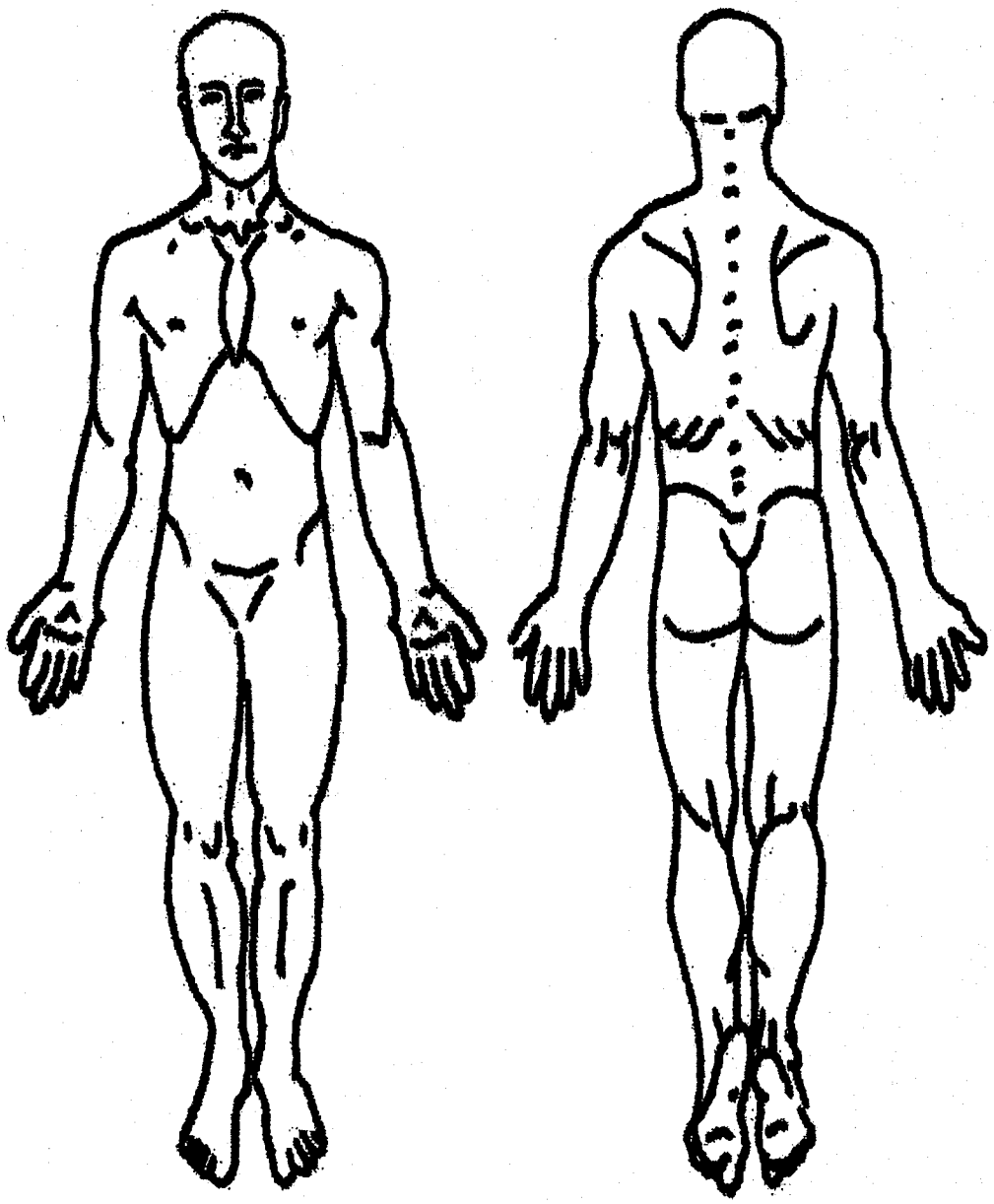
PLEASE CIRCLE:

WHAT MAKES YOUR PAIN WORSE?	SITTING	STANDING	WALKING	LAYING
WHAT MAKES YOUR PAIN BETTER?	SITTING	STANDING	WALKING	LAYING

ON A ONE TO TEN SCALE HOW WOULD YOU RATE YOUR PAIN ON AN EVERY DAY BASIS?_____

Mark the area(s) on your body where you feel the described sensations. Use the appropriate symbols for areas of radiation (include all affected areas).

NUMBNESS/PINS & NEEDLES ++++ PAIN >>>>



PROGRESSIVE SPINE & ORTHOPAEDICS

440 Curry Avenue, Suite A
Englewood, NJ 07631
T: (201) 227-1299
F: (201) 227-0077

HIPAA

PRIVACY ACT

- Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving today a copy of the provider's notice of privacy policies. I consent to the provider's use of protected health information as described in the notice for treatment, payment, of health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

- Reminder/Notification: We may call you to remind you of your appointment or notify you of test results. Do you agree, that we may leave a voice message, identify ourselves and or the doctor as well as notify you of an upcoming appointment. We will not leave test results on your answering machine.

Signature: _____ Date: _____

Request for Restrictions: I request that my protected health information be disclosed to the following persons or facility:

(please list):

_____

_____

_____

Signature: _____

Date: _____

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ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical insurance benefits otherwise payable to me, be madedirectly to Progressive Spine & Orthopaedics.

I authorize the release of any medical or other pertinent information necessary to determine these benefits for payable services rendered by Progressive Spine &Orthopaedics.

I authorize Progressive Spine & Orthopaedics to submit appeals on my behalf for any denied benefits to my medical insurance carrier.

I also authorize Progressive Spine & Orthopaedics to pursue all legal remedies available for the collection of any and all fees and costs due and owing on account of professional services rendered to me by Progressive Spine & Orthopaedics. By this authorization I expressly confer upon Progressive Spine & Orthopaedics, the right to file suit against any party who may be responsible for paying any fees and costs incurred on account of professional services rendered to me, and to exercise the same rights and remedies which I have to collect all such sums, without limitation, including costs of suit and reasonable attorney's fees.

Patient Name: _____ D.O.B.: _____

Relationship if other than patient: _____

Signature: _____ Date: _____

New Jersey Department of Banking and Insurance

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 [Progressive Spine & Orthopaedics] 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.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.