ATLANTIC ORTHOPAEDIC ASSOCIATES

91 S. Jefferson Road Suite 201 Whippany, NJ 07981 ph) 973-599-9779 fax) 973-599-1179

Richard S. Schenk, MD Patricio Grob, DO Anthony O. Spinnickie, MD

PATIENT INFORMATION

PATIENT'S NAME (First) _____ (Last) _____

AGE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY # : _____ - _____ -_____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

MAILING ADDRESS (If Different): _____

HOME PH ( ) _____ WORK PH ( ) _____ CELL PH ( ) _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____

NAME OF SPOUSE/PARENT: _____ DOB: _____ SOCIAL SECURITY #: _____ - _____ - _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: ( )_____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

PHONE #: ( ) _____ RELATIONSHIP TO PATIENT: _____

HOW WERE YOU REFERRED TO US: NAME: _____

☐ Physician ☐ Friend ADDRESS: _____ CITY_____ ST_____

☐ Yellow Pages ☐ Newspaper ZIP: _____ TELEPHONE: ( )_____

Signature: _____ Date: _____

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PAST MEDICAL HISTORY

NAME: _____ DATE: _____/_____/_____

1. Please list any serious illnesses in your lifetime, (give dates):

   _____

   _____

2. Please list any PRIOR surgeries (names and dates of operations):

   _____

   _____

3. Please list any PRIOR fracture(s) or dislocation(s):

   _____

   _____

4. Please give the names of treated conditions/and physicians being treated at the present time:

   _____

   _____

5. Please list names and dosage(s) of any medications you are now taking:

   _____

   _____

6. Please list any allergies, particularly to any medications:

   _____

   _____

7. If you have had any of the following, please give the date of onset:

   Arthritis _____ Gout _____ Ulcers_____

   Diabetes_____ High Blood Pressure_____

SIGNATURE_____

Relationship to Patient (Self, Mother,etc.) _____

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INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE: _____ ID #: _____

NAME OF INSURED: _____ DOB: _____ SSN#: _____

SECONDARY INSURANCE COMPANY: _____ ID #: _____

NAME OF INSURED: _____ DOB: _____ SSN #: _____

**** PLEASE EXPLAIN HOW AND WHERE YOUR INJURIES OCCURRED:***

_____

_____

_____

ARE YOUR INJURIES A RESULT OF A WORK-RELATED ACCIDENT? Y / N

ARE YOUR INJURIES A RESULT OF A MOTOR VEHICLE ACCIDENT? Y / N

DATE OF ACCIDENT: _____ CLAIM #: _____ POLICY #: _____

NAME & ADDRESS OF AUTO/WC CARRIER: _____

NAME OF CASE MANAGER: _____ PHONE #: ( ) _____ (EXT)

NAME OF ADJUSTER: _____ PHONE #: ( ) _____ _____ (EXT)

Signature: _____ **Date:** _____

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Please Be Aware:

PRESCRIPTION REFILLS: Due to the increased number of refill prescriptions being requested in our office, we must strictly enforce a 48-hour notice policy for prescription refills. Prescriptions will be filled within 48 hours after your request has been made. Calls for prescription refills should always be made during our usual business hours. Absolutely no refills will be called in on the weekends or after office hours. Always provide the following information when calling for a refill:

1. Name of doctor in our office who issued the prescription.
2. Name and spelling of the medication.
3. Dosage taken (how many milligrams, etc.), and how it is taken (i.e.: 2 a day with food).
4. Pharmacy phone number.
5. Prescription number (found on bottle of your prescription).
6. Advise of any allergies.

Please be aware that some controlled substances (such as Percocet) cannot be called into the pharmacy. The state of New Jersey requires that the original prescription must be picked-up from our office. Your prescription will be ready for pick-up within 48 hours of your request.
**Please make sure you are up-to-date on your follow-up appointments before requesting a refill. Prescriptions will not be refilled if a patient continues to miss scheduled appointments.*
**Prescriptions are always refilled at the discretion of your physician.*

DISABILITY FORMS: We will be happy to fill out your disability forms at NO CHARGE to you, we just ask that you give 7-10 BUSINESS days for your forms to be completed. You will receive a call from us once they are complete, at which time they can be mailed to your home or disability address, or we can fax them.
****OUR DOCTORS CAN NOT FILL OUT ANY FORMS DURING YOUR OFFICE VISIT!***

By signing, I agree that I have read the above:

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

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FINANCIAL POLICY

We participate with the following insurances:
Medicare
Motor Vehicle Insurance
Workers Compensation

We treat many patients who have insurance providers with which we do not participate. We are pleased to look at each situation and work with our patients so the financial aspect of their treatment will not be a burden.

Payment Information:
-If your insurance company does not pay the bill in full, or pays based on their usual and customary fees, the balance will be billed to you.

-If we do not participate with your insurance, you will be expected to pay at the time of service.

-Please be aware that we do not bill secondary insurances. Our office will be more than happy to provide you with all the necessary forms for you to submit to your secondary carrier.

Workers Compensation & No Fault / Auto: Your insurance will be verified prior to your visit. Any deductible or co-payments will be billed to you after your insurance pays. All office visits will be pre-authorized with your insurance company before your visit. 72 hours are required before authorization/approval can be obtained.

Payment Options:
Cash
Check
Money Order
Visa, MasterCard, American Express

Patients who do not show up for a scheduled appointment without notice will be charged a $100.00 no-show fee. Please call with at least 24 hour notice if you are unable to keep your appointment.

Accounts 90 days passed due will be sent to collections. If an account is sent to an attorney for collections/suit, reasonable attorney's fee's, costs of collection, and any interest accumulated will be added to the unpaid balance.

I have fully reviewed this financial policy and agree to honor the terms outlined. I further authorize disclosure of portions of the patient record which are requested by the insurance company (these may be necessary to determine reimbursement)

_____ _____

Responsible Party Signature Date

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RICHARD S. SCHENK, MD

Diplomate of the American Board of Orthopaedic Surgery

Fellow of the American Academy of Orthopaedic Surgeons

Member of the Orthopaedic Trauma Association

PATRICIO GROB, DO

Board Certified: American Osteopathic Board

Member of the Orthopaedic Trauma Association

Fellowship Trained in Spine Surgery

ANTHONY O. SPINNICKIE, MD

Board Eligible: American Board of Orthopaedic Surgery

Fellowship Trained in Orthopaedic Trauma

Member of the Orthopaedic Trauma Association

PRIVACY PRACTICES

PATIENT NAME: _____

WITNESS: _____

DATE: _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING:

_____

_____

_____

_____

_____

_____

_____

_____

(On the lines above, please write the names of family members, friends, or personal attorneys that may call our office on your behalf. If someone is to call our office on your behalf and is not named in the lines above, we will not be able to share any medical information with them.)

SIGNATURE: _____

(PATIENT / OR REPRESENTATIVE)

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ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER TO ATLANTIC ORTHOPAEDIC ASSOCIATES, ALL RIGHTS IN ANY AND ALL CLAIMS WE HAVE WITH:

_____

(NAME OF INSURANCE CARRIER)

FOR PAYMENT OF INSURANCE CLAIMS MADE BY ATLANTIC ORTHOPAEDIC ASSOCIATES FOR SERVICES RENDERED TO ME AS A RESULT OF THE INJURIES IN MY ACCIDENT/INJURY ON

_____

(DATE OF ACCIDENT/INJURY)

I AUTHORIZE AOA TO SUBMIT APPEALS, ON MY BEHALF, FOR ANY UNPAID CHARGES FOR SERVICES RENDERED TO ME AND BILLED TO ABOVE-MENTIONED INSURANCE CARRIER.

PATIENT NAME: _____ **WITNESS NAME:** _____

ADDRESS: _____ **ADDRESS:** 91 S. JEFFERSON ROAD

_____ SUITE #201 - WHIPPANY, NJ 07981

TELEPHONE: (_____) _____ - _____ **TELEPHONE:** (973) 599 - 9779

X _____ X _____

(PATIENT SIGNATURE) (WITNESS SIGNATURE)

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 [AOA] 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.