PATIENT INFORMATION

• Doctor you are seeing today: _____ • Appointment Date: _____

• PATIENT NAME _____

• PLEASE CHECK: ☐ Male ☐ Female • ARE YOU: ☐ Right ☐ Left Handed ☐ Ambidextrous

• BIRTH DATE _____ • AGE _____ • HEIGHT ____ ft _____ in • WEIGHT _____ lbs

• OCCUPATION: _____

☐ FT / ☐ PT / ☐ Self-Employed / ☐ Unemployed / ☐ Retired / ☐ Disabled / ☐ FT Student / ☐ PT Student

DOCTOR INFORMATION

Referring Doctor / Athletic Trainer / Physical Therapist / Friend

Family Medical Doctor

INJURY INFORMATION

• Date of injury or accident or onset of symptoms: _____

• Side of the body you are being seen for today (circle one): **LEFT** **RIGHT** **BILATERAL**

• **Please list body part(s):**_____

• Describe your injury/onset of your symptoms

_____

_____

_____

_____

Have you been seen for a previous injury or symptoms for this body part? ☐ Yes ☐ No

If yes, by whom: _____

• ☐ Auto Accident?** • ☐ Work Injury?

****If you selected <u>Auto Accident</u>, please sign below:****

I hereby authorize my motor vehicle insurance carrier to release information to Professional Orthopaedic Associates regarding the PIP benefits that have been paid to date on my claim.

Signature: _____ Date: _____

TREATMENT

Seen in ER? When: _____ Where: _____

Treatments? ☐ Injection ☐ Physical Therapy ☐ NSAID / Pain Meds ☐ Brace

Tests/Scans Done? ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

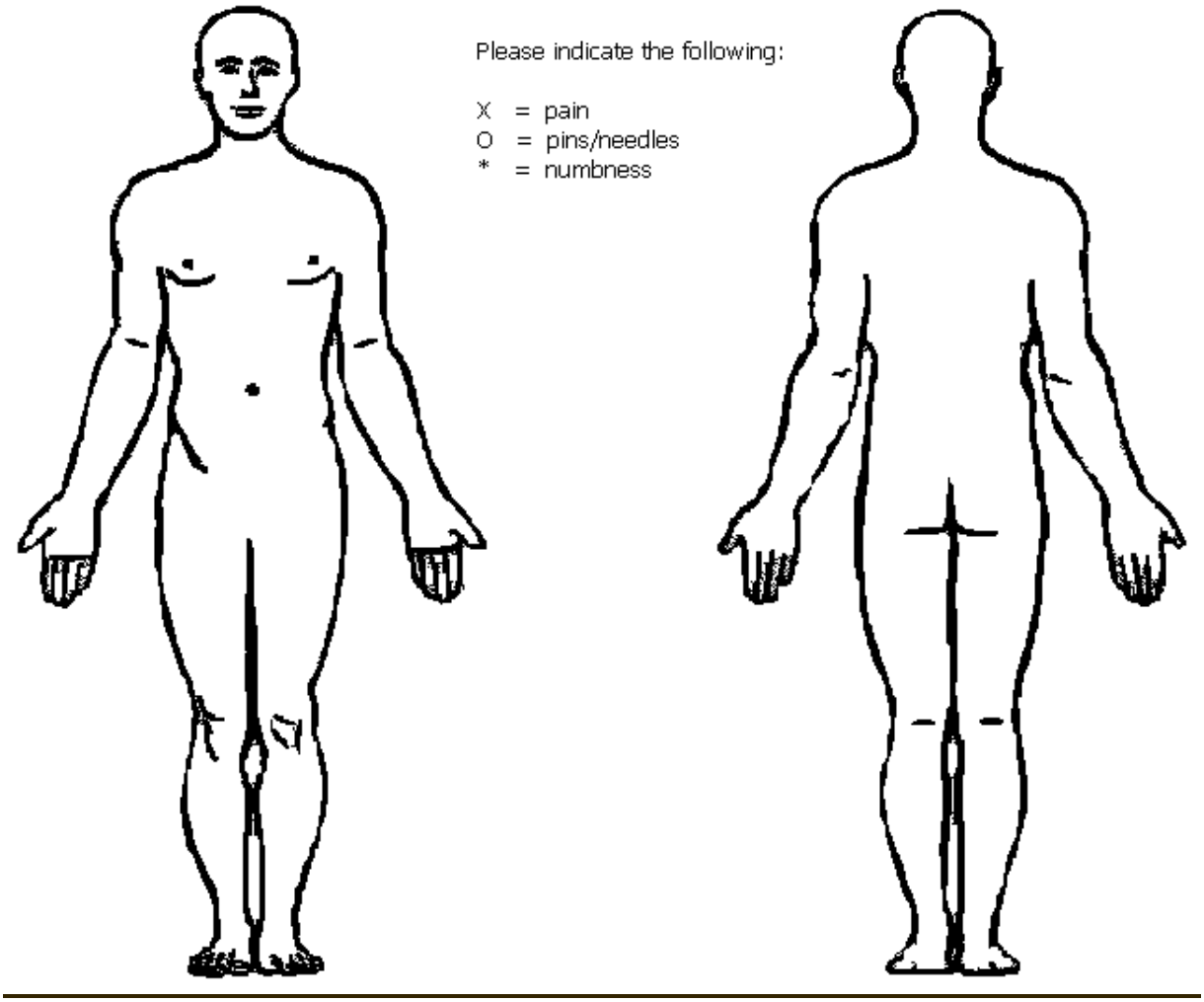
Where? _____ Did you bring them with you today? ☐ Yes ☐ No

PAIN ASSESSMENT

Please indicate the level of your pain for the injury listed above. Please circle the number below.

0 1 2 3 4 5 6 7 8 9 10

- Location of pain (place mark(s) where you have pain)



- Character of pain (circle all that apply)

SHARP ACHY DULL BURNING TINGLING ELECTRIC STABBING

- What activities or positions make the pain worse? _____

PAST MEDICAL HISTORY ☐ None

Do you have any of the following medical problems? Please check all that apply:

☐ Anemia	☐ Heart Murmur	☐ Liver Disease/Hepatitis	☐ Pulmonary Emboli/Blood clots
☐ Asthma	☐ High Blood Pressure	☐ Lupus/SLE	☐ Rheumatoid Arthritis
☐ Diabetes	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Skin Rash/Psoriasis
☐ Emphysema/COPD	☐ Irregular Heartbeat	☐ Osteoarthritis	☐ Stroke
☐ Gout	☐ Irritable Bowel	☐ Osteoporosis	☐ Thyroid Disease
☐ Heart Attack /CAD	☐ Kidney Problems	☐ Phlebitis	☐ Ulcers

☐ Cancer- type: _____

PAST SURGICAL HISTORY ☐ None

Have you ever had surgery? Please check and give the dates to all that apply.

	DATE		DATE		DATE
☐ Appendix	_____	☐ Bowel/Colon	_____	☐ Breast Biopsy	_____
☐ Gallbladder	_____	☐ Gynecologic	_____	☐ Heart Surgery	_____
☐ Pacemaker	_____	☐ Hernia Repair	_____	☐ Tonsils	_____

☐ Cosmetic Surgery_____(type & date)

☐ ORTHOPAEDIC (please list all)_____

☐ Other surgery:_____

MEDICATIONS ☐None

Do you take any of the following medications on a regular basis? Please check all that apply.

☐ Anti-Inflammatory ☐ Aspirin ☐ Birth Control Pills ☐ Coumadin/Xarelto/Eliquis

Please list any prescription medications you are currently taking: _____

_____

_____

ALLERGIES ☐ None

Please list and/or check all that apply:

☐ Cats/Dogs ☐ Dairy ☐ Eggs ☐ Hay Fever ☐ Iodine ☐ Latex ☐ Mold ☐ Nuts
☐ NSAIDS ☐ Penicillin ☐ Pollen ☐ Poultry ☐ Seafood/shellfish ☐ Sulfa/Sulfur

If not listed above, please provide:

Drugs:_____ Food:_____ Environmental:_____

Other:_____

PHARMACY INFORMATION

Please list your **complete** pharmacy information.

Name & Address:_____

FAMILY HISTORY

Please list any significant family medical history: _____

_____

SOCIAL HISTORY

Please check all that apply:

Do you smoke tobacco/Vape? ☐ Every day? ☐ Some days? ☐ Never smoked? ☐ Former Smoker?
How much per day/week? _____ Years smoked? _____ When quit? _____

Do you drink alcohol? ☐ No ☐ Yes If Yes, how often? ___Daily ____Other ____/ week

Have you ever been treated for chemical dependence? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Hobbies_____

Musical Instrument_____ Sports_____

Are you HIV Positive? ☐ NO ☐ YES **Have you received a COVID vaccination?** ☐ YES ☐ NO

REVIEW OF TODAY'S SYMPTOMS

Circle the SYMPTOM(S) that apply or if none apply circle: DENIES ANY

SYSTEM		SYMPTOMS				
Gastrointestinal	-	heartburn/ulcers	nausea/vomiting	bloody stools	hepatitis	liver disease
Endocrine	-	thyroid disease	heat/cold intolerable			
Constitutional	-	weight loss	loss of appetite			
Eyes	-	blurred vision	double vision	vision loss		
ENT	-	hearing loss	hoarseness	trouble swallowing		
Cardiovascular	-	chest pain	palpitations			
Respiratory	-	chronic cough	shortness of breath			
Genitourinary	-	painful urination	blood in urine	kidney problems		
Skin	-	frequent rashes	skin ulcers	lumps	psoriasis	
Neurologic	-	headaches	dizziness	seizures		
Psychiatric	-	depression	drug/alcohol addiction	sleep disorder		
Hematologic	-	easy bleeding	easy bruising	anemia		
Allergic	-	seasonal	other please list: _____			
Lymphatic	-	leg swelling				
Musculoskeletal	-	fracture	joint swelling	sprains	dislocation	
Vascular	-	claudication				
Miscellaneous	-	vitamin D / Calcium supplements		bone density test		

PATIENT DEMOGRAPHICS

Patient Name _____ Preferred Name: _____

Address _____ City _____

State _____ Zip Code _____ Birth Date _____ Social Security # _____

Phone #'s: Home _____ Work _____ Cell _____

****

Email address _____How would you like us to contact you? Phone:___home ___cell ___work

How did you hear about our practice? Family/Friend Brochure Yellow Pages Website Other _____

****

Patient Employer _____

Employer's Address/Phone # _____

Please list your attorney's information (if applicable to this injury):
Name/Address/Phone#: _____

****

PRIMARY INSURANCE

Will the primary insurance subscriber/insured party be responsible for the account? Y N

Name of Insurance Plan _____

Claim Address _____

Policy # _____ Group # _____

SUBSCRIBER /INSURED PARTY INFORMATION:

Name _____ Address _____

Home phone # _____ Date of Birth _____ Social Security # _____

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Is this insurance coverage through the subscriber's employer? YES NO

Employer _____

Employer address _____ Employer phone # _____

Effective date of Insurance _____

SECONDARY INSURANCE

Name of Insurance Plan _____

Claim Address _____

Policy # _____ Group # _____

SUBSCRIBER/INSURED PARTY INFORMATION:

Name _____ Address _____

Home phone # _____ Date of Birth _____ Social Security # _____

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Is this insurance coverage through the subscriber's employer? YES NO

Employer _____

Employer address _____ Employer phone # _____

Effective date of Insurance _____

GUARANTOR INFORMATION - **Please list who will be responsible for the account.**

☐ SELF ☐ SAME AS PRIMARY INSURANCE ☐ OTHER

Name _____ Address _____

Home phone # _____ Date of Birth _____ Social Security # _____

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Employer _____

Employer address _____ Employer phone # _____

**** If this is a workers comp or motor vehicle related injury please complete the information below****

Please circle one WORKERS COMP MOTOR VEHICLE

Insurance Company _____

Adjuster/Case Manager _____ Phone # _____

Address _____ Claim # _____

Employer _____

Patients with no insurance: Payment is expected at the time of service. A specific payment plan acceptable to both you and the office may be arranged.

PRACTICE POLICY

We extend to our patients the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out-of-pocket expense.

Please note the following:

1. **The privilege of insurance assignment begins when your insurance is qualified and the insurance forms received. Until that time you must pay for all services rendered.**
2. **All deductibles must be made prior to submitting your insurance claims.**
3. **Since we do not own your insurance policy, we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.**
4. **Due to the recent changes in our status with most insurance companies, it will be your responsibility to turn over to our office any checks and related explanations of benefits that your insurance company issues to you for services rendered with Professional Orthopaedic Associates in a timely manner.**
5. **It is our goal of this office to provide you with the finest quality of care available. If you have any questions regarding your healthcare or any of our office policies, please do not hesitate to let us know.**
6. **If it becomes necessary to utilize a collection agency due to nonpayment of your bill, you will be responsible for all fees charged by that agency as well as your balance.**
7. **I hereby authorize the release of information to and from my insurance company, attorney, school, pharmacy or any other entity involved as it is related to my care and treatment.**
8. **Patients with insurance: Deductibles, copays and all co-insurances are expected at the time of service. Your co-insurance is not covered by your insurance and is not always an exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility. If a patient's balance remains unpaid for more than 90 days, the patient's account may be turned over to an attorney/collection agency for collections. If your account is sent to collections, you will be responsible for all collection fees generated.**

Please sign below:

I have reviewed these office policies and accept my responsibility as detailed above. I authorize my insurance company to make payments for my unpaid balance directly to: Professional Orthopaedic Associates

Print Name: _____

Signature: _____ **Date:** _____

LEGAL ASSIGNMENT OF BENEFITS & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Professional Orthopaedic Associates and it's physicians (the "provider(s)"), as my designed Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefits payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insurance/Guardian Date

_____

Print Name of Insured/Guardian

ANTI-INFLAMMATORY MEDICATION

PATIENT NAME: _____

Your doctor may prescribe a non-steroidal anti-inflammatory (NSAID) medicine to help alleviate your symptoms of pain, swelling or inflammation, such as the following:

Advil	Mobic
Aleve	Naproxen
Celebrex	Naprosyn
Diclofenac-Sodium	Oxaprotin (Daypro)
Ibuprofen	Piroxicam (Feldene)
Indomethacin (Indocin)	Voltaren

The most frequent side effects of this medication include, stomach upset, nausea and diarrhea. Ulcers or bleeding may occur without warning. It is recommended that this medicine be taken with food, which may reduce the appearance or magnitude of these side effects. Do not drink alcoholic beverages while taking this medication.

For best results, this medicine should be taken at the prescribed dose for the period of time recommended by your physician. If you take any other medications prescribed by other physicians, you should consult your pharmacist prior to filling this prescription to check for drug interactions.

Should you develop any side effects with this medication, stop taking it immediately and contact your physican or this office. Patients with active ulcer disease or who are taking daily medicines for bronchial asthma; must be aware that use of this medicine may result in an exacerbation of these problems. This medicine should not be taken in combination with other NSAID or aspirin containing medications. **Please note that commonly used over the counter medicines such as Ibuprofen, Advil, and Aleve contain non-steroidal medications that could increase the risk of stomach side effects of prescribed medication. Tylenol, however, would not increase this risk.**

For your protection, periodic blood work, within 6-8 weeks after taking this medication will be necessary to monitor any possible liver or kidney irritation.

If you are pregnant, have the flu, fever or any viral illness; do not take this medication. Consult your physican.

I have read and understand the above information.

PATIENT SIGNATURE: _____ DATE: _____

HIPAA AUTHORIZATION AND ESIGNATURE CONSENT DISCLOSURE

I understand that I (patient), or an authorized representative, must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alphanumeric date (e.g., January 1, 2006) unless the signature is on file. I understand that in lieu of signing the claim, that I may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements" (see. Rev. 10540, 06-11-21)[1] I understand that the authorization is effective indefinitely unless I, or my representative revokes this arrangement. **Note: I understand that this can be a "Signature on File" and/or computer generated.**

I understand that my healthcare plan is required: 1) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care; 2) be comprehensive, requiring minimal augmentation by paper or other communications; and 3) provide for timely acknowledgment response. I understand this also includes but is not limited to status reporting that supports a transparent claims and denial management process (including adjudication and appeals), describing all data elements (including reason and remark codes) in unambiguous terms. (see. Section 1104 ACA)

I understand and acknowledge that the Provider has, to the extent feasible and appropriate, verified eligibility, obtained preauthorization, and informed me of my financial responsibility for specific service(s) prior to or at the point of care consistent the Health Information Technology for Economic and Clinical Health Act. Pub. L. No. 111-5, 1234 Stat. 226 and the Department of Health and Human Services Regulations, 45 C.F.R. § 160 et seq. (collectively, "HIPAA").

I certify that I knowingly, voluntarily, and specifically agreed to the use of my signature on all my insurance and/or employee health care benefit claims submission(s) consistent with the regulations explained to me within this **HIPAA Authorization and Electronic Signature Consent Disclosure**. This includes signatures in compliance with the E-Sign Act and Uniform Electronic Transactions Act. A photocopy, computer generated, or any other reproduction of this signature and assignment/authorization is to be considered valid, and the same as if it was the original.

This form is intended to protect patients from surprise medical bills and increase transparency by requiring certain health care facilities and insurers to disclose certain required information.

Patient Name: _____

Patient Date of Birth: _____

Subscriber Employer: _____

Authorized Rep Name (If different from patient) : _____

Patient/Authorized Rep Signature: _____

Date: _____

Staff Acknowledgement (*for office use only*): _____

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
PROFESSIONAL ORTHOPAEDIC ASSOCIATES, P.A.

Patient Name _____ **Date of Birth** _____

Address _____

****As required by the Privacy Regulations, Professional Orthopaedic Associates, P.A. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.****

I give permission for Professional Orthopaedic Associates, P.A. and any of its employees to contact me via the following type of electronic communication, if needed: (please circle YES or NO)

Email: Yes No **SMS Text Messaging: Yes No**

I give permission for Professional Orthopaedic Associates, P.A. and any of its employees to release any or all of my Patient Health Information to the following relatives, friends, or acquaintances:

_____

_____

I give permission for Professional Orthopaedic Associates, P.A. and any of its employees to leave information related to any or all of my care at the following number:

_____ **Home Cell Work**
(please indicate what kind of number you have listed)

Patient information to be disclosed : <u>All</u> **For the specific purpose of : <u>Any</u>**

Effective date for authorization _____/_____/_____ .

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and is no longer protected by these regulations.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

I understand I have the right to:

1. Revoke this authorization by sending a written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

_____ _____
Signature of Patient or Patient's authorized representative **Date**

_____ _____
Authorized signature of Professional Orthopaedic Associates staff **Date**

DISCLOSURE(S) TO COVERED PERSON(S) REGARDING OUT-OF-NETWORK TREATMENT

Please read carefully before you sign

I certify that I have insurance and/or employee health care benefits coverage which provides both In- Network (INET) and/or Out of Network (ONET) benefits. I certify that I have been informed that the referenced Provider organization and/or its associated Providers are Out-of-Network (ONET) as required under the Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L. 2018, c. 32 ("Act").

I understand and acknowledge that the Act was to limit a covered person's financial responsibility to the network level cost-sharing as applied to the allowed amount/charge when inadvertent and/or involuntary services are rendered by Providers who are not members of a managed care network (i.e., PPO Network).

I understand and acknowledge that "a covered person's cost-sharing liability under the Act is based upon the application of network cost-sharing, not a network level reimbursement amount." (Bulletin NO. 18-14) The transparency and claims processing provisions apply to all carriers operating in New Jersey consistent with the Administrative Simplification provisions mandated under numerous State and Federal healthcare regulations as detailed within this disclosure/notification.

I understand and acknowledge that the Provider has, to the extent feasible and appropriate, verified eligibility, obtained preauthorization and informed me of my financial responsibility for specific service(s) prior to or at the point of care consistent the Health Information Technology for Economic and Clinical Health Act. Pub. L. No. 111-5, 1234 Stat. 226 and the Department of Health and Human Services Regulations, 45 C.F.R. § 160 et seq. (collectively, "HIPAA").

I certify that I knowingly, voluntarily, and specifically selected the referenced ONET Provider(s) with full knowledge that the provider is ONET with respect to my health benefits plan and consent to the treatment plan the Provider may recommend.

I authorize the use of my signature on all my insurance and/or employee health care benefit claims processing including but not limited to, requesting data, verifying eligibility, adjudication and appeals consistent with section 1104(b)(2) of the Affordable Care Act. This includes signatures in compliance with the E-Sign Act and Uniform Electronic Transactions Act.[2] A photocopy, computer generated, or any other reproduction of this signature and assignment/authorization is to be considered valid, and the same as if it was the original.

I have read this express assignment/authorization and it has been explained to me prior to the Provider submitting my healthcare claims for reimbursement.

Patient Name: _____

Patient Date of Birth: _____

Subscriber Employer: _____

Authorized Rep Name (If different from patient) : _____

Patient/Authorized Rep Signature: _____

Date: _____

Staff Acknowledgement (for office use only): _____

[2] 15 U.S.C.A. § 7001(a)(2)

Professional Orthopaedic Associates

Office Locations

Tinton Falls Office

776 Shrewsbury Ave. Suite #105 - Tinton Falls, NJ 07724 - P: 732-530-4949 - F: 732-530-3618

Toms River Office

1430 Hooper Ave. Suite # 101 - Toms River, NJ 08753 - P: 732-530-4949 - F: 732-349-7722

Freehold Office

303 West Main Street - Freehold, NJ 07728 - P: 732-530-4949 - F: 732-577-0036

****

If your injury does warrant surgery, please be advised that your ambulatory surgery may be scheduled at the:

Shrewsbury Surgery Center

655 Shrewsbury Ave. - Shrewsbury, New Jersey

Toms River Surgery Center

1430 Hooper Ave. - Toms River, New Jersey

SurgiCare

901 West Main St. – Freehold, New Jersey

The physicians at Professional Orthopaedic Associates
have an ownership interest in the Surgery Centers.
Patients that wish to have their ambulatory surgery performed
elsewhere may do so at a hospital where the physician maintains privileges.
Thank you