North Jersey Orthopaedic Group

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TODAY'S DATE:___/___/_____

Patient Information PLEASE PRINT

Last Name:_____ First Name: _____ Middle:_____

Email:_____Marital Status: Married Single Divorced Separated Widowed

Sex: M F Date of Birth:___/___/_____ Age:___ Social Security #:____-___-_____

Street Address:_____Apt./Floor:_____

City:_____ State:_____ ZIP Code:_____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____ Work Phone: (____)_____-_____

Occupation:_____Employer: _____

Employer Address:_____Driver's License #:_____

Primary Care Physician:_____ ZIP Code _____ Phone: (____)_____-_____

Pharmacy Name:_____ ZIP Code _____ Phone: (____)_____-_____

Insurance Information PLEASE GIVE INSURANCE CARD TO RECEPTIONIST

Type of Insurance: Worker's Comp._____ MVA _____ Other *(please specify)*: _____

Subscriber Name:_____Subscriber's DOB:___/___/_____

Primary Insurance ID #:_____Group #: _____

Patient's Relationship to Subscriber: Self Spouse Child Other:_____

Secondary Insurance ID #:_____Group #:_____

Patient's Relationship to Subscriber: Self Spouse Child Other:_____

In Case of Emergency Contact

Name of Relative or Friend:_____ Phone: (____)_____-_____

Name of Relative or Friend:_____ Phone: (____)_____-_____

The above information is true to the best of my knowledge. I authorize Garrick Cox, MD, to provide myself or my child with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third-party payer to pay any benefits due directly to this office should they accept assignment on my claims. I understand that Garrick Cox, MD, has the right to refuse or accept AOB. If I receive any payment from my insurance carrier relating to any services rendered, I agree to hold such payment in trust for Garrick Cox, MD, and I agree to send such payment to Garrick Cox, MD, within one week after I receive same. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.

X_____ Date:___/___/_____

Patient/Guardian Signature

Purpose of Your Consult/Visit

Was injury/pain a result of an accident? Yes, No If Yes, Job Related Auto Other:_____

What is the condition for which you are seeking medical attention?_____

Site of injury (which body part):_____Side: Right Left

Date of injury or onset:___/___/_____Having pain since: ____/___/_____

ATTORNEY INFORMATION *(if applicable)*

Name:_____Phone: (____)____-_____Fax: (____)____-_____

Describe the events of the injury/accident/pain: _____

_____

_____

_____

Have you previously been treated for this or a similar condition? Yes No

If yes, what was the treatment?_____

_____

_____

_____

What were the results of the treatment?_____

_____

_____

_____

List any previous major injuries/surgeries: _____

_____

_____

_____

Have you had any diagnostic tests related to condition *(i.e., x-ray, MRI, CT, EMG)*? Yes No

If yes, please list: _____

_____

_____

_____

PLEASE GIVE ANY REPORTS/RESULTS OF TESTING TO RECEPTIONIST

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

*X*_____*Date*:____/___/_____

Patient/Guardian Signature

Personal History PLEASE PRINT

Have You Had?	*./ YES*	*Family History (list family member)*	*Please list any surgeries related to disorder/injury*
Recurrent Headaches			
Bone Injuries/Fractures			*Body Part(s):*
Joint Injuries *(i.e., Arthritis, Carpal Tunnel)*			*Body Part(s):*
Epilepsy/Seizures			
Cancer			*Type of cancer(s):*
Thyroid Disorder			
Heart Murmur			
Angina			
Congestive Heart Failure			
Heart Disease			
Heart Arrhythmia			
Heart Stents			
Diabetes			*Type I* *Type II*
High Blood Pressure			
High Cholesterol			
Anemia			
Sickle Cell			
Bleeding Disorders			
Hepatitis			*Type A* *Type B*
Kidney/Liver Disorders			*Type of disorder:*
Lupus			
Alcohol/Drug Abuse			*How often?* *How long?*
Lyme Disease			
Tuberculosis			
Gout			
Asthma/Emphysema			*With use of inhaler?*
Other:			

Do you smoke or did you ever? Yes No Packs per day?_____ For how many years?_____

Are you allergic to Latex? Yes No

If Yes, what is the reaction? Redness Swelling Rash Hives Other: _____

List any medications that you are allergic to: _____

If Yes, what is the reaction? Redness Swelling Rash Hives Other: _____

List any medication(s) you are currently taking: _____

HIPAA Compliant Authorization for the Release of Patient Information

PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

Street Address:_____ Apt./Floor:_____

City:_____ State:_____ ZIP Code:_____

RE: Patient Name:_____

Date of Birth:___/___/_____ Social Security #:____-___-_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurses' notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/ histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- All physical, occupational and rehab requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All employment, personnel or wage records.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period____/___/_____to_____/___/_____.

I understand 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.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative: _____

Representative Capacity *(e.g. attorney, records requestor, agent, etc.)*:_____

Street Address:_____ Apt./Floor:_____

City: _____ State:_____ ZIP Code:_____

I understand the following: See CFR §164.508(c) (2) (i-iii)

X _____ Date:___/___/_____

Patient Signature

X _____ Date:___/___/_____

Signature of Legal Representative

Acknowledgement of Receipt of Notice of Privacy Practices

We keep record of the healthcare services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your records to others unless you direct us to do so or unless the law authorizes or tells us to do so. You may see your record or get more information about it by contacting our office's Practice Administrator/Manager.

Our notice of Privacy Practices describes in more detail how your health information may be used and revealed, and how you can obtain your information.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

*I,*_____*, received a copy of the Office's Notice of Privacy Practice.*

X _____ Date:___/___/_____

Patient/Guardian Signature

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

Individual refused to sign

An emergency situation prevented us from obtaining acknowledgement

Other _____

X _____ Date:___/___/_____

Employee Signature

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0805

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLKLUNG (SSN) Other (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME(Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED ...

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) Yes No

a. INSURED'S DATE OF BIRTH MM DD YY M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY M F

b. AUTO ACCIDENT? Place (State) Yes No

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? Yes No

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? Yes No *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY From To MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY From To MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? $ CHARGES Yes No

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $CHARGE	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) Yes No

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

Assignment of Benefits

Patient Name: _____

Street Address: _____ Apt./Floor: _____

City: _____ State: _____ ZIP Code: _____

Date of Loss *(accident if applies)*: ___/___/_____

Insurance Company: _____

Name of Policyholder: _____

Policy #: _____ Claim #: _____

1. *I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my rights and interests to Garrick Cox, MD, hereafter referred to as "Medical Provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include, but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statues of the State of New Jersey. In addition, I appoint the Medical Provider as my Designated Authorized Representative and will sign a separate authorization which will be provided to my insurance carrier. Should my insurance carrier require additional forms relating to this designation, I agree to sign them and return the originals to the Medical Provider's office.*
2. *I, the patient, do hereby acknowledge that I have an obligation to comply with reasonable requests made of me by the insurance carrier. I, the patient, do further agree to cooperate with the attorney selected by the Medical Provider.*
3. *For any balances owed by me, not covered by my insurance policy, or monies not turned over that are paid directly to me, I agree to pay an attorney's collection fee equal to 33 1/3% of the outstanding balance, plus court and related costs, in the event my account is turned over to an attorney for collection.*
4. *I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.*
5. *I, the patient, authorized my bodily injury attorney and/or insurance carrier to pay directly to the Medical Provider any monies due on my account, and will direct my attorney to provide the Medical Provider with a letter of protection against any settlement that is made on my behalf.*
6. *I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above Medical Provider's medical bills. I agree to have the Medical Provider's attorney represent me (or my child) if legal action is necessary to collect from my insurance carrier. I waive any conflict of interest that may exist between me and the Medical Provider.*
7. *The Medical Provider will comply with the decision point review request as required by the plan.*
8. *The Medical Provider shall submit disputes to personal injury protection dispute arbitration if the decision point review plan requires same.*
9. *In the event it is determined by an Arbitrator and/or Court of Law that the imposition of a copayment penalty was as a result of the Medical Provider's failure to pre-certify treatment or comply with other decision point review requirements the provider will hold the patient harmless for such copayment penalty.*

X _____ Date: ___/___/___

Patient/Guardian Signature

Patient Name *(print)*: _____

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 Garrick Cox, MD (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, 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 benefit 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.

X _____ Date:___/___/___

Signature of Insured/Guardian

Name of Insured/Guardian *(print)*: _____

DATE:___/___/_____

Certified Letter, Return Receipt Requested

Attn: Plan Administrator

RE: Request for Summary Plan Description (SPD) & 5500 Form

Patient Name:_____ Plan #:_____

Insured Name:_____ Insured ID:_____

Date of Service:___/___/_____

Dear Plan Administrator:

I hereby request from you a complete copy of the governing plan documents, a written explanation of how level of benefit payments are determined for out-of-network providers, the Summary Plan Description (SPD) & the 5500 Form (Plan Annual Return). For the purpose of the applicability of compliance with PPACA, we specifically request a certified copy of your Certificate for PPACA Grandfathered Health Plan. In absence of such a certificate, you are statutorily required to comply with all provisions of PPACA and ERISA claim regulations.

Please provide to me c/o Garrick Cox, MD, 246 Hamburg Turnpike, Ste. 301/302, Wayne, New Jersey, 07470, as soon as possible, but no later than 30 days from the date of this letter, the requested SPD and 5500 Form. A statutory SPD penalty of up to $110 per day for each day beyond 30 days may apply for failure to timely provide us with the requested information.

If the governing plan or SPD has any specific procedures and provisions on how to designate an authorized representative or how to verify plan participants designees, please provide us with such specific plan provisions within five business days in order for us to comply with the plan's requirements.

Sincerely,

X _____ Date: ___/___/_____

Patient/Guardian Signature

Patient Name *(print)*: _____

Encls. Legal Assignment of Benefits/ Authorized Representative

EFFECTIVE IMMEDIATELY OUR OFFICE HAS A POLICY IN PLACE FOR ALL NO SHOW APPOINTMENTS.
IF A PATIENT APPOINTMENT IS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE OF THEIR APPOINTMENT THERE WILL BE A CHARGE OF $50.00.

"When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call at least 24 hours in advance to cancel your appointment."

PLEASE SIGN BELOW THAT YOU BEEN ADVISED OF THE POLICY.

If you have any questions feel free to ask our office staff. We will be more than happy to help.

PATIENT NAME PATIENT SIGNATURE DATE