DATE: _____/_____/_____

NAME: _____HOME PHONE: _____

ADDRESS: _____CELL PHONE: _____

CITY: _____STATE: _____ZIP: _____WORK PHONE: _____

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

SPOUSE NAME: _____DOB: _____/_____/_____ SS#_____

EMERGENCY CONTACT: _____ PHONE #: _____

Work History

Current Employer Name: _____ Address: _____

Phone Number: _____ Occupational Description: _____

Email: _____Height: _____Weight: _____

Race: □Asian □Black □Hispanic □White □Other □Refuse to Answer

Ethnicity: □Latino □Non-Latino □Refuse to Answer **Language:** □English □Spanish □Other: _____

Phone# at employer to obtain health plan documents for billing purposes only:_____

PHYSICIAN INFORMATION

REFFERRED BY: _____PHONE: _____

PRIMARY DOCTOR: _____PHONE: _____

CARDIOLOGIST: _____PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ID#_____

SECONDARY INSURANCE: _____ ID#_____

PHARMACY INFORMATION

NAME: _____Town & Street: _____ PHONE: _____

1. 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 and how? _____

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:

---

2. 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.**

Name and Address of Doctor: _____Phone: _____

Treatment received: _____Fax: _____

Name and Address of Doctor: _____Phone: _____

Treatment received: _____Fax: _____

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

Surgery: Date/Doctor/Hospital: _____

Surgery: Date/Doctor/Hospital: _____

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

Name of Medicine	Dose	Name of Medicine	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

5. Alcohol How often? _____ Other Substance abuse. Please describe: _____

□ Smoker □Non-Smoker □ Quit Smoking: How long ago? _____

Please circle one: Everyday / Not every day How many per day? _____

How soon after waking up do you smoke your first cigarette? _____

What do you like to do for fun? (Recreational activities) _____

6. Do you use any tobaccoless nicotine or synthetic nicotine products? (ex:zyn, velo) ☐No ☐Yes which: _____

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) _____	

Pain diagram

Mark the location of your pain on the body

XXX where you have pain.

OOO where you have numbness.

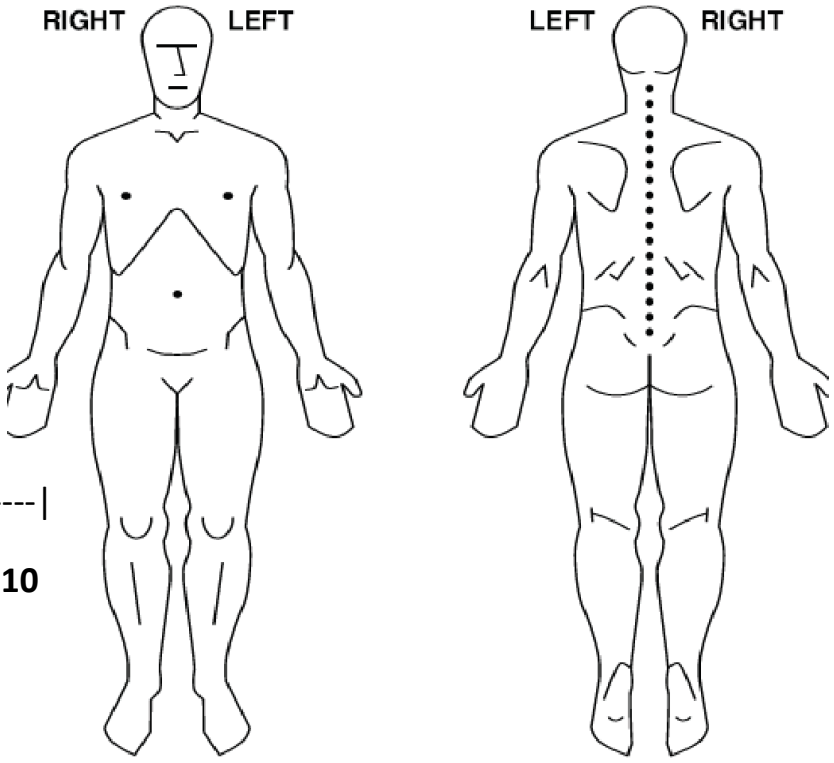
ZZZ where you have weakness**.**

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.

Patient Signature: _____

ASSIGNMENT OF BENEFITS

&

LIMITED POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/healthcare carrier/worker's compensation carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the New Jersey Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept assignment, or my assignment is challenge or deemed invalid. I execute this limited/special power of attorney and appointment and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing arbitration demand or lawsuit. I specifically authorize the attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact.

I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding las: payment made by said Insurer on my claim, including date of payment and balance of benefits remaining. I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospital, diagnostic center, etc., and I specifically authorize such healthcare provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient name: _____Date: _____

Patient Signature: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information is used to

- Conduct, plan, and direct my treatment and follow up among multiple healthcare providers that may be involved in my treatment directly and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physicians' certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses of disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy of Practices*.

If you wish to have University Spine Center discuss your condition with any family members, relatives, physicians, athletic trainers, etc. or to release any information concerning your health and/or treatment by telephone, fax, mail, email, etc. Please list them below:

Name_____ Relationship _____

Name_____ Relationship _____

Name_____ Relationship _____

I understand that I may also request, in writing, that you restrict how my private information is used and/or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions. I understand that request to forward my medical records to another treating physician other than my primary care physician must be in writing.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

NOTICE TO PATIENT

INSURANCE PARTICIPATION AND REFERRALS

Please be advised that it is the patient's responsibility to advise the practice of any insurance coverage changes or termination of coverage. It is not the responsibility of the practice to know your personal insurance coverage, participation, and/or any out-of-pocket expenses you may incur. If you have questions or concerns you are advised to notify your insurance company Member Services Department, or Human Resource Department at your place of employment.

Please note that if your plan requires a referral, it is the patient's responsibility to obtain one and it must be presented at the time of service. If you do not have one then you will have to reschedule your appointment until the time that you obtain a referral. If you choose to see a doctor without the required referral, you way become responsible for payment in full, should your insurance company deny your claim.

LITIGATION MATTERS

In order to allow our physicians to devote as much time as possible to the care and treatment of our patients, it is the policy of this office that our physicians do not testify in court as expert witnesses in connection with patient litigation or prepare narrative reports in connection with a patient's litigation. If the physician, in his or her sole discretion, agrees in any litigation, the physician will furnish the testimony by means of a videotaped deposition to be performed in our office at the physician's convenience, at the patient's sole cost and expense, and we will be entitled to compensation for the physician's time. Payment for such services will be coordinated with your attorney and must be paid in advance.

University Spine Center will not wait for payment of services rendered until the case is settled. We will not accept a lien. Payment is due at the time of service.

Please acknowledge by signing and dating below that you have received and reviewed the above policy. A copy of this document will be forwarded to your attorney if and when the need arises.

Patient name: _____Date: _____

Patient Signature: _____

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I,_____, hereby acknowledge and understand that even with the best

training, skill and 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 treatment/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 fellow-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 cam risk my current health or increase future health risks.**

- I understand that is **solely my responsibility to follow any of the medical advice given by any medical person in this office** and any bad health outcome from my failure to follow the advice of my doctors should be expected.

_____

Print Name

_____

Signature/Date

Patient Name_____

Patient Address_____

Attorney Name_____ Phone_____

Attorney Address_____Fax_____

Re: My Pending Lawsuit
Letter of Protection
Lien for Professional services

Dear Attorney_____:

I hereby authorize and direct you, my attorneys, to pay directly to University Spine Center, 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 University Spine Center. Further, I hereby further give a lien on my case to University Spine Center, 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 University Spine Center, 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.
For consideration received, I, _____, assign to University Spine Center 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 University Spine Center or his employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to University Spine Center.
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 University Spine Center. 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 University Spine Center 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 University Spine Center for all medical bills submitted by them for the services rendered and that this agreement is made solely for University Spine Center 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: _____

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_____

Does not apply to me. Initial: _____