HUNTSPINE

GABRIEL E. HUNT, JR., M.D.

Patient Information Sheet

***Please present ALL Insurance cards and Driver's License at time of visit.**

COMPLETE ALL FIELDS as best as possible.

Name: (First) _____ (MI)_____ (Last)_____

Date of Birth:_____ Social Security #: _____ Age:_____ Sex:____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Mailing Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____Cell:_____ Email Address:_____

Occupation: _____ Employer: _____Work Phone: _____

Employer Address: _____

Pharmacy Name: _____Town:_____Phone:_____

Primary Care Physician: _____Town: _____ Phone:_____

Referring Physician: _____Town: _____ Phone:_____

Emergency Contact Name: _____Relationship: _____Phone:_____

Primary Insurance Plan: _____ ID #:_____

Address:_____

Primary Insurance Plan Holder's Name: _____DOB: _____

Relationship to Patient:_____

Secondary Insurance Plan: _____ID #:_____

Address: _____

Primary Insurance Plan Holder's Name: _____ DOB: _____

Relationship to Patient:_____

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Patient Release: MUST BE SIGNED BY PATIENT: I understand that Hunt Spine LLC, will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Hunt Spine LLC, will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false of misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Hunt Spine LLC, staff to release any information pertinent to my care concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ Date: _____

HUNTSPINE

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Past Medical History

PATIENT NAME: _____

Please mark your past medical history (Illnesses, Injuries, Hospitalizations, etc.)

☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Osteoporosis
☐ Asthma/Lung Disease	☐ Gastritis or Ulcers	☐ High Blood Pressure	☐ Thyroid Problems
☐ Blood Clots	☐ Headaches	☐ High Cholesterol	☐ Seizures
☐ Cancer	☐ Head Injury/Concussion	☐ Kidney or Liver Disease	☐ Stroke

☐ Other_____

Past Surgical History

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Allergies to Medication or foods (Please list all) _____

_____

_____

Please list your history of motor vehicle accidents, back injuries, etc. (Date, Did your symptoms resolve?, Duration of symptoms) _____

_____

_____

Medications (Please list all medications, over the counter drugs, vitamins and any herbal remedies)

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

*Female Patients: I hereby state that, to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this particular time.

YES NO

Patient Signature: _____Date: _____

HUNTSPINE

GABRIEL E. HUNT, JR., M.D.

Conservative Treatment Prior to Office Visit today

	Successful (Yes/No)	Did it provide any relief?	Comments (Last Visit)
Cervical Collar/LSO Brace			
Analgesics			
Physical Therapy			
Chiropractic Therapy Name of Dr.			
Pain Management Name of Dr.			
Epidural Steroid Injection / Facet How many?			

Social History

	Never	Occasionally	Frequently	Daily
Tobacco				
Recreational Drugs Please Specify:				
Vape/Nicotine				

HUNTSPINE

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Auto Accident / Worker's Comp

***If you are being seen as the result of an Auto Accident or Worker's Compensation Case,**

COMPLETE ALL FIELDS as best as possible.

Name: (First) _____ (MI)_____ (Last)_____

Were you in an accident: ☐ Motor Vehicle ☐ Workers Comp ☐ Fall ☐ Lifting

☐ Other: _____

Date of Accident/Injury: _____State of Accident/Injury: _____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

☐ Other: _____

ATTORNEY INFORMATION

Attorney's Name: _____ Attorneys Phone #:_____

Attorney's Firm: _____ Attorneys Fax #:_____

Attorney's Address: _____

Paralegal Name/Email:_____

INSURANCE INFORMATION

Insurance Company: _____

Claim #:_____ Policy #: _____

Insurance Co. Billing Address: _____

Insurance Co. City: _____ State: _____ Zip: _____

Claims Rep. Name: _____ Email: _____

Claims Rep. Phone: _____ Fax #: _____

Case Manager/Pre-Cert Company:_____

Case Manager/Company Phone #: _____

Does Office Visit/Treatment require auth? _____

HUNTSPINE

GABRIEL E. HUNT, JR., M.D.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature, that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed: _____

This consent was signed by: _____

(PRINT NAME)

Signature: _____ Date: _____

Witness: _____ Date: _____

HUNTSPINE

GABRIEL E. HUNT, JR., M.D.

HIPAA Compliant Authorization for the release of

Patient Information

I, _____, hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, summary, narrative or my protected health information, to Dr. Gabriel E. Hunt Jr., under Hunt Spine LLC.

Patient's Signature: _____

Date of Birth: _____

Social Security Number: _____

HUNTSPINE

GABRIEL E. HUNT, JR., M.D.

Assignment of Benefits

1. I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my benefits, rights and interests, including the right to direct payment from any insurance carrier or other payor to Hunt Spine LLC, hereafter referred to as "the medical provider" as well as the right to pursue and obtain payment from the above-mentioned insurance carrier or other payor. This assignment shall include but is not limited to, all benefits, rights and interests available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey, New York, and Pennsylvania, Federal Statutes, including ERISA, and/or the common law.
2. I assign, to the medical provider, all my benefits, rights and interests, including the right to direct payment, under the insurance contract for payment for services rendered to me.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier or other payor, payment of my medical bills may be denied, and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or have same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier or other payor and/or other insurance carrier or other payor to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier or other payor fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance provider.
7. To prevent the insurance carrier or other payor and/or the vendor designated by the insurance carrier or other payor from refusing to accept my Assignment or submitting a challenge to my Assignment as being invalid, I execute this Special Power of Attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier or other payor in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retainer agreement between me and the attorney chosen by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if an arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical provider's bills whom I have not executed an Assignment of Benefits with could make me liable for payment to that provider. In consideration, this medical provider has agreed to accept as payment in full, the amount awarded and/or settled and will not seek additional payment from other insurance carrier or other payors.

Signature of the Patient: _____ Date: _____

Print name: _____

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, [ ], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] 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 or the Chapter 32 Independent Arbitration System, 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.

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 ☐ 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: _____

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.