Interventional Pain Spine & Orthopedics, PA

Remittance: 185 KINGSLAND ST NUTLEY, NJ 07110
Tel 973-688-8543 Fax: 973-200-8587

DEMOGRAPHICS

Patient Name:_____Social Security# _____
Date of Birth: _____Age: _____Sex: Male_____Female _____Marital Status: _____
_____ Address: _____City: _____State: _____
Zip Code: _____ Home Phone:_____Cell: _____
Email: _____ Emergency Contact: _____
Relation: _____Phone:_____ Reason for Visit: ☐ MVA ☐
Health ☐ WC Date of Onset: _____ Nature of Injury: _____
_____

INSURANCE INFORMATION

INFORMATION	PRIMARY	SECONDARY
Policy Holder Name		
Name of carrier		
Claims Address		
ID/CLAIM/CARRIER CASE #		
GROUP/ POLICY / WCB#		
Claim Handler if MVA or WC		
Phone Number		
Employer Name & Phone#		
Job title at time of Injury		

Have you returned to work: ☐ YES ☐ NO Date:

ATTORNEY INFORMATION

Attorney Name: _____Phone: _____
Address: _____ City: _____ State: _ Zip Code: _____
_____ Fax: _____

PATIENT AUTHORIZATION

I hereby authorize IPSO PA to bill my carrier for services rendered on my behalf. I understand IPSO PA is not a participating provider with my carrier, and I may receive payment directly from my carrier for services rendered in which I am then responsible for said payment to IPSO PA. I grant permission to release my medical records when necessary to facilitate the collection, verification, or settlement of my account. If I fail to meet the financial commitment to IPSO PA, all costs and expenses incurred in the collection of the account, including attorney and collection fees, will be my responsibility.

Patient Signature | Print Name | Date

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DESIGNATION OF DISCLOSURE

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that ISPO PA may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care, in that case is IPSO PA will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner(check all that apply):

You can disclose my health information as described below:

1 ☐ OK to leave message with detailed information at my home/cell number: _____

☐ On my answer machine

☐ With my spouse

☐ With anyone answering my phone

☐ Leave message with callback numbers only

---

2 ☐ OK to leave message with detailed information at my work number: _____

☐ OK to leave message with callback numbers only

---

3 ☐ OK to fax my work fax number _____

☐ OK to fax my home fax number _____

---

4 ☐ OK to email. Email address _____

☐ OK to text my cell phone number _____

I designate the persons listed below as persons involved with my health care of payment relating to my health care for the purpose of IPSO PA making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that I may change this at any time in writing. I understand that IPSO PA will not disclose health information to any person not designated except in case of an emergency.

Name: _____ Last 4 digits of his/her SSN or DOB (required as identifier) _____
Name: _____ Last 4 digits of his/her SSN or DOB (required as identifier) _____
Name: _____ Last 4 digits of his/her SSN or DOB (required as identifier) _____

The following person(s) are NOT authorized to receive my Patient Health Information:

Name: _____ Name: _____

Name: _____ Name: _____

Signature: _____ Print Name: _____

Date (mm/dd/yyyy): ____/____/____

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____

Date of Birth: (mm/dd/yyyy) ____/____/____

I hereby authorize: Interventional Pain Spine & Orthopedics PA SS# ____/____/____

Name of physician/attorney/auto insurance

973-688-8543
Physician's office phone number

to disclose the following protected health information to

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or

dates: _____

☐ All healthcare information

☐ Pip Ledger and DEC page

☐ Yes ☐ No

I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No

I authorize the release of any records regarding drug, alcohol, or mental health treatment

Signature: _____ Print name: _____
Patient or Authorized Representative

Date (mm/dd/yyyy): ____/____/____

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NEW JERSEY MOTOR VEHICLE NO FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to Interventional Pain Spine & Orthopedics, PA, ("Assignee")

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under NJCA 11:3-4.9 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on_____, notwithstanding any other agreement to the contrary. **(please print)**

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Patient:

_____ (Print name of patient)

_____ (Signature of Patient)

_____ (Date of signature)

_____ (Address of Patient)

Provider: Interventional Pain Spine & Orthopedics, PA
185 KINGSLAND ST, NUTLEY, NJ 07110

Jacob Peacock MD

Robert Drazic MD

Christine Chung, PA

Christopher Bilbao, DO.

_____ (Print Provider Name)

_____ (Provider Signature)

_____ (Date)

Interventional Pain Spine & Orthopedics, PA

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your Insurance

- **All patients are required to provide up to date insurance information that would cover services from the initial date of treatment. If during the course of treatment insurance has changed you must notify the practice immediately.**

- **NY / NJ NO FAULT**: We will bill directly the carrier you have provided for services rendered. Any copays, deductible and coinsurance will be your responsibility. In the event you are not covered or your claim is denied for whatever reason you will be held responsible for payment of services.

- **WORKERS COMPENSATION:** We will bill directly the carrier you have provided as well as the workers' compensation board. In the event that your claim has not been established, denied or closed, you will be responsible for such payment.

- **HMO/PPO/MEDICARE/MEDICAID:** Please be aware that Metro Pain Specialists and its providers do NOT participate with any carriers. As a courtesy we will bill your health insurance on your behalf only if you have out of network coverage. Please note that you will be responsible for any deductible, copay and coinsurance that may be applied.

- **MISSED / CANCELLED APPOINTMENTS**: Please note that time and coordination between our office, the surgical center, transportation and providers are done in order to provide a service to you. We ask that every attempt is made by you, the patient to keep your scheduled appointments. We do understand that emergency may arise and consideration will be given for those circumstances. Thank you.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name: _____

Address: _____

City/State/Zip: _____

Patient Signature: _____ Date: _____

Interventional Pain Spine & Orthopedics PA

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that. under the health pursuance Portability & Accountability Act of 1998 ("HIPAA *j,* I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who maybe i12.volved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

" Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices contain a more complete description of the uses and disclosures of my health information. r understand that this organization has the right to cb.an.ge its Notice of Privacy Practices from time to time and that I may contact this organization.at any time at the address above to obtain a current copy of the Notice of Privacy Practices. .I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. !"also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____
Relationship to Patient:_____
Signature:_____
Date:_____

OFFICE USE **ONLY**
I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____
Reason:_____
[initials:_____

Interventional Pain Spine & Orthopedics, PA

Remittance: 185 KINGSLAND ST NUTLEY, NJ 07110
Tel 973-688-8543 Fax: 973-200-8587

MEDICAL LIEN

Please print:

Attorney's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Patient's Name:

_____

Address:

_____

City/State/Zip:

_____

Phone #:

_____

DOA: _____ **CLAIM#:** _____ **CARRIER:** _____

I do hereby authorize Interventional Pain Spine & Orthopedics, PA to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself, in regards to the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly Interventional Pain Spine & Orthopedics, PA such sums as may be due andowing him for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect Interventional Pain Spine & Orthopedics, PA. I hereby further give a lien on my case to Interventional Pain Spine & Orthopedics, PA against any and all proceeds of any settlement, judgment or verdict which maybe paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Interventional Pain Spine & Orthopedics, PA for all the medical bills submitted by him for services rendered to me and, that this agreement is made solely for Interventional Pain Spine & Orthopedics, PA additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify any subsequent attorney of this lien and notify you of the name, address, telephone number of my new attorney.

This lien agreement will be effective if the assignment becomes null and void through patients' violation of any policy condition and/ or the policy is deemed void ab initio and/ or is voided at any time before payment is made and /or when policy is exhausted and/or if the accident is found to be staged and/or if the undersigned patient committed fraud in procuring this policy or commits fraud at any time before the payment for the services is made.

Patient's Signature: **Date:**

This agreement cannot be changed, altered or modified without written consent of the medical provider.

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Interventional Pain Spine & Orthopedics, PA prior to the payment of any part of such settlement, judgment, award, or verdict to the Patient named above.

I agree to notify you if I discontinue the patient in pursuit of their claim. I agree to provide you status of their claim upon your written request.

Attorney's Signature: **Date:**

Interventional Pain Spine & Orthopedics PA
Remittance: 185 Kingsland Street Nutley NJ
07110 Tel: 973-688-8543 Fax: 973-200-8587

Letter

Date:

Insurance Company:

_____
_____
_____

Name: _____
D/A: _____
Claim# _____

To whom it may concern:

With regard the above reference matter, please be advised that _____: states that they currently do not have health insurance or has Medicaid only, on the date of DOA.

Thanking you in advance

_____
Patient signature.

Interventional Pain Spine & Orthopedics PA

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Claim No.:_____

AFFIDAVIT OF NO OTHER SOURCES OF INSURANCE

State of:_____ **County of:**_____

I, _____ of full age, being duly sworn according to law, on his/her oath says:

1. I currently reside at _____ and have done so since _____
2. My home phone number is _____.
3. My date of birth ("DOB") is _____.
4. My social security number ("SSN") is _____. (if none, enter "none")
5. My Individual Taxpayer Identification number ("ITIN") is _____. (if none, enter "none")
6. Gender is _____Male _____Female
7. a. _____ I am not a Medicare beneficiary
   b. _____ I am a Medicare beneficiary and my Health Insurance Claim Number ("HICN") is _____.
8. My driver's license information is . State _____ Number _____.
9. On _____, the date the accident occurred:
   a. I resided at _____.
   b. If my driver's license was different that in (7) above, it was:
      i. State _____ Number_____.
   c. Other residents of my household on the date the accident occurred were:
      i. Name _____DOB_____SSN_____
      Driver's License # _____State_____
      Their relationship to you _____
      ii. Name _____DOB_____SSN_____
      Driver's License # _____State_____
      Their relationship to you _____
      iii. Name _____DOB_____SSN_____
      Driver's License # _____State_____
      Their relationship to you _____
      (Attached additional sheet, if necessary.)

Check all that apply below:

10. _____On_____, the date the accident occurred, I was not a resident of a household wherein any resident was the registered owner of a motor vehicle covered by a policy issued by an insurance company.
11. _____On_____, the date the accident occurred, I was not insured by any medical insurance carrier for coverage of medical services.
12. _____On_____, the date the accident occurred, I personally did not own an automobile with liability insurance coverage that would afford me Personal Injury Protection/No-Fault benefits.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statement made by me are willfully false, I am subject to punishment.

_____
Signature

_____
Print Name

Sworn to and subscribed before me this
_____day of_____, 20____.

_____

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 I: 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, I _____ I, by marking [] (or ☐) and signing below, agree to:

D representation by I=:] inan appeal of an adverse UM determination as allowed by N.!.S.A. 26:2S-1 I, 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.

D release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, 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: D I am the Patient D I am the Personal Representative (provide contact information on back)

• 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 I has been completed, signed and dated.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care - Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to 20 West State Street OR by fax to: (609) 633-0807 You

may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

D I hereby revoke my consent to representation by ◆ and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no
further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID# _____ Date: _____

Relationship to Patient: D I am the Patient D Iam the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information: PRINT

NAME: Interventional Pain Spine and Orthopedics

ADDRESS: 185 Kingsland st

Nutley NJ 07110

PHONE: 973-688-8543 FAX: 973-200-8587 EMAIL: sugeilly@docsnopain.com

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE I has been completed, signed and dated.

Interventional Pain, Spine and Orthopedics, PA

185 KINGSLAND STREET NUTLEY NJ 07110

Tel: 973-688-8543

OUT OF NETWORK PROVIDER WAIVER FORM

I _____, have been advised that INTERVENTIONAL PAIN, SPINE AND ORTHOPEDICS, PA, are not an "in-network provider" for my insurance plan; therefore, services provided to me and billed by INTERVENTIONAL PAIN, SPINE AND ORTHOPEDICS, PA, will be considered "out-of-network" services. Under this acknowledgement, I understand that my insurance carrier may pay for services rendered at a lower rate compared to those considered as "in-network."

Your insurance carrier may issue you payment for services rendered by an Out-Of-Network provider. Under this acknowledgement, I understand payment received from my insurance carrier will be giving to the appropriate provider, as stated on your explanation of benefits from your insurance carrier.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

_____ or
_____ Patient's signature
Guardian/authorized representative's signature

_____ _____
Print name of patient Print name of guardian/authorized representative

_____ _____
Date and time of signature Date and time of signature