Arash Emami, M.D. Ki Soo Hwang, M.D. Kumar Sinha, M.D. Michelle Brenner, N.P.

DATE: _____/_____/_____

NAME: ____HOME PHONE: ____________________________

ADDRESS: ______________________________________CELL PHONE: _____________________________

CITY: ______________________STATE:_______ZIP:___________WORK PHONE: ___________________

DATE OF BIRTH: _____/_____/_____ AGE: _________ SS#____________________________________

SPOUSE NAME: _____________________DOB:_____/_____/_____ SS#___________________________

EMERGENCY CONTACT: ______________________________ PHONE # : __________________________

PHYSICIAN INFORMATION

PRIMARY DOCTOR: _________________________________PHONE:_____________________________

ADDRESS: ____FAX:________________________________

CARDIOLOGIST: _____________________________________PHONE:_____________________________

REFFERRED BY: ____________________________________ PHONE: _____________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: _________________________________ID#______________________________

SECONDARY INSURANCE: ______________________________ ID#______________________________

PHARMACY INFORMATION

NAME: ____ PHONE: ____________________________

University Spine Center

Please State the Main Reason You Are Here Today:

____

When did you first notice any symptoms (Date of injury if known)? ________________________________

Where did the injury or illness occur? ____

How did they first occur? ____

Are your symptoms due to an injury at **work**? ☐No ☐Yes

Are your symptoms due to a **motor vehicle accident**? ☐No ☐Yes

Have you ever been involved in a motor vehicle accident? ☐No ☐Yes—If yes, please explain:

Have you received treatment for similar symptoms before visiting this office? ☐No ☐Yes

If yes, please provide name/address of Physician, Chiropractor, Pain management, or Physical Therapy.

1. Name and Address of Doctor:________________________Phone:________________
   Treatment received: ______________________________Fax:_________________
2. Name and Address of Doctor:________________________Phone:________________
   Treatment received: ______________________________Fax:_________________
3. Name and Address of Doctor:________________________Phone:________________
   Treatment received: ______________________________Fax:_________________

Have you had any **Surgeries**? ☐No ☐Yes—If yes, list operations, date, doctor/hospital:

1. Surgery: Date/Doctor/Hospital:____
2. Surgery: Date/Doctor/Hospital:____
3. Surgery: Date/Doctor/Hospital:____
4. Surgery: Date/Doctor/Hospital:____

Please list all your **Current Medications** (including herbal, vitamins and over the counter medications).

Name of Medicine	Dose	Name of Medicine	Dose
______________________	_______________	______________________	_______________
______________________	_______________	______________________	_______________
______________________	_______________	______________________	_______________
______________________	_______________	______________________	_______________
______________________	_______________	______________________	_______________

Allergies to medicine or other product (latex, tape, peanuts, etc.)? ☐No ☐Yes—If yes, please explain:

Please check the following illnesses you have had or have now:

☐ Arthritis __________	☐ Diabetes (Insulin?) _________	☐ Eyes _________________	☐ Ear/Nose/Throat __________
☐ Epilepsy __________	☐ Heart Disease _____________	☐ Psychiatric ____________	☐ Bleeding/Clotting _________
☐ Hypertension ______	☐ Cancer __________________	☐ Headaches ____________	☐ Lungs __________________
☐ Stroke ____________	☐ Anemia _________________	☐ Bowel Dysfunction ______	☐ Bladder Dysfunction _______
☐ Tuberculosis _______	☐ Asthma/COPD ____________	☐ Balance/Dizziness ______	☐ Numbness/Tingling ________
☐ Depression ________	☐ Vascular disease ___________	☐ Blackouts/Fainting ______	☐ Stomach ulcers ___________
☐ Osteoarthritis ______	☐ Rheumatoid Arthritis _______	☐ Lyme _________________	☐ Fibromyalgia _____________
☐ HIV/AIDS ________	☐ Hepatitis Type ____________	☐ Others (specify)___________________________________	

Social History: ☐ Smoke ________ a day, ☐ Quit (When: _______), ☐ Alcohol How often? _____________

☐ Other Substance abuse. Please describe: ____

Work History

Current Employer: ____

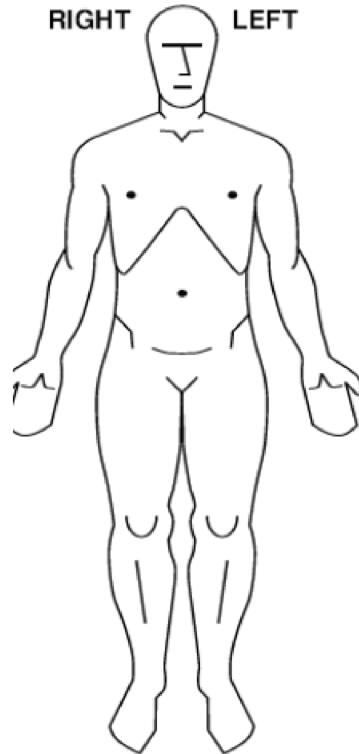
Occupational Description: ____

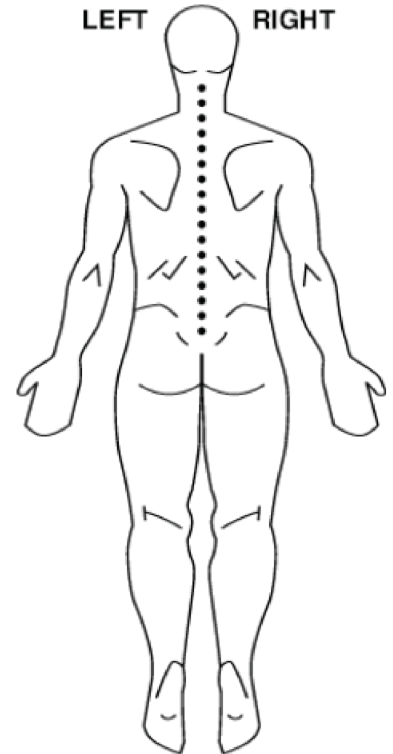
Previous Employer (please list employer, job title, dates for the past 5 years):

1.____

2.____

Pain diagram





Mark the location of your pain on the body

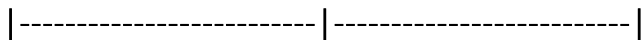
X X X where you have pain.

O O O where you have numbness.

Z Z Z where you have weakness.

Mark where your pain is TODAY.

No pain ***Worst***



0 1 2 3 4 5 6 7 8 9 10

I have noted any changes made and to the best of my knowledge, I believe all information to be true.

Signature:____ Date: ____________________________

University Spine Center

Arash Emami MD, Ki Soo Hwang MD, Kumar Sinha MD, Michelle Brenner NP

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. If you have any questions about this notice, please contact our privacy contact.

This Notice of Privacy Practices advises you about the way we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information. We are required to abide by the terms of this notice and may change the terms at any time. Upon you request we will provide you with any revision made to this notice.

Uses and disclosures of Protected Health Information
Your protected health information may be used and disclosed for your ongoing treatment, our ongoing healthcare operations or to secure payment of services.

Treatment
The provision, coordination or management of healthcare and related services among providers or with third party.

Healthcare Operations
Necessary disclosures to run our practice and monitor quality of care including staff performance, evaluation of practice enhancements, and staff education.

Payment
Necessary disclosure to secure reimbursement from you, your insurance company, or other third party payer for services rendered. In addition, PHI may be disclosed to obtain prior approval from your insurance company to assure payment for services yet to be rendered.

Appointment Confirmation
We will continue our practice of telephone confirmation of all appointments.

Individuals Involved In Your Ongoing Care
Upon you verbal authorization we will disclose your information about you to your designated care givers, other family members, or other individuals.

Case Management for Workers' Compensation/PIP/Disability
We may release PHI for your workers' compensation, auto related or other liability claim, or your claim for disability benefits or similar programs that provide benefits for injuries or illness. This may include claims adjusters, nurse case managers and may be telephonic.

As Required By Law
We will disclose medical information about you when required to do so by federal, state, or local law. This may include activities by the government to monitor the healthcare system and compliance with civil rights laws, audits, inspection and licensor. We may disclose PHI for matters involving public health risks including disease exposure, child abuse or neglect or other domestic abuse, neglect or violence. If you are involved in a lawsuit we may disclose PHI in response to a subpoena or other court order. PHI may be disclosed to other legal authority pursuant to law enforcement.

Other Uses and Disclosures of Your PHI
Other disclosures of you PHI will be made only upon written authorization and payment of allowable fee. You may obtain an authorization form from our office. You may revoke this authorization at any time in writing. You understand that we are unable to take back any disclosures that have already been made with your prior permission.

Methods of Disclosure
We will respond to your request by mailing copies of your records via US Postal Service. We will not disclose any PHI through e-mail. Under limited circumstances at our discretion your medical records may be faxed.

Your Rights Regarding Your Protected Health Information
Right to Inspect
You have the right to inspect a copy of your PHI including medical and billing information which is used to make decisions about you. You must submit you request in writing. We may charge a fee as permitted by state law for the costs of copying and mailing. We will not fax your medical information to you. We may deny your request under limited circumstances.

Right to Amend

If you feel the medical information we have is incorrect or incomplete, you may ask us to amend it. We will provide an amendment form which you must complete. You must provide a reason which must support your request. In the absence of a reason we will deny your request.

Rights to an Accounting of Disclosure

We will keep an accounting of all disclosures we made about you. You may request this list in writing and must state a time period no longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions

You have the right to request a restriction on the medical information we disclose for treatment, payment, operations or your care givers and other involved persons. *We are not required to agree with your request.* We will comply with your request unless the information is needed for emergency treatment. Your request for limitations must be made in writing and must include what information you want limited and to whom you want these limits to apply.

Changes to this Notice

We reserve the right to change this notice and apply the changes to information we already have about you or may receive in the future. We will post a copy of the current notice in the office. The effective date will appear in the upper right hand corner. We will offer you a copy of the current notice.

Complaints

If you believe that your rights have been violated, you may file a complaint with our office. Your complaint must be made in writing and addressed to Doranne Moncavage, University Spine Center, Arash Emami MD, Ki Soo Hwang MD, Kumar Sinha MD, Michelle Brenner NP 504 Valley Road, 2nd Floor, Suite 203, Wayne, NJ 07470. No complaints will be acknowledged by phone.

Assignment and Release

I, the undersigned, certify that I (or my dependent/s) have insurance coverage with ________________________ and assign directly to University Spine Center, Arash Emami MD, Ki Soo Hwang MD, Kumar Sinha MD, Michelle Brenner NP all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

× Responsible Party Signature: ____ Relationship: ______________________ Date: ____________

Acknowledgment of Receipt of Privacy Notice

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions about our privacy practices. The terms of this notice may change. Upon request a copy of our revised notice will be made available to you. By signing this for you acknowledge that you have received our Notice of Privacy Practices.

Name of Patient: ____ Date: ____________________________

× Signature of Patient/ Guardian: ____

Please release any information to the following people:

____ ____

____ ____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on behalf to University Spine Center, Arash Emami MD, Ki Soo Hwang MD, Kumar Sinha MD, Michelle Brenner NP for any services furnished to me by University Spine Center, Arash Emami MD, Ki Soo Hwang MD, Kumar Sinha MD, Michelle Brenner NP. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charger determination of the Medicare carrier.

× Beneficiary Signature: ____ Date: _______________________________

Effective October 22, 2007

Arash Emami MD   Ki Soo Hwang, MD   Kumar Sinha, MD   Michelle Brenner, NP

Phone (973)686-0700   Fax (973)686-0701

Claims Department

Date: _________________________

Re: ______________________________________

ID#______________________________________

I authorize payment of medical benefits for services performed by Dr. Arash Emami, Dr. Ki Soo Hwang, Kumar Sinha, MD, Michelle Brenner, NP to be sent directly to:

Dr. Arash Emami, Dr. Ki Soo Hwang, Kumar Sinha, MD, Michelle Brenner, NP
504 Valley Road
Suite 203
Wayne, NJ 07470

Sincerely,

____

Arash Emami,MD Ki Soo Hwang, MD Kumar Sinha,MD Michelle Brenner, NP

Phone (973)686-0700 Fax (973)686-0701

DATE: ___________________________

I, ____________________understand that I am utilizing my out of network benefits and that my insurance company may send to me, the payment(s) for services by Arash Emami, MD, Ki Soo Hwang, MD, Kumar Sinha, MD, Michelle Brenner, NP in my treatment. I also understand that by paying a partial payment at the time services are rendered, in no way means the doctors are in network. I understand that the partial payment collected will be posted to my account as a payment towards my co/insurance and or deductible. I agree to sign over the full amount to Arash Emami, MD, Ki Soo Hwang MD, Kumar Sinha, MD, Michelle Brenner, NP within thirty days of receipt of the same. If I fail to do so, I understand that in addition to being responsible for the full amount charged by Dr. Emami, Dr. Hwang, Kumar Sinha, MD, Michelle Brenner, NP for said services, I will be responsible for any charges incurred by him in pursuing and collecting from me.

Sincerely,

____

Arash Emami MD Ki Soo Hwang, MD Kumar Sinha, MD Michelle Brenner, NP

Phone (973)686-0700 Fax (973)686-0701

ASSIGNMENT OF BENEFITS

I, ______________________________ (patient name) hereby irrevocably assign all my rights to proceed directly against _________________________________ (insurance company) for payment of medical expenses incurred in connection with a motor vehicle accident on ___________________ (date of accident) **to Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P.** Copies of this assignment shall have same force and effect as the original.

This assignment applies to the medical charges for all treatment rendered to date and to be rendered in the future for injuries sustained in the above mentioned automobile accident. This assignment allows the above referenced medical service provider to immediately institute whatever action deemed necessary, including the filing of a demand for arbitration through the American Arbitration Association, without awaiting the outcome of protracted litigation. As such, this assignment supersedes and takes precedence solely as to the above referenced medical service provider over any claim for unpaid PIP benefits instituted or to be instituted directly on my behalf by the way demand for arbitration with the National Arbitration Forum or Complaint filed with the Superior Court of New Jersey.

Print Patient Name: ____ Date: __________________

Signature of Patient: ____ Date: __________________

Arash Emami MD Ki Soo Hwang, MD Kumar Sinha, MD Michelle Brenner, NP

Phone (973)686-0700 Fax (973)686-0701

LIEN FOR PROFESSIONAL SERVICES

Re: ________________________________ Date of Accident: _________________

For consideration received, I, ____________________________, assign to Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P. my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care, and diagnostic treatment given by the office of Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P. or his employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P.

1) The right to collect from the insurer of the policy with respect to the PIP benefit mentioned above.
2) The right to file a lawsuit or PIP arbitration directly against the insurance company in the name of Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P. Assignee and to designate an attorney of the choosing of them for the purpose of filing said lawsuit.
3) I agree to fully cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any Interrogatories, the appearance at any deposition and the appearance at the arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P. such sums as may be due and owing for medical services rendered to me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Arash Emami, M.D. / Ki Soo Hwang, M.D. / Kumar Sinha, MD / Michelle Brenner, N.P. for all medical bills submitted by them for the services rendered and that this agreement is made solely for Arash Emami, M.D. / Ki Soo Hwang, M.D. / Michelle Brenner, N.P. additional protection and in consideration of their awaiting payment. And I further understand that such payments is not contingent on any settlement, judgment, or verdict by which I will eventually recover said fee and that payment on the account is due and payable upon demand.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Print Patient Name: ____ Date: ________________

Signature of Patient: ____ Date: ________________

UNIVERSITY SPINE CENTER
504 Valley Road, Suite 203
Wayne, NJ 07470
Phone: 973-686-0700
Fax: 973-686-0701

University Spine Center policies and positions regarding: attendance, awareness of your personal health insurance plan, refills, position of waiver of co-payments, responsibilities for deductible and co-payment amounts.

Initial & Date Below	Please read each statement and initial to the left
________________	**Cancellations:** Keeping all scheduled appointments is in the best interest of the patient. All cancellations will be documented in you medical record and appropriately reported to your referring physician. The patient may incur a fee in the amount of $15.00 for cancellation of appointment if not done before 4:00 pm the previous day.
________________	**It is the patient's duty to know and advise this office of your insurance requirements prior to the start of your treatment.** It is your responsibility to know the specific details of your own plan and it is especially important for you to notify us if there are any restrictions regarding referrals, labs, or services to be performed by outside facilities or specialists. You may be responsible for charges if they are not contracted with your insurance company or you have not received proper pre-authorization. You will also be responsible for any "Non-Covered Services". Obtaining pre-certification for office visits/treatment is the patient's responsibility. It is the patient's right and responsibility to know the extent of their insurance coverage. Be advised that if necessary treatment is rendered which is not covered by your insurance plan, you will be responsible for payment of such service.
________________	**Co-pay amounts, co-insurance, and deductibles:** Co-pay amounts for a specialist office visit that is printed on your insurance card will be due at the time of your visit and will be collected when you check in and posted to your deductible and/or co-insurance. For your convenience, we accept payments by cash, check, Visa and MasterCard.
________________	**Please do not put us in the awkward position of being asked to waive your co-payment amount.** Your individual insurance plan is an *agreement between you and your insurance company* and is against the law to be waived. If you are unable to make your required co-payment amount at this time, your appointment will be cancelled or re-scheduled.
________________	**Medical Records:** Medical records are stored for seven years per legal requirements. Copies of records will be transferred to other physicians/lawyers upon receipts of completed Release of Information Form. There will be a charge for duplication of medical records based on the number of pages that need to be copied. Please provide at least (2) Two weeks' notice for duplication of records. Also, please allow at least (1) One week notice for request of X-Ray, MRI, CT-Scan films and/or discs.
________________	**Disability Papers:** Disability papers are filled out on Mondays and there is a $10.00 fee for completing each form that needs to be filled out. Our office will contact you once the forms are completed. It is the patient's responsibility to provide our office with disability forms in a timely manner to ensure proper completion.

________________	**<u>Pre-Certification:</u>** Any patients requiring authorizations for any imaging studies will be called with the authorization number within (7) Seven to (10) Ten business days of the last office visit. If our office has not contacted you within this time, please feel free to call us.
________________	**<u>Returned Check Fee:</u>** There will be a $25.00 fee charged, in addition to the original amount paid, for each check that is returned unpaid.
________________	**<u>Medication Refills:</u>** Medication refills must be completed during normal business hours only. Request for medication refills should be done (3) Three working days before the refill is needed. Medications will not be refilled from Friday 3:00 pm to Tuesday 9:00 am. This allows accurate records for medical usage to be maintained in the patient chart review by the State Pharmacy Board, if necessary. Please do not ask us to mail prescriptions. **Due to State Pharmacy Regulations, refills WILL NOT be authorized to any patient who has not been seen in the office during the prior (3) Three months.**

I have read and understand the above listed policies and positions for University Spine Center.

____ ______________________
Printed Name Date

____ ______________________
Signature Date

Patient Name____________________
Patient Address____________________

Date:

Attorney Name____________________
Attorney Address____________________
Attorney Phone and Fax____________________

Re: My Pending Lawsuit
Letter of Protection

Dear Attorney____________________:

I hereby authorize and direct you, my attorneys, to pay directly to Arash Emami, MD , Ki Soo Hwang, MD, Kumar Sinha, MD and Michelle Brenner, NP, such sums as may be due and owing them of medical services rendered to me both by reason of this accident and by reason of any other bills, including interest on the unpaid balance of my account, that are due said office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Arash Emami, MD , Ki Soo Hwang, MD, Kumar Sinha, MD and Michelle Brenner, NP. Further, I hereby further give a lien on my case to Arash Emami, MD, Ki Soo Hwang, MD, Kumar Sinha, MD and Michelle Brenner, NP, against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorneys 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 responsible to Arash Emami, MD , Ki Soo Hwang, MD, Kumar Sinha, MD and Michelle Brenner, NP, for all medical bills submitted by them for services rendered to me and that this agreement is made solely for said payment, additional protection and in consideration of their 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.

____
Patient Signature and Date

Date:

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 said doctor named above.

Behalf of __________________________Law Firm______________________Attorney on