Today's Date: ______________ Co-Pay: ______________

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

How did you learn about our practice? ____

Patient's Name: ____
Last First Middle

Patient's Home Address: ____

City: ______________________ State: __________ Zip: __________

SSN: __________________ Birthdate: ______________ Age: __________ Sex: M F

Home Phone: (____) __________________ Cell Phone: (____) __________________

Email Address: __________________ May we correspond with you by email? Yes No

Employer: __________________ Employer's Address: __________________

Work Phone: (____) ______________ Ext: _______ City: ______________ State: _____ Zip: ________

Occupation: __________________ Preferred Pharmacy: __________________

PLEASE PROVIDE THE RECEPTIONIST WITH CURRENT INSURANCE CARDS AND DRIVERS LICENSE

Primary Insurance Plan: __________________ **Secondary Insurance Plan**: __________________

Plan ID#: __________________ Plan ID#: __________________

Subscriber: ______________ DOB: ________ Subscriber: ______________ DOB: ________

FINANCIALLY RESPONSIBLE PARTY (SUBSCRIBER FOR INSURANCE IF OTHER THAN PATIENT)

Name: ______________________________ Relationship to Patient: ______________
Last First Middle

Home Address: __________________ City: ______________ State: _______ Zip: __________

Birthdate: ____________ Age: _______ SSN: ______________ Phone: (_____) ______________

Employer: __________________ Address: __________________

City: ______________ State: ______ Zip: __________ Work Phone: (____) __________ Ext: _____

How did your injury occur? ____

On what date did the injury occur? ______________ Where did it happen: ______________________

Did your injury happen on the job? Yes No If yes, did you report the accident to your employer? Yes No

Family Physician: ______________________ Drug Allergies: ______________________

Current Medications: ____

Major Illnesses: ____

In case of emergency, contact: ______________________ *Relationship:* ______________

Home Phone: (____) ______________ *Work or Cell Phone:* (_____) ______________

Signature of Patient or Responsible Party: ______________________________

PLEASE TURN THIS SHEET OVER AND COMPLETE THE FINANCIAL INFORMATION

Premier Orthopaedic Associates Financial Policies

Thank you for choosing Premier Orthopaedic Associates of Southern NJ (POASNJ) for your orthopaedic care. We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

Referrals If you have an HMO plan we are contracted with, you need a referral from your PCP authorizing your treatment. If we have not received the referral prior to your arrival at the office, you may use the telephone available to call your PCP to obtain it. **If you are unable to obtain the referral for your visit, you may be rescheduled or required to fill out and sign our responsibility waiver, which makes you financially responsible for all charges incurred at your visit. (*Emergency cases only)**

Your Financial Responsibilities:

Our office will file insurance claims for all reimbursable services, to your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, co-insurance, and non-covered service amounts. We accept payment by cash, check,Visa or MasterCard.

You will receive billing statement(s) from our office for account balances that are your responsibility. Balance in full is due within 15 business days. If the patient portion of your account is not paid in a timely manner, legal collection efforts will be made. All legal collection fees incurred to collect the patient balance will be the responsibility of the patient.

HMO, POS and PPO plans that POASNJ contracts with: If the services you receive are covered by the plan and you have provided any required referral and/or authorization, you are responsible for all applicable copays and deductibles. These are to be paid at the time of service. If the services you receive are not covered by the plan, payment in full is requested at the time of service.

Commercial Insurance or PPO's that POASNJ does NOT contract with: POASNJ will submit your claims to your carrier as a courtesy if all current and accurate information is provided. You will be billed for any remaining balance with the total amount due within 15 days of billing. It is the responsibility of the patient to contact your insurance to verify if our office is contracted with your carrier.

Medicare: You will be responsible for any portion of your deductible that is not paid or covered by your secondary insurance. You will be responsible for any service not covered by Medicare. POASNJ will submit Medicare and secondary claims. All patient balances remaining after Medicare and/or secondary payments will be billed to you and will be due within 15 days of billing by this office.

Medicaid: POASNJ physicians are **NOT** participating in NJ Medicaid. Payment is required at the time of service. We will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request to speak to a billing representative to discuss a possible self-pay patient discount, and/or payment plan.

NO Insurance: Payment in full is required at the time of service. If you have financial hardships, we will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request to speak to a billing representative to discuss a possible self-pay discount and/or payment plan.

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copays and deductibles, are my responsibility. I authorize the release of any information concerning me or my child's healthcare, for the purpose of evaluating and administering claims for insurance benefits and to my primary care physician.

I authorize my insurance benefits be paid directly to Premier Orthopaedic Associates of Southern NJ, (POASNJ) I authorize Medicare benefits to be paid directly to Premier Orthopaedic Associates of Southern NJ, (POASNJ) I authorize any holder of medical information about me to release the centers of Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

____ ______________________

Signature of Patient or Responsible Party **Date**

____

Name Printed

PREMIER ORTHOPAEDIC ASSOCIATES
of Southern New Jersey

THOMAS A. DWYER, M.D. • FRED MCALPIN, III, D.O.
JOHN B. CATALANO, M.D. • RICHARD C. DIVERNIERO, M.D.
KIMBERLEY Y. SMITH-MARTIN, M.D.
MARTIN A. RAMSI, PA-C • IAN R. GRAY, PA-C

PATIENT HISTORY FORM

Today's date ____/____/____ Date of last physical exam ____/____/____ Date of Birth ____/____/____ Age ____

Chief Complaint: (What is the main reason for your visit today?) ______________________________

____

How long has the problem bothered you? ______ days ______ weeks ______ months ______ years

Result of: Car accident ______ Work Accident ______ Injury______ Other ______________

Have you ever injured this area before? ______________________________

Have you ever had a workers compensation injury? ______________________________

Present Occupation:______________ Employer:______________ How Long: ______

SYMPTOMS (Circle all that apply):

Discomfort: none — 1— 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 — Severe

Location: Neck — Back — Shoulder — Elbow — Wrist — Hip — Knee — Ankle — Foot — Other

Quality: Sharp — Dull — Throbbing — Burning — Tingling — Electric Shocks — Constant — Intermittent — Night Pain

Associated Symptoms: Stiffness — Catching/Locking — Giving Way — Numbness — Weakness

What Makes Better: Medications:______________ Brace / Bandage — Cold — Heat — Rest

Previous Treatment: X-rays — MRI — Surgery — Physical Therapy — Chiropractor — Injection — None

PAST MEDICAL HISTORY / SOCIAL HISTORY

MEDICAL CONDITIONS (Circle all that apply):

Asthma	Lupus	Liver Problems	Migraines	Pacemaker
Arthritis	Heart Condition	Hepatitis	Nervous Condition	Cardiac Bypass
Bronchitis	Diabetes	Emphysema	Sleep apnea	Cardiac Stent
Stroke	COPD	High Blood Pressure	Cancer	Heart Attack
Kidney Problems	Fibromyalgia	Vascular Disease	CHF	
Heart Murmur	Thyroid Condition	Ulcers	MS/MD	
Anemia	Irregular Heartbeat	Shortness of Breath	Blood Clots	

Past Surgical History (please list all): ______________________________

____

____

Medications With Dosages (Include Herbs, Vitamins/Supplements, OTC Medication) Do you take any of the following: Coumadin ______

______________________________ Plavix ______

______________________________ Aspirin ______

____

Allergies (Medications/Food): ______________________________

Do you smoke? ❑ Yes ❑ No How Much?______________ Do you drink? ❑ Yes ❑ No How Much?______________

Substance abuse? ❑ Yes ❑ No How Much?______________

Family History (Grandparents / Parents / Siblings, Circle all that apply):

Osteoarthritis	Rheumatoid	Osteoporosis	Gout	Cancer	Psoriasis
Lymes Disease	Arthritis	Heart Disease	Diabetes	Lupus	Other ______

Physician______________________________ Date ______________

(Priv. 2/8)

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REVIEW OF SYMPTOMS:

Are you currently having or have you had problems with your: (Circle all that apply)

Constitutional Symptoms: Fever — Chills — Headache — Other: ____________________

Eyes: Blurred Vision — Double Vision — Pain — Other: ____________________

Allergic / Immunologic: Hay Fever — Drug Allergies — Other: ____________________

Neurological: Tremors — Dizzy Spells — Numbness/Tingling — Other: ____________________

Endocrine: Excessive Thirst — Too Hot/Cold — Tired/Sluggish — Other: ____________________

Cardiovascular: Chest Pain— Varicose Veins — Hypertension — Other: ____________________

Skin: Rash — Boils — Persistent Itch — Other: ____________________

Musculoskeletal: Joint Pain — Neck Pain — Back Pain — Other: ____________________

Ear/Nose/Throat: Ear Infection — Sore Throat — Sinus Problems — Other: ____________________

Genitourinary: Urine Infection — Painful Urination — Urinary Frequency — Other: ____________________

Respiratory: Wheezing — Coughing — Shortness of Breath — Other: ____________________

Hematologic/Lymphatic: Swollen Glands — Blood Clotting — Other: ____________________

Psychologic: Depression — Suicidal Thoughts — Mood Swings — Other: ____________________

Initial Review by Physician: ____________________ Date: ____________

Updated by Physician ____________________ Date: ____________

Updated by Physician ____________________ Date: ____________

Updated by Physician ____________________ Date: ____________

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, ______________________________, by marking ☐√ (or ☐x) and signing below, agree to:

☐ representation by ______ 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)

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* 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.