THE SPINE & HEALTH CENTER OF NEW JERSEY

PLEASE COMPLETE **ALL** OF THE FOLLOWING INFORMATION AS ACCURATELY AS POSSIBLE. THANK YOU.

How did you hear about our office? [ ] Yellow Pages [ ] Sign [ ] Friend [ ] Patient [ ] Promotion ____________________________

[ ] Other (Please specify) __________________________________ If referred by a patient, WHOM? ___________________________

ABOUT YOU

Full Name _____________________________ Prefer to be called _________________________Home Phone________________________

Cell Phone _____________________________Work Phone _____________________________ Email _____________________________

Address____ City______________________________ State____________ Zip_________

Employer ________________________________ Occupation _______________________________________ Marital Status _____________

Employer Address____ City __________________________State_____ Zip___________

SSN_______-____-________ Date of Birth_____/_____/_____ Age _____ Driver's License # _______________________ State _________

PRIMARY INSURANCE

Company Name____ ID Number _________________________ Group # ______________

Policy Holder's Name ___________________________________Telephone # (____) _____________ Policy Holder's SSN_____-____-_____ Policy Holder's DOB_____/_____/_____ Relationship to Patient___________________ Policy Holder's Employer _____________________

SECONDARY INSURANCE (if applicable)

Company Name____ Insured's Name____

Company Address____ City____________________________ State_____ Zip___________

Telephone # (______) _____________ Insured's SSN:_____-____-_____ Insured's DOB_____/_____/_____ Group # ___________________

EMERGENCY CONTACT

Name__________________________________ Relationship_____________________ Telephone (_____) ___________________________

PRIMARY CARE PHYSICIAN (MEDICAL DOCTOR)

Name_____________________________ Office Address ____ Telephone (____) _____________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been to a chiropractor before? ☐ No ☐ Yes If "Yes", when? ______________________________________
2. Were you ever injured in an automobile accident either as a passenger or the driver? ☐ No ☐ Yes If "Yes", when? ______________________________________
3. Were you ever injured at work or as the result of employment? ☐ No ☐ Yes If "Yes", when? ______________________________________

CHIEF COMPLAINT

What is the primary symptom that prompted today's visit? ____

What other symptoms are you experiencing, if any? ____

Have you seen anyone else for this condition? ☐ No ☐ Yes

If "Yes", who else have you seen? (Include hospital/E.R. visits and names of physicians. Please note details, if known. If you need additional space, use the back of this page. If any of these practitioners referred you here, please indicate that as well.) ___________________________

____

When did you first experience the problem that prompted your visit? ____

Onset characteristics: ☐ Occurred suddenly ☐ Occurred gradually ☐ Progressively worsened over time

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Do you have a personal or family history of cancer/malignancy? ☐ No ☐ Yes, personal ☐ Yes, family
If "family", please indicate family relation: ____

Do you have any personal or family history of Diabetes? ☐ No ☐ Yes, personal ☐ Yes, family
If "family", please indicate family relation: ____

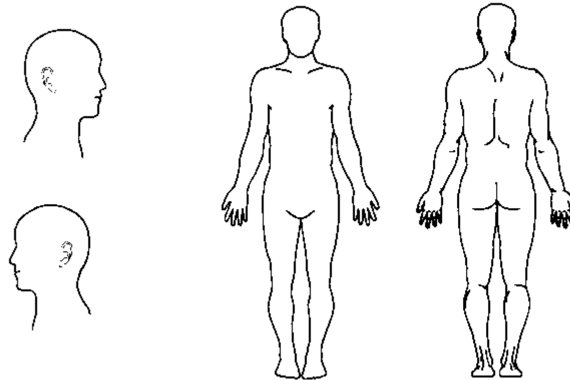
Do you have any other pertinent personal or family history? ☐ No ☐ Yes, personal ☐ Yes, family
If "yes" please list: ____

CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR MEDICAL HISTORY AND CURRENT SYMPTOMS

[ ] Allergies
[ ] Anemia
[ ] Arm/Shoulder Pain
[ ] Arthritis
[ ] Asthma/Difficulty Breathing
[ ] Bladder Infection
[ ] Buzzing/Ringing Ears
[ ] Cancer
[ ] Chest Pain/Heart Trouble
[ ] Cold, Tingling Extremities
[ ] Concentration Loss
[ ] Constipation/Diarrhea/Colon
[ ] Convulsions/Epilepsy
[ ] Cold Sweats
[ ] Depression
[ ] Diabetes
[ ] Disc Problems
[ ] Dizziness
[ ] Ear Infections
[ ] Fainting
[ ] Fatigue
[ ] Fever
[ ] Gallbladder Symptoms
[ ] Head seems too Heavy
[ ] Headaches/Migraines
[ ] Hepatitis/liver symptoms
[ ] Hip Pain
[ ] Indigestion/Stomach
[ ] Insomnia/Sleeping Problems
[ ] Joint Pain
[ ] Kidney Problems
[ ] Light bothers eyes
[ ] Loss of energy
[ ] Loss of memory
[ ] Loss of smell/taste
[ ] Low Back Pain
[ ] Menstrual Pain/PMS
[ ] Mid-back Pain
[ ] Neck Pain
[ ] Nervousness
[ ] Numbness
[ ] Pain down legs
[ ] Pinched Nerves
[ ] Poor Circulation
[ ] Poor Posture
[ ] Scoliosis
[ ] Sinus
[ ] Stress/Tension
[ ] Tight Muscles
[ ] Tuberculosis
[ ] Venereal Disease
[ ] Vision Blurred
[ ] Weight Loss
[ ] Other ____________________

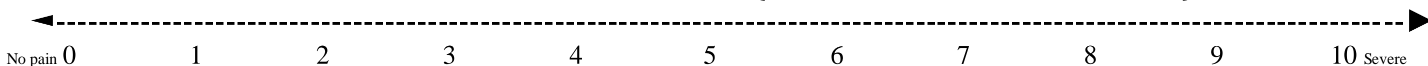
IF YOU CHECKED ANY OF THE ABOVE, PLEASE EXPLAIN: ____

PLEASE OUTLINE ON THE DIAGRAMS BELOW THE AREAS OF YOUR DISCOMFORT



A = Aching	N = Numbness
B = Burning	R = Throbbing
C = Cold	S = Stabbing
H = Hypersensitivity	T = Tingling

PLEASE RATE YOUR PAIN (PLACE AN "X" ON THE SCALE)



No pain 0 1 2 3 4 5 6 7 8 9 10 Severe

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PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

☐ I have missed work because of my symptoms.

☐ The quality of my work/my productivity at work has been affected.

☐ I am unable to perform routine household chores.

☐ My social life has suffered because of my symptoms.

☐ I am unable to participate in recreational activities because of my symptoms.

Current Medications (and dosages, if known): ☐ None

____

____

Previous Surgeries: ☐ None

____

____

Previous Hospitalizations: ☐ None

____

____

Previous Significant Illnesses: ☐ None

____

____

Previous Injuries and Traumas: ☐ None

____

____

Previous History of Similar Condition(s): ☐ None

____

____

ACCOUNT INFORMATION AND TERMS OF ACCEPTANCE

I hereby give my authorization to treat me, or my minor child, as named herein on this form. I also understand that if I suspend or terminate my care and/or treatment, any fees for professional services or goods rendered to me will be immediately due and payable at the regular rates, irrespective of any concessions made, discounts applied and/or other such arrangements I further authorize the physician and/or supplier to release my information as required to process any and all insurance claims. We do not offer to treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of an examination, if we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider. Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others.

I understand the above information in its entirety and hereby guarantee that this form was completed accurately as to the best of my knowledge. I also understand that it is my sole responsibility to inform this office, in a timely manner, of any and all changes to this information.

____________________________________ ____________________________

Patient Signature or Parent/Guardian if patient is a minor **Date Signed**

THE SPINE & HEALTH CENTER OF NEW JERSEY

BLUE CROSS/ BLUE SHIELD PAYMENT POLICY

Dear Patient:

Recently our office received a notice that BC/BS will no longer be paying doctors directly for care. Instead they will only send insurance payments directly to patients.

For this reason, many doctors and hospitals will be requiring patients to pay at the time of service. For many, this will be a financial hardship. In an attempt to make our care more affordable and accessible to all of our patients, we will allow patients the courtesy of receiving payment from the insurance carrier first, and then forward those payment(s) to our office upon receipt.

Understand this is a courtesy and can be withdrawn at any time if we find a patient's account overdue.

By signing this letter you agree to forward all payments to our office immediately upon receipt. If we received payment within 10 days of your receiving them, endorsed and un-cashed, with documentation we will accept those insurance payments in full and you will not be responsible for any additional amounts should they pay less than anticipated. (*Understand this may not include deductible amounts or co-payments, which you may have to pay under your plan.)*

Should you fail to forward payments immediately, however, our office will make you responsible for all charges, even those not covered by the insurance company. After 30 days if we do not receive payment, your account will be sent to our collection agency, or your credit card on file will be billed.

I agree to send all insurance payments received with 10 days of receipt.

____

Patient Name (PRINT)

____ _________________

Patient Signature Date

Please retain your credit card number on file with us.

Credit Card: O Master Card **O** Visa

Name on Credit Card: ______________________ Card Security ID Number:______________

Account Number: __________________________ Exp Date: _______________________

Remember:

1. Send or bring all original checks to our office and **do not cash them**. Sign your name on the back of the check and write "Pay to the order of The Spine & Health Center of Montvale"
2. Include all paperwork sent with the check by the insurance company
3. Advise your spouse if they are the primary insured that payments meant for our office may be sent to their name, and to do the same as above.

THE SPINE & HEALTH CENTER OF NEW JERSEY

RELEASE OF MEDICAL RECORDS

PATIENT NAME: ______________________________ ______________________________
Please Print (Last Name) (First Name)

DATE OF BIRTH: ________________ SOCIAL SECURITY: _______-______-_______

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:
3. The Type of information to be used or disclosed is as follows: (included dates where appropriate)
   - ☐ **Emergency Records** **Date:** ______________
   - ☐ **Operative Reports** **Date:** ______________
   - ☐ **Admission** **Date:** ______________
   - ☐ **X-ray & Imaging Reports** **Date:** ______________
   - ☐ **Consultation Reports** **(Doctor's name):** ________________
   - ☐ **Most Recent Discharge Summary**
   - ☐ **Laboratory Results**
   - ☐ **Entire Records**
   - ☐ **Other** ________________________________
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired Immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

___________________________ ___________________________
(Facility Name) (Facility Address)

For the purpose of: Investigating and pursuing a bodily injury case on my behalf.

1. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: __________. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524, I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individual's name or contact information).

Signature of Patient X______________________ ________________
(Please sign here) (Date)

Signature of Witness X ______________________ ________________
(Please sign here) (Date)

Any person who knowingly files a statement of claim containing any False or Misleading Information is subject to criminal and civil penalties

TO OUR VALUED PATIENTS:
Due to changing Governmental Regulations, we are required to gather additional information for all patients. Please answer the following questions. **ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL.**

Thank you for your cooperation.

Name: ______________________________

Date of Birth: ______________

Race (select one):
Hispanic or Latino: ______________
Not Hispanic or Latino: ______________
Decline to answer: ______________

Ethnicity: (select one)
American Indian or Alaska Native: ______________
Asian: ______________
Black or African American: ______________
Native Hawaiian or other Pacific Island: ______________
Other Race: ______________
White: __________

Height: ____________

Weight: ___________

Allergies: ____

Alcohol Consumption (select one):
None: __________
Yes: __________ # of drinks per day: __________
Occasional/Social: __________________

Do You Smoke Cigarettes?:
Yes: __________ # packs per day: __________ # of cigarettes per day: __________
No: __________

Did You Ever Smoke Cigarettes?:
If Yes: __________ from when: __________ to when: __________
No: __________

PATIENT SIGNATURE: ______________________________ **DATE:** __________

THE SPINE & HEALTH CENTER OF NEW JERSEY

PAYMENT POLICIES/ASSIGNMENT OF BENEFITS

We are committed to providing you with the best possible care. Please read carefully and sign at the bottom of the page indicating your acceptance of our policies and procedures.

1. PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.
   a. Your insurance is a contract between you, your employer and the insurance company. We are not included in your contract.
   b. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover
   c. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
   d. If your account becomes past due and goes to our collections agency, you are responsible for all fees incurred.
2. OUR OFFICE PRIDES ITSELF ON OUR ABILITY TO SEE PATIENTS IN A TIMELY MANNER.

THEREFORE, WE REQUIRE 24 HOURS NOTICE FOR ALL CANCELLATIONS.
THERE WILL BE A $25.00 NO-SHOW OR SAME DAY CANCELLATION FEE.
REPEATED SAME DAY CANCELLATIONS OR NO-SHOWS WILL REQUIRE US TO TAKE A $49 HOLD FEE VIA CREDIT CARD WHICH WILL BE CHARGED AT THE TIME THE APPOINTMENT IS MADE IN ORDER TO BOOK ANY FUTURE APPOINTMENTS. THIS $49 WILL BE CREDITED TO YOUR ACCOUNT (CO-PAY, DEDUCTIBLE, NON-COVERED SERVICE) AFTER YOU COME IN FOR THE APPOINTMENT.

1ST CANCELLATION: $25.00 CANCELLATION OR NO-SHOW FEE.
2ND CANCELLATION: $25.00 CANCELLATION OR NO-SHOW FEE
3RD + CANCELLATION: $49 HOLD FEE TO BOOK FUTURE APPOINTMENTS
(CREDITED TO PATIENT ACCOUNT AFTER VISIT)

3. I HEREBY INSTRUCT MY INSURANCE COMPANY TO PAY BY CHECK MADE OUT TO THE SPINE AND HEALTH CENTER OF MONTVALE.
   a. This is a direct assignment of my rights and benefits under my health insurance policy.
   I agree to pay any balance of professional services charged over and above this insurance payment.
   b. If my current policy prohibits payments directly to the doctor, I agree to mail the check (original or personal) as payment for services rendered.

4. I HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

_______________________________ ____________________

Patient/Policy holder signature **Date**

THE SPINE & HEALTH CENTER OF NEW JERSEY

INFORMED CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, Physical Therapy, Acupuncture and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic, Physical Therapists or Acupuncturists who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments, physical therapy, acupuncture and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to; Temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments. Dizziness, nausea, and flushing: these symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care. Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen. Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before their stroke. Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ____________________________ **Date:** ____________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Spine and Health Center of Montvale is required by law to maintain the privacy and confidentiality of your protected health information.

DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment—We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment—We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers Compensation— We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies—We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes. We may call you at home to remind you of appointments and may leave a message if there is no answer or you are not available. No health information will be disclosed other than the date and time of your next appointment. We may send a letter, postcard, invitation, or call your home in order to participate in certain events. We may from time to time send you newsletters, birthday cards, reminder cards, holiday greeting cards, thank you cards, or office letters.

Change of Ownership

In the event that The Spine and Health Center of Montvale, PC is sold or merges, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. The Spine and Health Center is not required to agree to the restriction.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location. You have the right to copy and inspect your health information. You have the right to request the office amend your protected health information. If your request is denied you will be provided an explanation and about how you can disagree with the denial. You have the right to receive an accounting of disclosures of your protected health information. You have a right to a copy of this Notice of Privacy Practices any time upon request.

Treatment

This office uses both open and closed room adjusting and therapy. Per request, we will accommodate you to a closed room for adjusting and therapy.

Changes to this Notice of Privacy Practices

The Spine and Health Center of Montvale, PC reserves the right to amend this Notice of Privacy Practices at any time and will make the new provisions effective for all information it maintains. If you have any questions about any part of this notice or if you want more information contact Dr. Wohl at 201-746-6577. If Dr. Wohl is not available, you may make an appointment to meet with him in person or via telephone within two working days.

Complaints

Complaints about how The Spine and Health Center of Montvale has handled your health information should be directed towards Dr. Wohl at 201-746-6577. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights; 200 Independence Ave, S.W.; Room 509F HHH Building; Washington, D.C. 20201. This notice is effective as of April 07, 2008.

ASSIGNMENT OF BENEFITS (AOB)
REGISTRATION FORM

Last Name__________________First Name______________________Initial___________________________

Home Phone______________________Work Phone______________________Email___________________________

Street Address____

City____State__________________Zip________________________

Sex ☐ M ☐ F Age_____Birth date____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #___________________________ Driver's License #____

Insured Name______________________________How and where did you learn about this clinic?_____________________
Last Name First Name Initial

Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER

Company Name____________________________Occupation________________________Years Employed_______ ☐ Full-time

Address City State Zip Phone ☐ Part-time

SPOUSE (PARENT)

Name____________________________________Birthdate:______________SSN:______________________
Last Name First Name Initial

Employer Name____________________________Occupation_________________________Years Employed_______ ☐ Full-time

Address City State Zip Phone ☐ Part-time

PATIENT INSURANCE INFORMATION

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan

Name______________________________Name of Insured: ___________________

Policy/Group #:_____________________ID#:______________________________ Effective Date:________________

SPOUSE COINSURANCE INFORMATION

Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan

Name______________________________Name of Insured: ___________________

Policy/Group #:_____________________ID#:______________________________ Effective Date:________________

MEDICAL AND LEGAL INFORMATION

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u>? ☐ Yes ☐ No Your Initials:________ If you answered yes, please fill out accident specific form, available at the front desk.

Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician____________________Attorney ____________________

Person to contact in emergency: Name________________________Phone:______________________________

Consent to Representation in Utilization Management (UM) Appeals and Authorization to Release of Information in UM Appeals and Arbitration of Claims

____ I agree to representation in a 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 appeals. 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.

____ I have received Revocation of Consent to Representation and Release of Medical Records in UM Determination Appeals.

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws.

<u>Legal Assignment Of Benefits And Designation Of Authorized Representative</u>

I hereby assign and convey directly to the above designated provider, as my Statutory Derivative Beneficiary (SDB), commonly known as designated authorized representative or assignee, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above- named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless f any applicable insurance or benefit payments. <u>I hereby authorize above designated provider to release all medical information necessary to process my claims to the fullest extent allowed under the Health Insurance</u> Portability Accountability Act (HIPAA). **I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.**

I expressly assign to above designated provider any and all rights that I may have to enforce my legal rights under the Employee Retirement Income Securities Act (ERISA), Patient Protection and Affordable Care Act (PPACA), Sarbanes-Oxley Act (SOX), NJ Open Public Records Act and any other applicable state and federal law related to my healthcare benefits. This includes any and all relief to the above noted fullest extent permissible. This includes but is not limited to; 1) obtain information regarding the claim to the same extent as me; 2) submit evidence; 3) make statements about facts or law; 4) make any request including providing or receiving notice of appeal proceedings; and 5) participate in any administrative and judicial actions; and enforce any and all ERISA provisions. This also includes bringing civil action to; 1) enjoin any act or practice which violates any provision of ERISA; 2) obtain other appropriate equitable relief; 3) redress any violations of the above law; and 4) to enforce any provisions of my healthcare benefit plan terms.

I hereby authorize any and all plan administrators or fiduciaries, insurer and attorney to release to above designated provider my designated authorized representative(s)/Assignee(s) any and all plan documents, including but not limited to all Governing Plan Documents, written explanations of how level of benefit payments are determined, Summary Plan Description, Administrative Service Only (ASO) agreements and Certificate for PPACA Grandfathered Health Plan. Additionally, I authorize the release of any and all financial disclosures as mandated by (SOX), (ERISA), (HIPPA) and any other state and federal law(s). This includes but not limited to insurance policy and/or settlement information, 835 EDI [Invoice to Plan Sponsor] and 837 EDI (ANSI X12 Format), 5500 Form (Plan Annual Return)(Direct or Indirect fee's), upon written request, from the Designated Authorized Representative(s) in connection with healthcare services provided by above designated provider.

I hereby consent to any and all causes of action allowed under applicable state and federal laws related to my health care benefit plan, employee benefit plan, plan administrator, insurance carrier or fiduciary in my name, with derivative standing, at provider's expense. This includes but is not limited to; 1) pursuing claims, causes of action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, plan administrators or plan fiduciaries; and 2) claim any applicable statutory penalties and fee's on behalf of the plan participant, beneficiary or the plan to the extent of state and federal law(s).

This assignment is valid for any and all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state law(s). A photocopy, computer generated, or any other reproduction of this signature and assignment is to be considered valid, the same as if it was the original.

I have fully read this express assignment of benefits and it has been explained to me, prior to submitting this healthcare claim for reimbursement

Signature of Insured / Guardian **Date**

Disclosure and Authorization Form for Patient Referral to Other Non-Participating Physician(s) or Facility

Patient Name:___________________________________

Diagnosis: _____________________________________

For Treatment:__________________________________

Patient Plan In-Network: _________________________

Physician Name: ______________________________

Other Physician: ______________________________

Other Entity: _________________________________

Location:_____________________________________

DearPatient:

In order to better serve you with the highest care quality and safety at most affordable costs, sometimes it is necessary and important to have other or more provider(s) or entities to join our team to complete or continue your medical procedures or treatment in order to ensure the speedy recovery for you. We would like to keep you informed of your choice and our recommendation of these other provider(s) or entities and obtain your informed authorization before our referral and scheduling for your next treatment procedure(s).

While no provider or entity could be participating every managed care network, such as the one your health plan has contracted with, these other provider(s) or entities may or may not be in your health plan's network. This Form is used to inform you of our verification that the above named provider(s) or entities are non-participating provider(s) or entities with your health plan.

We have verified your insurance coverage for non-participating provider(s) or entities and the recommended treatment / procedure(s) and obtain pre-certification if applicable for all services as a courtesy to you.

Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan.

If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider, please call the member services number on your Insurance Identification Card.

Compliance & Disclosure under N.J.S.A. 45:9-22.5 (Commonly known as the Codey Act)

In compliance with N.J.S.A. 45:9-22.5 in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation of patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and/or clinic (facility) have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and / or facility:

(A) his/her affiliation or ownership, if any, with the doctor or facility for whom the patient is referred when my referring and /or attending physician personally performs the procedure, and (B) that he / she will receive, directly or indirectly, remuneration, which is directly proportional to his or her ownership interest in the clinic/facility/ASC and not to the volume of referrals, when making such a referral upon my such request and exercising my rights of freedom of choice for the provider(s) and facility/ASC under the in-network or out-of-network or PIP coverage as provided by my health plan or policies, in compliance with all applicable federal and state laws, Medicare, ERISA, PPACA and the Codey Act, N.J.S.A. 45:9-22.5.

Doctor or Facility with affiliation and remuneration: ____

I certify that I was informed of the effective alternative resources reasonable available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

I certify that my attending physician(s) has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, because all clinically-related decisions are made in my best interest, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving, and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

I have read and fully understand this Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network provider(s) or entities as named above.

________________________________ X________________________________ ________

Patient Name **Signature of Patient** **Date**

Patient Last Name: **Patient First Name:** **Insureds ID:**

Name of Insured: **Group#**

COMMUNITY ADVOCACY POLICY & AGREEMENT

Our community advocacy discount is no different than all PPO negotiated discounts from all other commercial insurers in compliance with all applicable federal and state laws with respect to Indigency assistance without any routine waiver of cost sharing, advertising, or solicitation, for underinsured or uninsured patients. The exception with our discount is that all of the savings go directly to the Patient and their Employer. Once Indigency is determined or discount is negotiated, collection is no longer undertaken with regard to the patient for the forgiven amount without waiving any patient financial and legal obligation or responsibility to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage, based on the provider's actual total and reasonable charges in accordance with Provider's Corporate Indigency Policy, as the Indigency determination itself is a good effort to collect, and hospitals or doctors are NOT required under any federal or state laws, Medicare, ERISA & PPACA, to take low-income, medically indigent, uninsured or underinsured patients to court, garnish their wages, or seize their homes, or send claims out to a collection agency when those patients don't or can't pay their hospital or doctor bills. New federal Affordable Care Act (ACA) laws protect low income and middle-class Americans with ACA Indigency Discount.

In consideration of my particular medical needs and care expenses to be incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage, and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional actual total charges regardless of any applicable insurance coverage, I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:

- ☐ Middle class income; with high deductible / co-insurance, as medically indigent (see CMS Definition below)
- ☐ Middle class income, Cash Pay - without any or applicable insurance for treatment from this provider / facility
- ☐ Low or a fixed income, with financial hardship, as financially indigent

More importantly, I declare that without following indigent assistance or negotiating a discount, seeking for and continuing with medically appropriate and important health care would be impossible for me or would make me indigent if I were forced to pay full charges for my medically necessary care expenses. I also declare that I personally requested and negotiated for such indigent assistance or discount only after I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs and availability of this provider Indigency Policy:

"Nothing in the Centers for Medicare & Medicaid Services' (CMS') regulations, Provider Reimbursement Manual, or Program Instructions prohibit a healthcare provider from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically indigent individuals, if it is done as part of the healthcare provider Indigency policy."

"By "Advocacy policy" or "Indigency Policy" we mean a policy developed and utilized by a healthcare provider to determine patients' financial ability to pay for services. By "medically indigent," we mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and that their medical expenses, in relationship to their income, would make them indigent if they were forced to pay full charges for their medical expenses."

I understand that this Provider is Out of Network ("OON") and as such does not have any "Contractual Obligations" with my health insurance Plan, intermediaries, Third Party Administrators ("TPA") or any agents acting on the behalf of my Healthcare Plan. I authorize the above name healthcare provider to contact my Health Plan and/or Plan Sponsor to deliver or negotiate any other discounts.

I specifically request under this provider Indigency policy for the following indigent discount assistance for the specific time periods from_______________to________________:

- ☐ Waiving collection of deductible
- ☐ Waiving collection of co-pays/encounter fees
- ☐ Waiving collection of co-insurance
- ☐ Waiving collection of partial ________

Patient's Signature: ___________________________________