TO ALL MOTOR VEHICLE ACCIDENT PATIENTS AND OTHER INJURIES WHERE A LAWYER/LITIGATION IS INVOLVED.

Please read carefully.

- We will work with you and your lawyer in getting your bills paid. If you have health insurance as secondary, we will bill them for your co-pays and deductibles. However, if a referral is required, this must be obtained prior to your visits. For motor vehicle cases, once the insurance has terminated your benefits, we will then bill your health insurance as primary. At that time, we will collect any co-pays or referrals for which you are responsible. However, we expect that all bill be paid, whether or not you or your lawyer has successfully pursued a lawsuit. This includes all deductibles, co-pays and any outstanding medical bills not covered or paid for by your insurance company or legal settlement.
- Medications will only be filled during business hours.
- All cellular devices must be turned off in the examining rooms.
- Eating and drinking are not allowed in the examining rooms.
- **Disability papers must be pre-paid.** $15 per form. Forms are not filled out everyday.

Motor Vehicle Cases

If our offices refers you for an MRI, bone scan and/or CT scan, it must be authorized through your motor vehicle insurance first. Once approval is received, it will be faxed to an MRI facility, and they will contact you for an appointment. Our office does not schedule patients for radiologic testing. If testing is denied, our office will contact you. X-rays do not require authorization. Out of NJ-state claims do not require authorization. The authorization process will take 7-14 business days from the date you were seen.

Motorcycle cases must use your health insurance.

GARDEN STATE ORTHOPAEDICS
Patient Registration Form

Account #: ____________ Date:______________ Referred by: Dr. ______________________________

Attorney__________________________

Patient's Name: ___________________________________

Address:____

City:_________________________State:______Zip:_______

Home phone#:____________________

Other phone#:____________________ ☐ cell ☐ work (please specify)

Referring Physician:___________________ Address:____________________________ Phone#___________
City:____________________State:______Zip:_______

Family Physician:____________________ Address:____________________________ Phone#___________
City:____________________State:______Zip:_______

Attorney:__________________________ Address:____________________________ Phone#___________
City:____________________State:______Zip:_______

Sex:_______ Date of Birth:__________________ Age:_____ SSN:______-_____-__________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Unemployed

Employer Name: __________________________ Phone: ___________________

Address: ____ Occupation: __________________________

City:_________________________State:__________Zip:_____________

Type of accident

Date of accident:_______________________

☐ Motor Vehicle Accident - If MVA, is your health insurance primary? ☐ YES ☐ NO

☐ Work related

☐ Medical

☐ Other: please specify place of accident:________________________________

Primary Insurance Carrier:_____________________ Claim/policy number:________________________

Address:___________________________________ Policy Holder:_____________________________

City:_________________________State:__________Zip:_____________

Did you file an accident report? ☐ YES ☐ NO

Adjuster:_________________Phone#_______________ Fax#_________________________

Secondary Insurance Carrier:___________________Subscriber:______________________________

Address:____

City:_________________________State:__________Zip:_____________

ID Number:________________ Group Number:______________Relationship to subscriber:__________

REASON FOR VISIT: ☐ Medical ☐ Accident related

If accident, state cause: ☐ Auto accident ☐ Auto accident work related ☐ At work ☐ At home

☐ Fall on another's property ☐ At school ☐ Other________________________________

Date of accident:_________________________Did you go to a hospital/ER? ☐ YES ☐ NO

If yes, where?___________________________Were you taken by ambulance? ☐ YES ☐ NO

Were x-ray-rays taken? ☐ YES ☐ NO If yes, of what body part(s)?____

ACCIDENT INFORMATION

Where did this accident/injury take place?____

How did it happen?____

What body parts were injured during the accident? ____

What was your position sitting in the vehicle?

☐ Driver ☐ Front passenger ☐ Rear right ☐ Rear left ☐ Other________________________________

Were you wearing a seat belt? ☐ YES ☐ NO (☐ harness ☐ lap belt ☐ both)

Was your car ☐ Moving or ☐ Stopped in traffic OR ☐ Stopped?

If moving, what was your approximately speed at the time of impact? _______mph

Were you ☐ hit or did you ☐ hit another vehicle?

If you were hit, where?: ☐ rear ended ☐ back driver's side ☐ back passenger's side ☐ head on

☐ front driver's side ☐ front passenger's side ☐ other___________________________

If you were the driver, did you have both hands on the steering wheel? ☐ YES ☐ NO ☐ Other_________________

If you were the passenger, did you brace with your hands on impact? ☐ YES ☐ NO

Did air bags deploy? ☐ YES ☐ NO

Did any part of your body come in contact with any part of the vehicle? ☐ YES ☐ NO

If yes, describe:____

____

Describe your body movement at the time of impact:____

____

How many vehicles were involved in the accident? _________

Did you lose consciousness? ☐ YES ☐ NO If yes, for how long?__________________________

Since the accident/injury, do you have trouble with the following? (please check all that are appropriate)

☐ physical exercise ☐ bending ☐ crawling ☐ sitting ☐ stiffness ☐ driving ☐ walking ☐ standing

☐ lifting ☐ kneeling ☐ climbing stairs ☐ sleeping ☐ overhead work ☐ getting up in the morning

Since the accident/injury, what are you having trouble doing (include sports, problems at work, household chores, etc.)?

____

____

Due to your injuries, what are your current symptoms?

☐ Nausea ☐ Vomiting ☐ Dizziness ☐ Fainting ☐ Nervousness

Do you have pain in your: ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Mid back ☐ Low back

☐ R shoulder ☐ L shoulder ☐ R arm ☐ L arm ☐ R hand ☐ L hand ☐ R wrist ☐ L wrist

☐ R leg ☐ L leg ☐ R knee ☐ L knee ☐ R foot ☐ L foot ☐ R ankle ☐ L ankle

Are there any complaints of numbness or tingling?____________________

How frequent is your pain? ☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

What makes the pain worse? ____

What makes the pain better? ____

Did you seek treatment with a doctor after the hospital? ☐ YES ☐ NO

Name of Doctor	Specialty	Date of 1st Visit	Still treating with doctor?

What tests did you have done?	Where were they done?	On what body part(s)?
X-rays		
MRI		
CT scan		
EMG		

Did you have any physical therapy treatment? ☐ YES ☐ NO If yes, where?_________________________________

Did you have any chiropractic treatment? ☐ YES ☐ NO If yes, where?_____________________________________

When did you start treatment?_______________________ Are you currently going? ☐ YES ☐ NO

What type(s) of treatment have you received? ☐ Hot packs ☐ Electric stimulation ☐ Exercise

☐ Ultrasound ☐ Traction ☐ Ice ☐ Manipulation

☐ Other____

How often do you or did you go?______________________How long did you go?______________________

Has it been helpful? ☐ YES ☐ NO

Have you missed any work due to the accident? ☐ YES ☐ NO If yes, how long?__________________

MEDICAL HISTORY

Height____________Weight____________ ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Have you had any prior motor vehicle accidents or significant injuries? ☐ YES ☐ NO If yes, when?______________

What areas of the body were involved in any PRIOR accident?______________________________

Were these injuries resolved prior to your current injuries? ☐ YES ☐ NO

If no, what complaints remained?______________________________

Are you still treating for these injuries? ☐ YES ☐ NO

List any fractures/sprains:______________________________

List any surgeries:______________________________

Current medical problems: ☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Epilepsy/seizure disorder

☐ Heart attack ☐ Migraines ☐ Stroke ☐ Cardiac disease ☐ Ulcers ☐ Cancer

☐ Anemia ☐ Thyroid disease ☐ Other______________________________

List current medications:______________________________

Are you allergic to any medications? ☐ YES ☐ NO

If yes, please list medications:______________________________

EMPLOYMENT HISTORY (if work-related)

When the accident/injury occurred, did you have a job? ☐ YES ☐ NO

Job title:______________________________

Job description:______________________________ ☐ Full time ☐ Part time____________hrs/wk

Job duties: Lifting/carrying__________________lbs. Sitting__________________hrs/wk

Standing__________________hrs/wk Walking__________________ hrs/wk

Did you miss time from work due to accident/injury? ☐ YES ☐ NO Date first missed work:__________________

If yes, how much time?__________________days/months Date returned to work:__________________

Employer for work comp claim at time of injury:______________________________

Hours worked weekly:______________________________ Years at job:______________

Are you actively working now? ☐ YES ☐ NO

If yes: ☐ same job (same duties) ☐ same job (different duties) ☐ new job ☐ side jobs

☐ Any work restrictions?______________________________

☐ List duties______________________________

Employment history (last five years):

Employer's Name	Job Description	Years Worked

SOCIAL HISTORY:

Do you use tobacco? ☐ YES ☐ NO

How many packs of cigarettes per day?_______

How many years have you smoked?__________

Do you drink alcohol? ☐ YES ☐ NO

How many drinks per day?________

If you quit, when?_______________

FAMILY HISTORY:

Have any family members had the following:

☐ diabetes, who?________________________ ☐ cancer, who?______________________

☐ heart disease, who?____________________ ☐ arthritis, who?_____________________

☐ other disease(s), who?____

FAMILY PHYSICIAN: Name: ____

Address: ____

____

Phone: ___________________________

PATIENT'S SIGNATURE: ________________________________

TODAY'S DATE:____________________

PATIENT NAME: ______________________________ DATE: ______________

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS

Good general health lately	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses or contacts	YES	NO
Blurred or double vision	YES	NO
Glaucoma	YES	NO

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	YES	NO
Earaches or drainage	YES	NO
Chronic sinus problem or rhinitis	YES	NO
Nose bleeds	YES	NO
Mouth sores	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pain or angina pectoris	YES	NO
Palpitation	YES	NO
Shortness of breath with walking or lying flat	YES	NO
Swelling of feet, ankles or hands	YES	NO

RESPIRATORY

Chronic or frequent coughs	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change in bowel movements	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movement or constipation	YES	NO
Rectal bleeding or blood in stool	YES	NO
Abdominal pain or heartburn	YES	NO
Peptic ulcer (stomach or duodenal)	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Insomnia	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty walking	YES	NO

INTEGUMENTARY (Skin, Breast)

Rash or itching	YES	NO
Changes in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Breast pain	YES	NO
Breast lump	YES	NO
Breast discharge	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Diabetes	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Skin becoming dryer	YES	NO
Change in hat or glove size	YES	NO

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts	YES	NO
Bleeding or bruising tendency	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusions	YES	NO
Enlarged glands	YES	NO

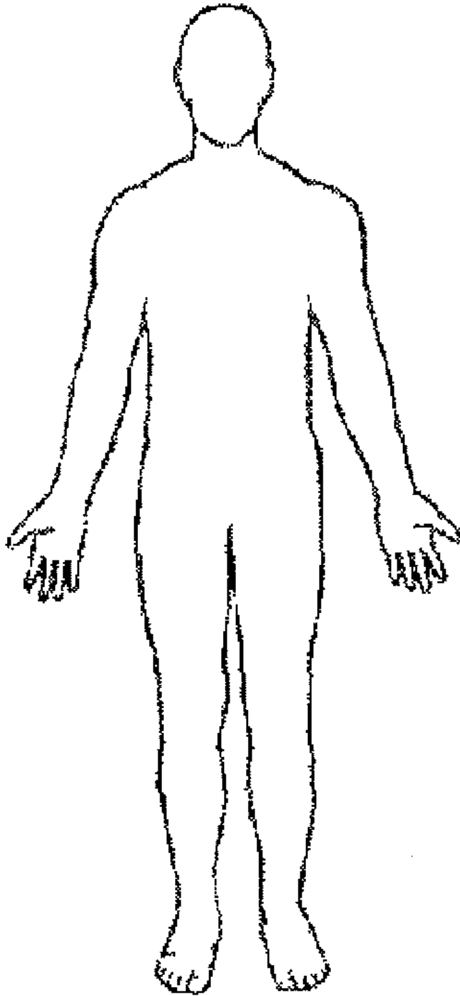
GENITOURINARY

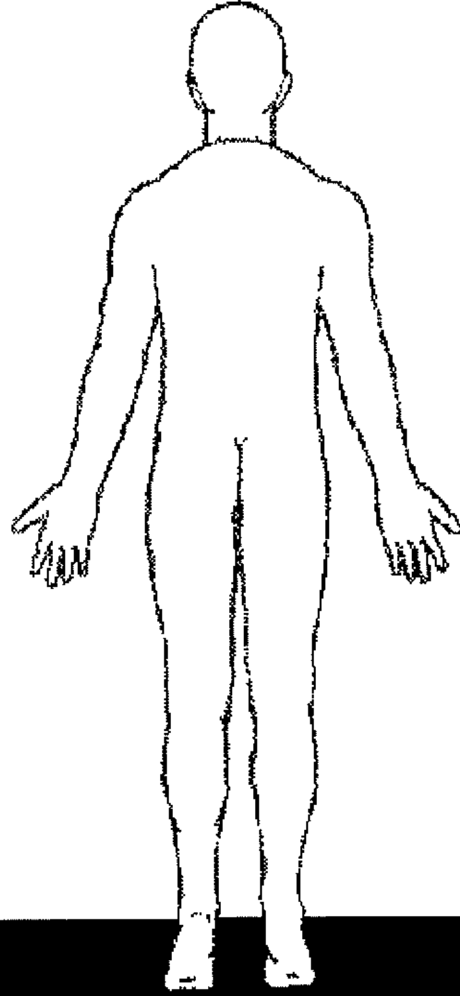
Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force/strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male - testicular pain	YES	NO
Female - pain with periods	YES	NO
Female - irregular periods	YES	NO
Female - vaginal discharge	YES	NO
Female - number of pregnancies	#________	
Female - number of miscarriages	#________	
Female - date of last pap smear	__________	

PAIN DRAWING

Using the symbols giving below, mark the area(s) on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	. . .





Front **Back**

Pain in the arm(s) compared to the neck: ☐ worse ☐ same ☐ less

Pain in the leg(s) compared to the back: ☐ worse ☐ same ☐ less

LAWRENCE I. BARR, D.O., F.A.O.A.O.
BOARD-CERTIFIED ORTHOPEDIC SURGEON
FELLOWSHIP-TRAINED ORTHOPEDIC SPINE SURGEON

SPORTS INJURIES • SPINE SURGERY • ARTHROSCOPY • INDUSTRIAL INJURIES
HAND SURGERY • GENERAL ORTHOPAEDICS • JOINT REPLACEMENTS • FRACTURE TREATMENT

Robert G. Ranelle, D.O., F.A.O.A.O.
Barbara Sayers, Administrator

PLEASE SEND ALL CORRESPONDENCE TO THE CHERRY HILL OFFICE

Consent for Treatment

The undersigned hereby consents to any medical services rendered to the patient by the physicians, employees and contracted healthcare providers of Garden State Orthopaedics.

Authorization to Release Information

The undersigned authorizes Garden State Orthopaedics (GSO) to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to GSO that may be required to assist GSO in patient's diagnosis and/or treatment.

Assignment of Insurance Benefits

As a convenience to our patients, Garden State Orthopaedics will bill your insurance carrier directly. I hereby assign, transfer and set over to GSO all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining precertification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA Privacy Policy

The undersigned acknowledges that he/she received a copy of GSO's notice of privacy policy as required by HIPAA.

Financial Responsibility

The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all and any unpaid portion of the bill incurred. The bill may include this office's administrative fees, such as no-show fees and fees for filling out disability forms. I further understand the unpaid section of the bill may be insurance deductibles, coinsurance, co-payments or the entire bill if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duty authorized representative of the patient and accepts and consents to the above terms.

____________________________________ ______________
Signature of patient/authorized representative Date

HIPPA 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.

The Health Insurance Portability and Accountability act of 1996 and its implementing regulations (HIPAA), as amended, is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse Protected Health Information (PHI).

This notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your Protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and conducting or arranging for other business activities. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may call your home and leave a message (either on an answering machine or with the person answering the phone) to remind you of your upcoming appointment, the need to schedule a new appointment or to call our office. We may also mail a postcard reminder to your home address. If you would prefer that we call or contact you at another telephone number or location, please let us know.

We may use or disclose your protected heath information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Heath and Human Services to investigate or determine our compliance with the requirements of HIPAA

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorizations, or Opportunity to Object unless required by law. Use and disclosures of PHI for marketing purposes, as well as disclosures that constitute and sale of PHI, require an authorization from you.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

<u>Your Rights</u>

The Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. If such information is maintained in an Electronic Health Record (EHR), your access rights include the right to a copy in electronic format. We have the right to charge you a fee for the copying of paper records, and in the case of a request for and electronic copy of your PHI maintained in and EHR (or a summary or explanation of such information) we have the right to charge you the amount of labor costs in responding to your request. Your right to inspect and obtain a copy of your PHI extends only to your PHI contained in our Designated Record Set for you. A "Designated Record Set" is the HIPAA term for medical and billing records and any other records that we use for making health care decisions about you.

You have the right to request a restriction of your health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved with you care or for notification purposes described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply. Any such request for restrictions must be in writing, be addressed to the Privacy Officer, and state the specific restriction requested and to whom you want the restriction to apply. However, we are not required to comply with your request, unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or heath care operation purposes and such information you wish to restrict pertains solely to a heath care item or service for which you have paid us "out-of-pocket" in full.

Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. However, we may condition this accommodation by asking you for information as to how payment will be handled or a specification of an alternate address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must be in writing, be addressed to the Privacy Officer, and state the specific alternate means or location.

You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information contained in your Designated Record Set if you believe it is incorrect or incomplete. However, we are not required to make any such amendments. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. All of these documents will be placed in the appropriate part of your Designated Record Set. If you are requesting that we amend your records because you believe that you are a victim of medical identity theft, we will use reasonable efforts to assist you in making corrections to your record which are determined to be appropriate under the circumstances.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Affected individuals have the right to be notified in the event of a breach of unsecured PHI.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this Notice.

To exercise any of your rights above, please contact our privacy officer in writing.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint at our office and main telephone number. **We will not retaliate against you for filing a complaint.**

This notice was originally published and became effective on April 14, 2003, as amended from time to time.

Garden State Orthopaedics & Sports Medicine, P.A.

HIPAA Notice of Privacy Practices
Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: ______________________________

Signature: ______________________________

Date: ______________________________

Assignment, Lien and Authorization Insurance
Benefits and Attorney

I hereby authorize and direct you, my insurance company, and or my attorney to pay directly to **Garden State Orthopaedics** such sums as may be due and owing this office for services rendered me both by reason of accident, or illness and by reason of any other bills that are due the office, and to withhold such sums from any disability benefits, medical payment benefits. No fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of benefits form to the extent of the offices services provided.

In the event my insurance company refuses to make such payments upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this office to compromise, settle or otherwise resolve said claim or cause of action they see fit.

I understand that I am financially responsible **Garden State Orthopaedics** for the total amount due and/or for any amount not covered by my insurance for their services. I further understand and agree that this assignment, lien and authorization does not constitute any consideration of the office to await payment and they may demand payments from me upon rendering services at their option.

In the event your account with **Garden State Orthopaedics** is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fee's, and/or court costs will be added to your total amount.

I authorize **Garden State Orthopaedics** to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this assignment, lien and authorization and I understand that **Garden State Orthopaedics** will be using my social security number as identification. I agree that the above mentioned office be given the power of attorney and to endorse/sign my name on any and all checks for payment of services rendered.

I certify that the information provided to **Garden State Orthopaedics** regarding the injuries I sustained in my accident is honest and truthful.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE LISTED ITEMS IN THESE PARAGRAPHS.

Signed:________________________________ Date:________________
(Patient or Guardian)

Assignment, Lien and Authorization Insurance Benefits and Attorney

I hereby authorize and direct you, my insurance company, and or my attorney to pay directly to **Garden State Orthopaedics** such sums as may be due and owing this office for services rendered me both by reason of accident, or illness and by reason of any other bills that are due the office, and to withhold such sums from any disability benefits, medical payment benefits. No fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of benefits form to the extent of the offices services provided.

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Signed:______________________________ Date:_______________

(Patient or Guardian)

PLEASE COMPLETE THIS FORM

Policy Number: ______________________ Claim Number: ______________________
Patient's Name: ______________________ Medical Provider: Garden State Orthopaedics

Authorize and request my insurance company with PIP (hereinafter referred to as the "Company) to pay directly to the above-named provider, the amount due me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associates with the provider's office.

Date: ____________ ____
Patient's Signature or Parent/Legal Guardian

I have read the information sent by the Company concerning the Decision Point Review plan, including any pre-certification requirements (collectively referred to hereafter as the "Plan") and, as a condition precedent to the Company's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1. I (we) have complied and will comply with all the procedures identified within the Plan;

2. I (we) will comply with all requests for additional information from the Company concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, casual relationship to the accident and care plan and if necessary submit to Examinations Under Oath;

3. I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the Plan;

4. I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the Plan until there has been a final determination of the Internal Appeal Procedure of the dispute; and

5. In the event that I (we) fail to comply with the requirements of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the Plan.

The Company does not provide coverage for any insured or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident or loss for which coverage or benefits are sought.

I (we) understand that the Company has the right to reject this assignment of benefits.

____
Provider's Signature

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: ____________________

<Name>
<Address 1>
<Address 2>
<Address 3>

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)	Gender: Male ☐ / Female ☐		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code	Date of Birth	Social Security No. (if none, enter "non	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)	Email:		

Date of Accident	Time of Accident AM ☐ PM ☐	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company ____________________
Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company ____________________
Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company ____________________

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: ____________________ Date: ____________

Describe your injury: ____________________

Were you treated by a doctor? Yes ☐ No ☐	Doctor's Name and Address
If you were treated in a hospital, were you an In-patient? ☐ Out-patient? ☐	Hospital's Name and Address

Amount of Medical Bills to Date: $________	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $ ______.____	What is your average weekly wage or salary? $________

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $__________ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) ____________________

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: ____________________ Date: ____________

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Signature: ____________________ Date: ____________

Do Not Detach - Authorization for Wage Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: ____________________ Date: ____________