NEW JERSEY
BRAIN AND SPINE

Patient Registration Form

Patient's Name (Last, First, MI): _____ Date:

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: ____-____-_____ Age: _____ Sex: M F Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Preferred Language: _____

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired ☐ Student ☐ Other:_____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Primary Insurance ID: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Secondary Insurance ID: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

Work Phone Number: _____ His or Her Employer: _____

MEDICAL TEAM INFORMATION

Referring Physician: _____

Address: _____ Phone: _____

Primary Care Provider: _____

Orthopedic/Pain Provider: _____

Neurologist: _____

IS THIS VISIT RELATED TO: ☐ **WORKER'S COMP** Date of Injury:_____ Claim #: _____

☐ **AUTO ACCIDENT** Date of Accident: _____ Claim #: _____

Claims Rep Name: _____

Phone: _____ Fax: _____

Case Mgr Name: _____

Phone: _____ Fax: _____

Insurance Company: _____

Billing Address: _____

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HEALTH HISTORY

Personal Information Date:_____

Patient Name: _____ Birth Date: _____/_____/_____ Age: ____

Occupation _____ Marital Status: _____ Name of Partner/Spouse: _____

Race: ☐ Asian ☐ Black or African American ☐ Native American or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ White / Caucasian ☐ Other: _____

Ethnicity: Do you identify with an Ethnic origin? If yes, please note: _____

Names/Specialties/Locations of Other Physicians Caring for You, including previous primary care doctor:_____

_____

_____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **Allergies** to Medication or Food (list reactions): _____

Preferred **Pharmacy (Name/Address/Number**: _____

Date of Last Complete Physical Exam: _____ Date of Last Blood Work: _____

Have you been to physical therapy in the last 12 months?

If yes:

Where did you attend? _____

How many sessions did you complete? _____

Please list the approximate date of your last PT session: _____

Please check any and all conditions that apply even if you are taking a medication for the condition.

☐ Anemia	☐ Depression	☐ Osteopenia/Osteoporosis
☐ Allergies/Hay Fever	☐ Type 1 or 2 Diabetes	☐ Respiratory Disease
☐ Asthma	☐ Epilepsy	☐ Skin Disease
☐ Arthritis	☐ Fractures	☐ Stomach/Colon Disease
☐ Anxiety	☐ High Blood Pressure	☐ Stroke
☐ Alcoholism	☐ High Cholesterol	☐ Seizure Disorder
☐ Blood Disease/Clots	☐ Heart Attack	☐ Thyroid Disorder
☐ Cancer	☐ Kidney Disease	☐ Stroke
Cancer Type(s)_____	☐ Liver Disease	☐ Other:
Cancer Year _____	☐ Neurological Disease	_____

Please list any SURGERIES you have had (please include the surgery, body part, month/year):

_____

_____

_____

_____

Social Information

Tobacco Use: Do you smoke? _____ If so, how many cigarettes/cigars per day: _____

No. of years smoking: _____ Do you chew tobacco? _____

Alcohol Use: Do you drink alcohol? ____ If so, what type? _____ How many in 1 week? _____

Drug Use: Any history of illegal drug use? _____ If so, what type/s? _____ When? _____

Do you **exercise**? _____ What activities do you do, and how often in 1 week?_____

__

SYMPTOMS: Please check any symptoms that you have experienced in the past 30 days:

☐ Abdominal Pain	☐ GI	☐ Nose Bleeds
☐ Allergic/Immunologic	☐ GU	☐ Respiratory
☐ Burning on Urination	☐ Hay Fever	☐ Ringing in the Ears
☐ Cardiovascular	☐ Head & Neck Pain	☐ Shortness of Breath
☐ Change in Appetite	☐ Hearing Loss	☐ Skin Rash
☐ Chest Pain	☐ Heart Palpitations	☐ Sluggishness
☐ Double Vision	☐ Hematologic/Lymphatic	☐ Sore Throat
☐ Easy Bruising or Bleeding	☐ High Blood Pressure	☐ Swollen Glands
☐ Endocrine	☐ Hives	☐ Urinary Retention
☐ Excessive Thirst	☐ Integumentary	☐ Vomiting
☐ Fatigability	☐ Nausea	☐ Weight Change
☐ Fever/Chills	☐ Night Sweats	☐ Wheezing
☐ Frequent Cough	☐ Other _____	

NEW JERSEY
BRAIN AND SPINE

Notice of Privacy Practices

Dear patient,

As required by privacy regulation mandated by HIPAA - Health Insurance Portability and Accountability Act, we are providing you with our Notice of Privacy Practices. We like to assure you we are fully committed to protecting your privacy. Please acknowledge receipt of New Jersey Brain and Spine's Notice of Privacy Practices by signing your name below.

I acknowledge receipt of New Jersey Brain and Spine's Notice of Privacy Practices.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ DATE _____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE _____ DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY _____

RELEASE OF INFORMATION

I authorize New Jersey Brain and Spine to disclose my personal health information to the person(s) or organization I have named on this form. I understand that my personal health information may be re-disclosed by the person or organization and may no longer be protected by law.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

680 Kinderkamack Rd. Suite 300, Oradell NJ, 07649
(p) 201.342.2550 (f) 201.342.7171

NEW JERSEY
BRAIN AND SPINE

INSURANCE AUTHORIZATION AND ASSIGNMENT
(Please read and sign)

PATIENT'S NAME _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, deductibles and co payments regardless of insurance coverage unless forbidden by prior insurance contracts. You are expected to pay for services at time they are rendered unless other arrangements have been made in advance.

I authorize Comprehensive Neurosurgical, DBA New Jersey Brain and Spine, to appeal to my insurance company on my behalf.

I hereby authorize New Jersey Brain and Spine to furnish to insurance companies, their representatives or designated attorney and requesting physicians, any information· concerning my (my d pendents) illness and treatments. I hereby assign to New Jersey Brain & Spine all payments for medical services render d to myself or my dependents. I agree that if my insurance company sends me a check for services:rendered to me or my dependents by New Jersey Brain & Spine, I will endorse this check and forward it to New Jersey Brain and Spine within five days.

I hereby further assign to New Jersey Brain and Spine all of my rights under my insurance contract, including all of my rights governed by the statues and regulations of he Employee Retirement Income Security Act (ERISA), including, without any limitation whatsoever, my rights to "recover benefits" under ERISA Section 502(a)(1)(B), my rights to recover civil statutory penalties under ERISA Section 502(c)(1)(B); and my rights to pursue breach of fiduciary claims under ERISA Sections 502(a)(2) and 502(a)(3).

I understand that I am responsible for co-payment, deductible or for any amount not covered by my insurance. If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs including attorney fees of 33.33% of the unpaid balance. These costs are above and beyond any balance for services rendered.

SIGNATURE OF PATIENT DATE

SIGNATURE OF INSURED DATE

NEW JERSEY
BRAIN AND SPINE

LEGAL ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

Patient Name _____Patient ID: _____

Insured Name _____Insured ID: _____

TO: INSURANCE COMPANY / PLAN ADMINISTRATOR / PLAN FIDUCIARY

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), **as my designated Authorized Representative(s)**, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named 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 such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such 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 above named provider(s), to the full extent permissible under the law, including but not limited to, any ERISA claim for benefits, breach of ERISA fiduciary duty, and ERISA claim for statutory penalties for failure to produce documents or information in accordance with ERISA §502(a)(1)(B), §502(a)(3) and §502(c)(1)(B), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the named 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 such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such 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. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my providers / New Jersey Brain and Spine in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

ADDENDUM TO PATIENT FINANCIAL RESPONIBILITY

To: **New Jersey Brain and Spine**

I acknowledge the possibility that a check and or checks may be sent directly to me instead of you, my provider. I understand this money is not mine even though the check may be written to me. I understand you are billing my insurance company as a courtesy to me but the money paid by the insurance company belongs entirely to you. I, therefore, agree to immediately, but certainly no later than 48 hours upon receipt of any such monies, forward this money directly to you. I will make no attempt to negotiate what portion I send to you. In any event, I acknowledge and agree that I am legally responsible for any charges for service rendered to me and I will pay all fees including any co-pays or deductibles, if applicable.

NOTE: Please read the above agreements carefully and make sure that you understand all the terms and conditions before signing below. If you do not understand, please review contents with the staff prior to signing. Your signature confirms that you have read and fully understand all the agreements, terms, and conditions above. Agreed and Accepted by:

PATIENT SIGNATURE_____

PATIENT PRINTED NAME_____

DATE _____

WITNESS SIGNATURE_____

WITNESS PRINTED NAME_____

DATE _____

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