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Orthopaedic & Spine Surgeons of New Jersey

PATIENT REGISTRATION

Today's Date: _____

PATIENT INFORMATION

PATIENT NAME (FIRST, LAST)

ADDRESS

CITY | STATE | ZIP CODE

HOME PHONE NO.
( )

WORK PHONE NO.
( )

DATE OF BIRTH | AGE | SEX ☐M ☐F | PATIENT'S DRIVER'S LICENSE #

SOCIAL SECURITY NO.

If patient IS UNDER 18 YEARS parent must complete this section

PARENT/GUARDIAN | **SOCIAL SECURITY NO.**

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

WHO REFERRED YOU?

REFERRING PHYSICIAN

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

AUTO ACCIDENT

If injury caused in accident patient must complete this section

INSURANCE

ADDRESS

CITY | STATE | ZIP CODE

DATE OF ACCIDENT | PHONE NO. ( )

POLICY HOLDER | POLICY NO.

CLAIM NO. | ADJUSTER'S NAME

EMERGENCY CONTACT

NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

INSURANCE INFO.

Must be completed even if accident injury

PRIMARY

NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

POLICY NO. | GROUP NO.

POLICY HOLDER | DATE OF BIRTH | RELATIONSHIP

SECONDARY

NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

POLICY NO. | GROUP NO.

POLICY HOLDER | RELATIONSHIP

EMPLOYMENT INFO.

All patients employed must complete this section

EMPLOYER'S NAME

ADDRESS

PHONE NO.
( )

DIRECT SUPERVISOR

WORK INJURY

If injury is work related patient must complete this section

EMPLOYER / SUPERVISOR

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO.
( )

WORKMANS COMPENSATION INSURANCE COMPANY NAME

ADDRESS

CITY | STATE | ZIP CODE

PHONE NO. ( ) | ADJUSTER'S NAME

DATE OF ACCIDENT | CASE NO.

Please Read Reverse And Sign Where Applicable *Thank You*

PLEASE COMPLETE FORM AND RETURN TO RECEPTIONIST WITH YOUR DRIVER'S LICENSE, INSURANCE CARD, AND INSURANCE FORM IF ANY.

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AUTHORIZATION

I hereby authorize and direct my insurance carrier to pay directly to ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I authorize ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY to release to my insurance company any of my medical information necessary to process this claim.

I _____ hereby authorize you, _____ as my attorney, to send to ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY a letter of protection concerning any litigation that may result. Furthermore, I understand that this authorization gives you permission to hold any monies out of settlement of my claim to fulfill the outstanding bill at ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY.

Authorized Signature: _____

PERMISSION FOR X-RAY EXAMINATION INVOLVING RADIATION WITHOUT PREGNANCY TESTING

ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY has ordered the following diagnostic procedures _____ to be performed on me. I understand that this diagnostic examination involving radiation can expose an unborn baby to small but significant risks of congenital deformity as well as other undesirable effects. Because it is difficult to know whether a pregnancy is present, ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY advises that a laboratory test for pregnancy be performed before the diagnostic examination. I believe that I am not pregnant, and I have decided not to have a pregnancy test before the diagnostic examination.

Signature: _____ Witness: _____

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PATIENT AUTHORIZATION FORM FOR AN INSURANCE APPEAL

Date: _____

Patient/Member Name: _____

ID #: _____

Date of Birth: _____

I hereby authorize ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY to appeal my claim with _____ on my behalf, as my Designated Representative. As part of my appeal, I hereby authorize my carrier to communicate with ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY in all aspects of my appeal. I understand that communications may contain the follow; all medical and financial information about my treatment relating to my examination.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or required or permitted by law. This authorization is valid for a period of one year.

Signature of Member or Legal Representative: _____

If signed by a legal representative, relationship to patient: _____

Signature of Witness: _____

Print Witness Name and Title: _____

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ASSIGNMENT OF BENEFITS

Name: _____

Insurance Company: _____

Claim #: _____

Date of Accident: _____

I hereby assign all of my benefits and rights from my insurance company to the medical provider designated below as well as other providers that render care on the same date of service. I assign all rights to pursue payment for services rendered to me by this medical provider and the medical provider may proceed against said insurance company obligated to make a payment to me or to this medical provider for services rendered to me. In the event that the insurance company refuses to make such payment upon demand, I expressly give permission for cause of action to be brought in my name as assigned.

A photocopy of this agreement may be valid as if it was an original.

I agree never to rescind this document and that a recession will not be honored by my attorney. I hereby instruct that if another attorney is substituted in this matter, the new attorney honor within assignment.

Date: _____

Patient's Signature: _____

Medical Provider: ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY

Address: 242 Claremont Avenue

Montclair, NJ 07042

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Orthopaedic & Spine Surgeons of New Jersey

BILLING AND COLLECTION AGREEMENT

Dear Patient,

Dr. Vizzone/Dr. Albano is not a participating provider. However, we will bill your insurance company as courtesy to you. Most insurance companies will deny a claim before they will pay for it. We will need your assurance that you will assist our office in providing all information to your insurance company in order to get pay. It may be necessary to do a 3-way conference call; a call between our office, yourself, and your insurance company since they often require written information from you. Also, be aware that if checks are cashed and we do not receive payment you will be placed in collections immediately. All checks must be endorsed to Dr. Vizzone/Dr. Albano.

You are responsible for any medical bill not paid by your insurance including deductibles and copays, as well as all attorney's fees and court cost in addition to your balance due to our office.

LIMITED POWER OF ATTORNEY

In addition to all services rendered to me by Dr. Vizzone/Dr. Albano, I _____ hereby authorize to endorse and deposit any checks payable to Dr. Vizzone/Dr. Albano and myself issued by my insurance company. This is Limited Power of Attorney and only applies for payment to all services rendered. This authorization shall stay in effect for two years unless cancelled by the parties.

Patient Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

1. I authorize the use or disclosure of the above-named individual's health information, as described below.

2. The following individuals or organizations are authorized to make the disclosure:
   ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY

3. The information may be disclosed to, and used by, the following individuals or organizations:
   Name(s): _____
   Address: _____
   Purpose: _____

4. The information to be disclosed shall be limited to that information necessary to fulfill the above-stated purpose(s) and may include the following items (unless crossed out by me).

   Drug and alcohol abuse information
   Information regarding Human Immunodeficiency Virus, HIV including lab results
   Diagnosis of AIDS or ARC, if applicable
   Consultations
   Genetic testing and counseling, if applicable
   Diagnostic testing, excluding HIV testing
   Discharge Summary
   Psychosocial history
   Treatment recommendations
   Other (specify): _____

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5. This authorization may be revoked by me at any time except to the extent that ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the Office Manager. If not revoked by me, this consent will terminate on: _____

6. I have the right to inspect the information to be disclosed.

7. Choose One
   I understand that I need not to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits

   OR

   I understand that if I refuse to sign this form, the organization can refuse
   A. Treatment
   B. Enrollment in health plan
   C. Eligibility for benefits

8. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer is protected by this rule.

Signature of Patient or Legal Representative: _____

If signed by a legal representative, relationship to patient: _____

Signature of Witness: _____

Date: _____

PHYSICIAN PRACTICE'S NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WE HAVE LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may noy use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below we describe the different categories of uses and disclosures.

A. Uses and disclosures which do not require authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. **For Treatment**. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in your care. For example, if you are being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your plan to get paid for the health care services we provided to you.

3. **For Health Care Operations**. We may disclose your PHI in order to operate this practice. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal state or local law judicial or administrative proceedings or law enforcement.** For example, we make disclosures when a aw requires that we report information to the government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds, or when ordered in a judicial of administrative proceeding.

5. **For public health activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions**. We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Use and Disclosure where you to have the opportunity to object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part.

C. **All other uses and disclosures require your prior written authorization**. In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses or disclosures (to the extent that we have not taken any action relying on the authorization).

D. **Incidental uses and disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

V.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The right t request limits on uses and disclosures of your PHI.** You have the right to ask that we limit how we use and disclose your Phi. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may limit the uses and disclosures that we are legally required or allowed to make.

VI.

B. **The right to choose how we send PHI to you.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

VII.

C. **The right to see and get copies of your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing our reasons for denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you $1.00 for every page and a $10.00 search fee. Instead of providing you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. **The right to get a list of the disclosures we have made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will include uses or disclosures that you have already consented to, such as those made for treatment, payment, or healthcare operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections, or law enforcement personnel, or before April 1, 2003.

E. **The right to correct or update your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial to be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you what we have done to it, and tell others that need to know about the change to your PHI.

F. The right to get notice by e-mail. You have the right to get a copy of this notice by e-mail. Even if you have to agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICE.

If you think that we may have violated your privacy rights, or disagree with a decision we made about accessing your PHI, you may file a complaint with the person listed in Section IV below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Health Services, please contact the office manager.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on February 1st 2003.

We will respond within 60 days of receiving your request. The list we will give you will include the disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure to which PHI was disclosed (including their address, if known) a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $1.00 per page plus a $10.00 search fee.

I acknowledge receipt of ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY's Provider's Notice of Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

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Orthopaedic & Spine Surgeons of New Jersey

PLEASE CHECK:	YES	NO
FEVER/CHILLS	_____	_____
UNEXPLAINED WEIGHT LOSS	_____	_____
RECENT WEIGHT LOSS	_____	_____
GLASSES/CONTACT LENSES	_____	_____
HEARING LOSS	_____	_____
OXYGEN DEPENDENCE	_____	_____
SLEEP APNEA	_____	_____
SHORTNESS OF BREATH	_____	_____
EASY BRUISING/BLEEDING	_____	_____
GI BLEED/BLACK STOOL	_____	_____
SENSITIVITY TO HEAT	_____	_____
SENSITIVITY TO COLD	_____	_____
SKIN RASH	_____	_____
OPEN SORES	_____	_____
HEADACHES	_____	_____
DIZZINESS	_____	_____
ANXIETY	_____	_____
DEPRESSION	_____	_____
ENVIRONMENTAL ALLERGIES	_____	_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: NAME: STRENGTH: 1. 2. 3. 4. 5.	PLEASE LIST ANY ALLERGIES: 1. 2. 3. 4. 5.

242 Claremont Avenue - Montclair, New Jersey 07042 - Telephone (973) 783-1444 - Fax (973) 783-7755

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PAIN LEVEL

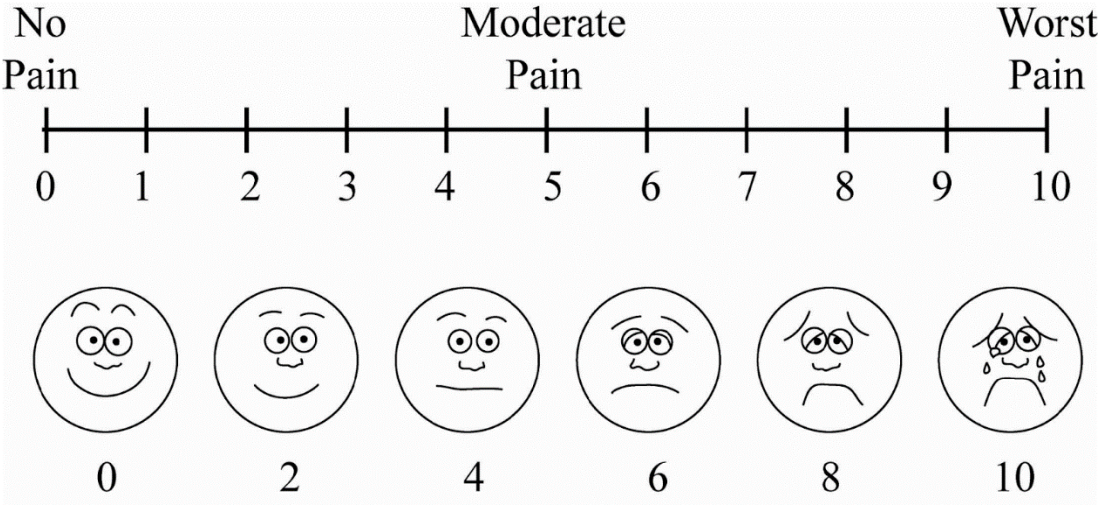
You can describe your pain using any of the following choices below:

_____ THROBBING
_____ STABBING
_____ DULL
_____ ACHING
_____ PINCHING
_____ STEADY
_____ LOCALIZED
_____ PERVASIVE
_____ CHRONIC (PERSISTENT)
_____ ACUTE (IN THE MOMENT)

OTHER COMMENTS:

_____
_____
_____
_____
_____

USE THE CHART BELOW TO ESTIMATE YOUR PAIN LEVEL: HOW MUCH DOES IT HURT?



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ORTHOPAEDIC AND SPINE SURGEONS OF NEW JERSEY
DISCLOSURE OF SIGNIFICANT FINANCIAL INTEREST

The laws of the State of New Jersey and the Board of Medical Examiners and/or New Jersey Department of Health require that a physician inform patients of any significant financial interest held in a health care service. Accordingly, please take notice that your physicians, Jerald P. Vizzone, D.O. does have a financial interest in the following Ambulatory Surgical Center to which a patient may be referred:

Orthopaedic & Spine Institute of NJ, L.L.C.

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory or the internet under the appropriate heading.

Please also be advised that Orthopaedic & Spine Institute of NJ, L.L.C., holds an ambulatory facility license issued by the New Jersey Department of Health and is overseen by this Department which has information on the surgical center's licensure and compliance with surgical center laws. You can obtain information in this regard at:
http://www.state.nj.us/health/healthfacilities/asc_info.shtml
or by calling: 609-341-2124

Orthopaedic & Spine Institute of NJ, L.L.C., is also Accreditation Association for Ambulatory Healthcare ("AAHC") Accredited. Additional information may be obtained from this entity.

Acknowledgement of Receipt

I, the undersigned patient, acknowledge receipt of this Disclosure of Significant Financial Interest from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment at alternative health care facilities that my health care provider does not hold a significant financial interest in and wish to obtain my treatment at Orthopaedic & Spine Institute of NJ, L.L.C.

Print Name: _____ Date: _____

Print Signature: _____