North Jersey Orthopaedic Group

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Patient Information PLEASE PRINT

TODAY'S DATE: ___/___/_____

Last Name:_____ First Name: _____ Middle:_____

Email: _____Marital Status: Married __ Single __ Divorced __ Separated __ Widowed __

Sex: M__ F__ Other __ Date of Birth: ___/___/_____ Age: ___Weight: ____ Height: ___ 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 YourConsult/Visit

Was injury/pain a result ofan 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 injuryor 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 of 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, correspondence, 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 NAME _____

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 records 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.

Signature_____ Date_____

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

Employee Signature_____Date_____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 0805

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER 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 MM DD YY To
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY From MM DD YY To
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? Yes No $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

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 # ( )		

GARRICK COX MD, LLC
ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY FORM

Patient's Name: _____ DOB: _____Physician's Name: _____

MR Number: _____ Date: _____

Assignment of Benefits and Claims

I hereby assign and transfer to Garrick Cox MD, LLC, all my rights, titles and benefits payable by insurance carrier for services performed by Garrick Cox MD, LLC.

I hereby authorize Garrick Cox MD, LLC to submit a claim to my insurance carrier or intermediary for all services rendered by Garrick Cox MD, LLC and exercise any appeals and other rights under my policy on my behalf.
I authorize and assign to Garrick Cox MD, LLC the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or my name, including the arbitration/ dispute resolution process, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor, or third party. This authorization includes the right to assignment to pursue declaratory relief or other legal remedies.

I authorize Garrick Cox MD, LLC to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits, and all other insurance benefits through the carriers themselves, plan administrator, payor or third party. I authorize Garrick Cox MD, LLC to obtain an attorney to represent me directly in appealing a claim to the State Health Benefits Commission for all state plans. I authorize Garrick Cox MD, LLC to represent me directly in appealing a claim to the appropriate Federal Agency for all federal plans. I authorize Garrick Cox MD, LLC to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.
I direct my insurance carrier, or intermediaries, to issue a payment check directly to Garrick Cox MD, LLC. If my insurance company will not directly pay Garrick Cox MD, LLC, I authorize and direct that the insurance company sends all checks and copies of Explanation of Benefits forms in connection with services of Garrick Cox MD, LLC to Garrick Cox MD, LLC at 246 Hamburg Tpke, Suite 302, Wayne NJ 07470. as my agent for delivery of said items and use.

Financial Responsibility

I understand and agree that I am responsible for all charges incurred in connection with the receipt of services and care from Garrick Cox MD, LLC and promise to pay promptly to Garrick Cox MD, LLC the amount of charges for services rendered.

I hereby authorize Garrick Cox MD, LLC to release all information necessary regarding services rendered to my insurance company and referring physician.

ASSIGNMENT OF BENEFITS & FINANCIAL RESPONSIBILITY FORM – Page 2

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges of services rendered not covered by the insurance company. I understand that co-payments or deductibles are due in full at the time of service. I agree to cooperate, aid and assist Garrick Cox MD, LLC in procuring all possible insurance benefits.

Patient Receipt of Checks

In the event that I received direct payment of any amount due for services rendered, I agree that I will hold such payment in trust for Garrick Cox MD, LLC and I also agree to send such payment to Garrick Cox MD, LLC within one week after receipt of same. I also agree to pay attorney's fees equal to 33 1/3% of the outstanding balance, plus court costs, if the account is turned over to an attorney for collection.

Consent to Disclose

I authorize Garrick Cox MD, LLC and its agents and attorneys to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider (s) to release all such information to Garrick Cox MD, LLC about me, including medical reports, X-Ray reports, narrative reports, and any other report or information regarding my physical condition.

Failure to Comply

I understand that failure to comply with my responsibilities under this form will result in my account remaining active. I guarantee payment of all said charges incurred. In the further event that the account must be placed with an attorney, I will also be responsible for collection agency fees and costs incurred in collection.

The undersigned has read and understands the above terms.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF WITNESS: _____ DATE: _____

Garrick Cox, MD LLC

Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID Number	
Member's Street Address	City	State	Zip
Designated Representative's Address	City	State	Zip
246 Hamburg Tpke, Suite 302	Wayne	NJ	07470
Provider of Service			
Date(s) of Service or Proposed Service			

I, _____, am appointing
Print the name of the member who is receiving the service or supply

Garrick Cox MD, LLC
_____
Print the name of the person/organization who is being authorized to act on the member's behalf

To act on my behalf as my authorized representative for an appeal.

I understand and agree that:

- This authorization is voluntary;
- my health information may be disclosed to my authorized representative and may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member or Approved Party	Date
X	
If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority

GARRICK COX MD, LLC

Garrick Cox, MD, Robert M. Masella, MD, Ryan Dowling, MD, Gary Drillings, MD, Mark Ruoff, MD, Kristin C. Riley, PA-C

BILLING DISCLOSURE

Thank you for choosing our office to help you achieve your health goals. We ask that you carefully read this *Disclosure*.

Our services may not be covered by insurance. Our office and providers are **not** 'in network" with any insurance plan and do not accept insurance assignment. Accordingly, to the extent you receive any "out of network" services from our office, you do so **intentionally**. You will be billed for your care and are responsible for payment. We will attempt to verify coverage as a courtesy. Insurance, however, is an agreement between you and your insurer and you are ultimately responsible for confirming information about coverage and for payment for services.

BALANCE BILLING RIGHTS

You are responsible for fees for all uncovered services and cost-sharing amounts required by your health plan for any covered services (copayments, deductibles, and/or coinsurance). When an out-of-network health care provider bills the difference between what an insurer decides is the eligible charge for a covered service and what the provider bills as the total charge, it is referred to as "balance" billing. New Jersey law protects against balance billing when a person receives emergency services in New Jersey, or **unintentionally** receives covered services from an out-of-network provider at an in-network New Jersey facility. This law does NOT apply to ALL health plans. In such cases:

EMERGENCY SERVICES: If you receive covered emergency services in most circumstances, the most you can be billed is your plan's in-network cost-sharing amounts. You cannot be balance-billed. This includes the emergency facility and providers that see you for emergency care. Not every service provided in an emergency department is an emergency service. Our office does not provide emergency services.

NONEMERGENCY SERVICES: At an in-network facility, you have the right to request that in-network providers perform all covered services; however, you may have to receive services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for covered services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance) and you cannot be balance billed. We are not 'in network" with any insurance plan and our providers are "out-of-network." Hence, all services are provided out-of-network, and you are responsible for your full bill.

ADDITIONAL PROTECTIONS

- Your insurer will pay out-of-network providers and facilities directly for covered services.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Providers and facilities must refund any amount you overpay within 60 days of notice.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency in any OTHER situation, you may be balance billed and may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

We will be happy to address any questions you may have. If you want to file a complaint against your health care provider, or have further questions, you can submit a complaint or questions to our practice administrator at:

Lainie Cox at lainie@affinitymedsol.com
201-799-4001 ext.: 108

_____ _____

Signature - Patient or Person with Authority to Consent Date

_____

Print Name