Centers for Neurosurgery Spine & Orthopedics

Todays Date: _____ Name:_____ SSN: _____

Height:_____ Weight: _____ DOB: _____ Sex: _____

Who referred you to this office? _____

Primary Care Doctor: _____

Race:

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Black/African American
- ☐ White
- ☐ Hispanic
- ☐ Other
- ☐ Refuse to Answer

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino
- ☐ Refuse to Answer

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Common Law

Email: _____ Employer: _____

Home Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Cell: _____

Primary Medical Insurance: _____ Member ID#: _____

Secondary Medical Insurance: _____ Member ID#: _____

Spouse Name: _____ Spouse Employer: _____

In case of an emergency: _____ Phone: _____

If patient is minor, list responsible relative/guardian: _____

Home Phone: _____Work Phone: _____ Cell: _____

Is this related to an accident or work injury? ☐ Motor Vehicle Accident ☐ Worker's Comp ☐

Is there litigation related to this injury? _____ Attorney's Name/Phone: _____

Insurance Company: _____ Claim #: _____ Adjuster: _____

Insurance Company Address: _____ Phone: _____

Do you have an Advance Directive (Living Will)?: _____ Name of Surrogate: _____

Centers for Neurosurgery & Spine & Orthopedics

PREVIOUS TREATMENT

Previous Treatments	Date Range Treatment was Utilized	Provider or Facility Name
Pain Management Doctor	_____	_____
Acupuncture	_____	_____
Heat/Cold application	_____	_____
Chiropractic Manipulations	_____	_____
Massage	_____	_____
Physical Therapy	_____	_____
Injections	_____	_____

What types of injections have you received? _____

Home exercises (stretching, etc.) _____ _____

Which of the above treatment modalities are you still currently using? Please list all:

_____

_____

_____

Current and previous over the counter PAIN medications:

_____

_____

_____

Name of medication	Dose (mg) # per day	Pain Relief		Currently Taking		Dates taken
Tylenol (Acetaminophen)	_____mg ____per day	☐ Yes	☐ No	☐ Yes	☐ No	_____
Advil (Ibuprofen, Motrin)	_____mg ____per day	☐ Yes	☐ No	☐ Yes	☐ No	_____
Aleve (Naproxen)	_____mg ____per day	☐ Yes	☐ No	☐ Yes	☐ No	_____

Other prescription medications for PAIN:

_____ _____mg _____per day Dates medication taken:_____

_____ _____mg _____per day Dates medication taken:_____

_____ _____mg _____per day Dates medication taken:_____

MEDICAL HISTORY

Do you take any medications? _____ (Please list your medications, dosage, and schedule)

_____

_____

_____

Do you take? Aspirin _____Birth Control _____Herbal Supplements _____
Do you have any allergies or adverse reaction to medication, anesthesia, latex or contracst dyes? (Please list):

_____

Please list prior hospitalizations or surgery including reason for hospitlizationa and dates:

_____

_____

Have you had the flu vaccine? _____ Date:_____Who administered the vaccine? _____
Have you had the pneumonia vaccine? _____ Date: _____Who administred the vaccine? _____
Have you had a colonoscopy? _____ If yes, list the date you had it done: _____ Results: _____

FEMALE PATIENTS ONLY: Date of last PAP Smear: _____ Results_____
Date of last Mammogram _____ Results _____

Do you or your family members (children, siblings, parents, or grandparents) have the following medical conditions? Next to each condition below put a Y if it applies to you, F if it applies to your family, or both Y and F if it applies both you and your family.

Bad reaction to anesthesia _____
Stroke _____
TIA (mini stroke) _____
Bleeding in brain _____
Aneurysm in brain _____
Seizures _____
Heart attack _____
Angina _____
Heart disease _____
Heart failure _____
Mitral valve prolapse _____
High blood pressure _____
Asthma _____
Emphysema _____
Tuberculosis _____
Cancer (type _____) _____
Diabetes _____
Anemia _____
Sickle cell _____

Thyroid disease _____
Elevated cholesterol _____
Ulcers _____
Diverticulosis/Diverticulitis _____
Hepatitis _____
Aortic aneurysm _____
Peripheral vascular disease _____
AIDS/HIV _____
Muscle disease _____
Rheumatoid arthritis _____
Osteoperosis _____
Osteopenia _____
Urinary infection _____
Kidney insufficiency/failure _____
Bleeding tendency _____
Depression _____
Psychiatric Illness _____
Migraines _____

Please list any other medical problems you have that are not listed above:

_____

Do you have any of the following symptoms? LIST ALL THAT APPLY.

Memory loss	Chronic cough	Diarrhea
Visual change or loss	Coughing blood	Blood in urine
Ringing in ears	Abnormal bruising or	Diffuclty urinating
Hearing loss	bleeding	Painful urination
Headaches	Fever or chills	Erectile dysfunction
Dizziness	Abnormal weight loss	Claubstraphobia
Chest pain	Heartburn	Rash or skin lesions
Palpitations	Persistant	Jaundice
Shortness of breath at	nasaeu/vomiting	Depression
rest	Abdominal pain	Anxiety/stress
Shortness of	Blood in bowels	Heat/cold intolerance
breath/activity	Constipation	Abnormal thirst

Has a family member ever had an adverse reaction to anesteheia or medication? _____ If yes, please explain:

_____

Do you smoke? Yes ☐ No ☐ If yes, for how long? _____ How much do you smoke? _____
Have you smoked in the past? Yes ☐ No ☐ If you used to smoke in the past, when did you quit? _____
How much did you smoke in the past? _____ How long did you smoke in the past? _____

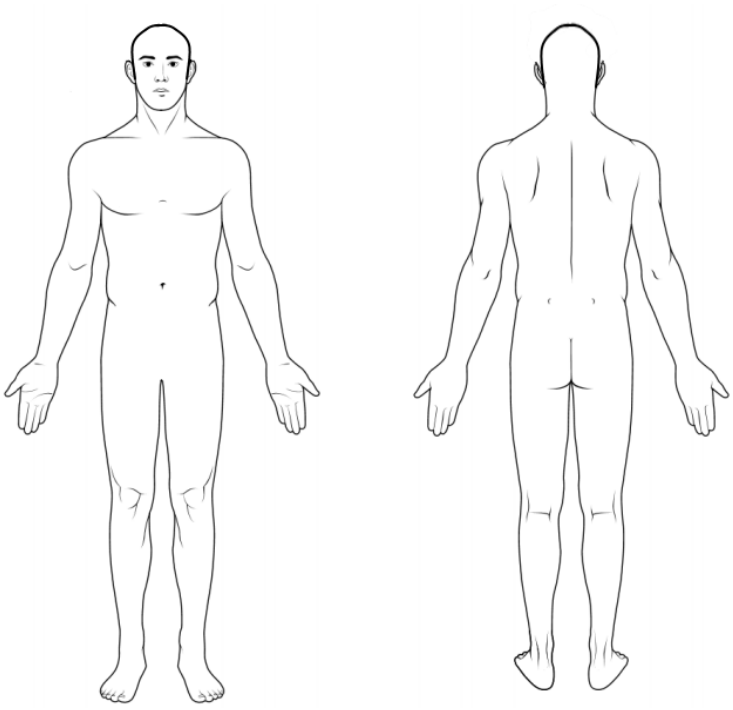
Do you drink alcohol? Regularly ☐ Occasionally ☐ Never ☐
How much wine do you drink daily? _____ How much beer daily? _____ How much liquor daily? _____

Do you currently use recreational drugs? Yes ☐ No ☐
Have you used recreational drugs in the past? Yes ☐ No ☐ Any intravenous drugs? Yes ☐ No ☐

YOUR SYMPTOMS
Do you have weakness in your foot or hand? Yes ☐ No ☐
How long have you suffered from these symptoms? Less than or equal to 5 wks ☐ 7-12 wks ☐ 4+ months ☐
Do you have any pain radiating PAST your knee or elbow? Yes ☐ No ☐
Does your leg or arm ever go numb? Yes ☐ No ☐
Have you had back or neck surgery before? Yes ☐ No ☐
Does your back or back pain wake you up at night? Yes ☐ No ☐
How many pills do you take each day for pain relief? No pills ☐ 1-4 pills ☐ 5 or more pills daily ☐

What is your pain level on a sacle of 1-10, with 1 being no pain at all and 10 being extreme pain? _____

Describe where on your body you have stabbing pain, burning pain, aching pain, pins and needles or numbness.



FRONT **BACK**

YOUR EXPECTATIONS

Answer the below questions regarding what result you expect from your care at the Centers for Neurosurgery, Spine, & Orthopedics.

Do you expect relief from pain symptoms?	Yes ☐	No ☐	Does not apply ☐
Do you expect to be able to return to your job?	Yes ☐	No ☐	Does not apply ☐
Do you expect to be able to return to leisure activties?	Yes ☐	No ☐	Does not apply ☐
Do you expect to have improved sleep?	Yes ☐	No ☐	Does not apply ☐

HOW YOUR SYMPTOMS AFFECT YOUR LIFE

Which of the following describes you currently?

☐ Working
☐ Not working because of back or neck problems
☐ Not working because of another health problem
☐ Homemaker, retired, or unemployed

Did your back/neck injury happen at work? Yes ☐ No ☐ N/A ☐

The following are activities you might do in a day. Does your back or neck pain limit you in these activties, and if so, how much?

Lifting or carrying groceries	A lot ☐	A little ☐	Not at all ☐
Climbing several flights of stairs	A lot ☐	A little ☐	Not at all ☐
Standing for 30 minutes	A lot ☐	A little ☐	Not at all ☐

We may have a nurse call you to follow-up on your symptoms and check to see how you are doing three months from now. Is it okay for us to call you at the number you provided? Yes ☐ No ☐

Centers for Neurosurgery & Spine & Orthopedics

PAIN MEDICATION POLICY

In the course of your treatment, you may receive pain medications. However, all physicians are required by federal law to follow stringent policies related to the use of prescription drugs, especially narcotics.

Consequently, all patients need to make arrangements to obtain any necessary prescription refills prior to the weekend. We will NOT provide pain prescriptions or refills during the weekend, which begins each Friday at 12 p.m. and ends the following Monday at 8:30 a.m.

The goal of our centers is to help patients become less dependent on pain medications. Consequently, our policy is to NOT provide prescription refills by phone. Therefore, you may need to see the physician or the physician assistant to make these arrangements. Please call at least two days prior to your last dose. This will assure the most prompt response to your request. Do not wait until the day your medication runs out. Our clinical staff needs enough time to review the request for your refill.

USE ONE PHARMACY

Using the same pharmacy helps assure that the pharmacy will stock your medication for refills and that the pharmacy will know that you have a legitimate need for pain medication. It is in your best interest to use only ONE pharmacy for refills of your pain medication.

PROTECT YOUR MEDICATION FROM LOSS

You are personally responsible for the safekeeping of your medication. Please do not sell, trade, or give it away. If your medication is damaged, stolen, or lost, you must notify us right away.

Please do not seek pain medication from any other doctor unless approved by our clinical staff. Let us know if at any time another doctor prescribes medication for you.

The above restrictions apply a variety of prescription drugs, including, but not limited to:

1. Narcotics *(Vicodin, Percocet, Oxycontin, Codeine)*
2. Non-Steroidal Anti-Inflammatory Drugs, "NSAIDS" *(Motrin, Celebrex, Naprosyn)*
3. Non-Narcotic and Other Pain Medication *(Ultram, Darvocet)*
4. Muscle Relaxants *(Flexeril, Soma)*

Centers for Neurosurgery Spine & Orthopedics

PAIN AGREEMENT INFORMED CONSENT

The purpose of this agreement is to prevent misunderstandings about your medical treatment and the medications you may be prescribed for pain management. It is important to understand that there are various medical interventions available to treat your pain and your doctor may prescribe medications or recommend other options available to treat your condition instead of or in addition to the use of pain medications. The physicians at Centers for Neurosurgery, Spine & Orthopedics (CNSO) are under no obligation to prescribe pain medications to you. Many of these medications have serious side effects and can be harmful if not taken properly. There may be times that a CNSO healthcare provider may contact your other treating physicians and/or pharmacy to clarify questions regarding your healthcare.

Below are various descriptive terms used in this agreement:

Opioid = a group of chemically related medications with strong pain relieving, narcotic qualities that also possess sedating qualities that may reduce suffering, fear and panic associated with pain through action on the brain and central nervous system.
Benzodiazepine = a class of medications with calming, sedating qualities frequently used to treat anxiety, tension and fear.
Other related drugs = for the purpose of this agreement, "other related drugs" include muscle relaxants, membrane stabilizing medications and other nonnarcotic pain-relieving medications. These medications may cause altered mental status, sedation, occasionally dangerous withdrawal effects when stopped abruptly and may have medication interactions similar to or different from opioids or benzodiazepines.
Controlled substance = for the purpose of this agreement, a controlled substance will apply to opioids, benzodiazepines or other related medications as described above.

Informed Consent: *There are various risks associated with the use of opioids, benzodiazepines and other related medications that are important for you to be aware of:*

Physical Dependence - the abrupt discontinuation of controlled substances which could lead to withdrawal symptoms including but not limited to chills, hot flashes, nausea/vomiting, muscle aches/joint pains, abdominal cramping, diarrhea, anxiety, hypertensive crisis, cardiac arrest or other cardiac dysfunction, seizures and death.
Psychological Dependence and Addiction – the use of these medications may lead to a behavior focused on the obtaining and misuse of controlled substances.
Tolerance – the need to increase an opioid dose over time to maintain a similar level of pain relief.
Overdose - may lead to low blood pressure, respiratory arrest and death.
Mental Changes - these classes of medications may cause confusion, sedation, drowsiness, problems with coordination and changes in thinking ability. This may make it unsafe to drive a motor vehicle, operate hazardous equipment and machinery or perform dangerous activities. Other side effects may include but are not limited to the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression and loss of sexual drive with testicular atrophy (in males).

There are other non-pharmacologic treatments available to treat your pain which could be used as an alternative to pain medications. These may include: physical therapy, acupuncture, chiropractic care, injection therapy and surgery.

Patient Printed Name: _____ Patient Signature: _____
Today's Date: _____

Centers for Neurosurgery Spine & Orthopedics

PAIN AGREEMENT

By placing your initials along the line at each numbered statement, you acknowledge that you have read, understood and will comply with each statement. PLEASE MAKE SURE TO PLACE YOUR INITIALS NEXT TO EACH ITEM. THIS AGREEMENT WILL NOT BE VALID IF YOU CHECK THE BOXES.

1. _____ I understand that this agreement is essential to create guidelines for the trust and confidence necessary to develop a responsible doctor/patient relationship when taking pain medications. If this trust is compromised, my continued treatment with pain medications may be discontinued and I may be dismissed from Centers for Neurosurgery, Spine & Orthopedics (CNSO).
2. _____ I understand that controlled substances may be prescribed by my physician only if it is believed that this treatment may have a medically reasonable chance of improving my quality of life, including participation in work and social activities.
3. _____ If my physician finds that treatment with controlled substances is not providing an adequate therapeutic benefit, or if addiction, rapid loss of effect, or significant side effects develop, I agree to have my medications tapered as directed.
4. _____ I understand the possible adverse effects and dependencies associated with opioids as outlined on the risks section of this agreement.
5. _____ I will not present to the practice for early controlled substance refills. I understand that early pain medication refills are not provided. Furthermore, I understand that medication renewals are at the discretion of the treating physician and will be prescribed at office appointments only.
6. _____ I understand that controlled substance refill prescriptions will only be provided at the time of a scheduled office visit and the medications will not be prescribed after office hours or weekends. The CNSO medication refill hours are 9 AM to 4 PM Monday through Friday.
7. _____ I understand that pain medication prescriptions will not be mailed to me.
8. _____ I understand that I should not drive a motor vehicle, operate heavy machinery or perform any other activity of responsibility while I am taking pain medications as these medications may make me sleepy, alter my judgment and ability to think clearly.
9. _____ I will notify CNSO immediately of any adverse effects with my prescribed pain medications.
10. _____ I understand that controlled substances and other drugs may potentially harm an unborn child or a breast fed infant, and I will notify my CNSO physician if I am or plan to become pregnant. Furthermore, I will use appropriate measures to safeguard and prevent pregnancy during the course of my treatment with pain medication.
11. _____ I will have all imaging studies, lab tests and diagnostic procedures as well as referrals to additional subspecialists as advised by my CNSO physician.
12. _____ **I will only use one pharmacy to fill my pain medication prescriptions**. Under extenuating circumstances when an alternative pharmacy must fill my prescriptions, I will notify CNSO of this change.

My pharmacy is: _____Pharmacy Address: _____
Pharmacy Telephone #: _____

13. _____ I agree to seek psychiatric treatment, psychotherapy and/or psychological treatment if my CNSO physician feels it's necessary.
14. _____ I agree to have all my pain medications managed solely by my CNSO physician**. I will not obtain any controlled medications, including pain medications, stimulants, or anti-anxiety medications from any other doctor without first obtaining the consent of my treating physician at CNSO.**
15. _____ **I will take my pain medications as prescribed and will never adjust the dosage or frequency of the medications without the direction and consent of a CNSO physician.**
16. _____ If, while under treatment with controlled substances, a substance abuse problem is suspected, I agree to evaluation and treatment of this problem as directed by my CNSO physician.
17. _____ I will never share, sell, exchange or misuse my pain medications for any reason.
18. _____ I currently am not and will not be involved in the sale, illegal possession, diversion or transport of controlled substances like narcotics, sleeping pills or nerve pills.
19. _____ I will safeguard my pain medication from loss, theft or damage; **and I understand that lost or stolen medications will not be replaced.**
20. _____ I agree to bring my unused pain medications to every office visit for random pill count to assess compliance with my medical treatment.
21. _____ I do not currently have any substance abuse problems (drugs and/or alcohol) and I agree that I will not use any illegal substances, including marijuana, nor will I misuse or self-prescribe/medicate with legal controlled substances.
22. _____ I will refrain from drinking alcohol, as alcohol can enhance the side effects of my pain medication, potentially causing over sedation, slowed breathing and respiratory depression, which could lead to coma or death.
23. _____ I agree to drug screening tests while under treatment at CNSO. I will submit to blood, urine, or salivary testing as requested by my doctor to determine my compliance with my treatment program. Refusal to participate in this testing may result in immediate termination of treatment with pain medications and possible discharge from the Centers for Neurosurgery, Spine & Orthopedics. Positive tests for any illegal substances or opioids not prescribed by CNSO will result in dismissal from the practice.
24. _____ I understand that abusive behavior or harassment towards CNSO's staff will not be tolerated and may result in dismissal from the practice.
25. _____ I authorize CNSO and my pharmacy to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale or diversion of my pain medication. I authorize my doctor to provide a copy of this agreement to my pharmacy, primary care physician or local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
26. _____ I understand that if I do not follow this agreement, I may be dismissed from the Centers for Neurosurgery, Spine & Orthopedics at their discretion.

Patient Printed Name: _____

Patient Signed Name: _____

Today's Date: _____

Centers for Neurosurgery Spine & Orthopedics

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your physician, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities, and your insurance company. This personal information includes items such as your name, address, phone number, date of birth, social security number, employer, health history, insurance policy and coverage, and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress, and any test results or films.

How your information is used

The personal and health information gathered may be used and disclose with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest, we may be required to disclose certain information to local, state, or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Safeguarding your personal and health information

We are required by law to (1) make sure that medical information that identifies you is kept private, (2) provide you with our privacy policy, and (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your person and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic, and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment. You have the right to request restrictions to our uses or disclosures of your person or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Centers for Neurosurgery Spine & Orthopedics

PATIENT RESPONSIBILITY
FOR FOLLOW-UP CARE PLEDGE

I, _____ (print first name), _____ (print last name), hereby acknowledge and understand that even with the best training, skill experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and health outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office; as in any bad health outcome resulting from my failure to follow the advice of my doctors.

_____ _____

Signature Date

Centers for Neurosurgery Spine & Orthopedics

AUTHORIZATION FOR ACCESS BY OTHER TO YOUR PERSONAL HEALTH INFORMATION (PHI)

Patient Name: _____
Home Address:_____

_____

Home Telephone: _____ Date of Birth:_____

Please check off all situations below where you would grant the individuals listed access to your PHI:

☐ Confirmation of appointment details (including surgical scheduling)
☐ Diagnostic testing results
☐ Details of surgery and outcome
☐ Picking up medical records
☐ Permission to leave a message on answering machines

Please list the individuals for whom you authorize access to your PHI:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Acknowledgement: By submitting this form, I hereby permit the Center for Neurosurgery, Spine & Orthopedics to disclose my PHI to the individuals listed above. Authorized individuals must present identification as proof that they are who they claim to be.

_____ _____
Patient Signature Date

Patient Financial Policy

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment. Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know your policy. If we do accept assignment of benefits, we require a credit card with authorization, which we will hold, in the event of non-payment otherwise. Your balance will become your responsibility if denied by your carrier for any reason. You reserve the right to appeal the reimbursement for services or lack of with your carrier pursuant to your health care insurance contract.

Please be aware that some and perhaps all services which we provide may be considered uncovered services, and therefore considered not medically necessary under the Medicare program and other insurance carriers.

You hereby authorize insurance payment directly to Centers for Neurosurgery, Spine & Orthopedics ("CNSO"). Should payment be sent to you, it is your responsibility to return check to CNSO, within seven (7) collection proceedings wherein you agree to pay our reasonable attorney fees and costs for collection as well as potential criminal liability for theft and conversion of funds.

You assign your rights to benefits under your contract of insurance or third-party payment to CNSO, and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plan. If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

Our office plans an extensive portion of time to spend with you on each visit. Cancelling or "no showing" causes a loss of this time, which could have been used to see other patients. We ask that you make every effort to keep your scheduled appointment. We reserve the right to charge you for the missed visit. This will not be covered by any insurance company. We ask that you please be considerate and help us to serve you better by keeping scheduled appointments.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE INFORMATION, OR THAT THE INFORMATION HAS BEEN READ OR TRANSLATED TO ME, AND THAT I UNDERSTAND MY RIGHTS AND OBLIGATIONS AS A PATIENT UNDER THE AGREEMENT.

_____	_____	_____	_____
Patient Name	Signature	Witness	Date

Consent for Minor

I grant the physicians associated with the authority to administer treatments and perform such procedures as may be deemed necessary for the patient.

_____	_____	_____
Signature	Relationship to patient	Date

Notice of Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area. I will be offered a copy of any amended Notice or Privacy Practices.

_____	_____
Signature	Date

If not signed by the patient, please indicate the relationship between the signee and the patient: _____

Centers for Neurosurgery Spine & Orthopedics

Assignment of Benefits & Authorization
[To pursue appeal and/or litigation of health care benefits]

In consideration of the professional services rendered by the Centers for Neurosurgery, Spine, & Orthopedics, and its affiliated health care providers ("Healthcare Providers"), I hereby irrevocably direct, authorize, assign, and consent to the following:

1. The assignment of my rights to bill, collect, appeal, and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to Healthcare Providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claim, pursuant to my rights under state and/or federal law including but not limited to the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).
2. The authorization of Healthcare Providers to act as my agent-in-fact with regard to all aspects regarding my claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully funded or self-funded.
3. The authorization of Healthcare Providers to initiate, prosecute, and resolved any and all appeals and/or arbitrations and/or legal action on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigation matters in state or federal court including but not limited to claim under the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).
4. The authorization of Healthcare Providers to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5. The authorization of Healthcare Providers to file a compliant with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, the Federal Department of Labor, as it relates to ERISA plan, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to Healthcare Providers to which I might be entitled under my claims.
7. I hereby further assign to the Centers for Neurosurgery, Spine & Orthopedics all of my rights under my insurance contract, including all of my rights governed by the statutes and regulations of the 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)

Patient Name (print) : _____ Patient Signature: _____Date: _____
Witness Name (print): _____Witness Signature: _____Date: _____

OFFICE USE ONLY: Insurer _____ Claim _____

Centers for Neurosurgery Spine & Orthopedics

OUT OF NETWORK PROVIDER WAIVER FORM

I, _____, have been advised that all providers at the Centers for Neurosurgery, Spine & Orthopedics are not in-network providers for my insurance plan, therefore, services provided to me and billed by the Centers for Neurosurgery, Spine & Orthopedics will be considered out of network services. Under this acknowledgement, I understand that my insurance carrier may deny payment if I do not have out of network benefits or am subject to an out of network deductible. I agree to pay any outstanding balance if my insurance company denies any claim submitted by the Centers for Neurosurgery, Spine & Orthopedics.

_____
Patient Name

_____ _____
Patient Signature Date

AUTHORIZATION FOR PAYMENT WHEN PATIENT RECEIVES CHECK

Date: _____

Patient Name: _____

Insurance Company: _____ ID#: _____

Based on our experience with your insurance company, CNSO's payment for services rendered to you may be sent directly to you (the patient) instead of us. If you receive any type of correspondence from the above-named insurance company for services rendered in this office, please bring the information to us within 10 days.

STATEMENT OF AGREEMENT:

I, _____, hereby agree to endorse any checks received by me from the above named insurance company for services rendered in this office or I will deposit the check and immediately reimburse this office within 10 days.

_____ _____
Patient or Guardian Signature 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.[1] 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, PRINT NAME, by marking [√] (or [x]) and signing below, agree to:

☐ representation by North Jersey Spine Group 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)

[1] 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.

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

☐ I hereby revoke my consent to representation by the Centers for Neurosurgery, Spine & Orthopedics 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: ☐ I am the Patient ☐ I am the Personal Representative

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Contact Information of Personal Representative

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

PRINT NAME: _____
ADDRESS:_____
PHONE: _____ FAX: _____ EMAIL: _____

Centers for Neurosurgery Spine & Orthopedics

AUTHORIZATION FOR DIRECT PAYEMENT, AUTHORIZATION TO RELEASE INSURANCE INFORMATION AND REQUEST FOR PIP PAYOUT LOG

Automobile Claim Insurance Carrier: _____

Claim Number: _____

Date of Loss/Accident: _____

I direct my automobile claim insurance carrier to provide the Centers for Neurosurgery, Spine, & Orthopedics. any coverage information, documents, PIP payout sheet/PIP log, declaration page, all applicable endorsements, transcripts and/or copies of any recorded statements, examinations under oath, independent medical evaluations and a listing of all PIP benefits paid to date which shall include when claims were made, when the claims were received, the payment or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefit.

_____ _____

Patients Name (Print) Date

_____ _____

Signature Date of Birth