Pain X Ortho Specialists

Date: ___________________

PATIENT INTAKE FORM

Patient Info					
Name		**DOB (mm/dd/yyyy)**		**How did you hear about us?**	
Address				City:	Postal Code:
Contact #'s	Home:	Mobile:		Email:	
Occupation		**Status**	❏ Single ❏ Divorced	❏ Married ❏ Separated	❏ Common Law ❏ Widowed
Emergency Contact		Relationship:		Phone:	

Auto Insurance Info	*Medical Insurance Info*
Name of Insurance Co ____________________________	**Name of Insurance Co** __________________________
Policy No ____	**Policy No** ____
Phone No ____	**Phone No** ____
Adjuster's Name ___________________________________	**Policy Holder Name** ____________________________
Claim No ____	**Date of Birth:**_____/_____/____ **Sex** □ **M** □**F**
Precertification Phone No _________________________	**Relationship to Patient:**
Address for Claims _________________________________	□ **Self** □ **Parent** □ **Guardian** □ **Spouse**
City:__________________**State:**_____ **Zip Code**_______	

Legal Information			
Do you have a lawyer for your accident?			❏ Yes ❏ No
Law Firm:		Telephone:	Fax:

Medical History: Please Complete as thoroughly as possible			
Significant Surgeries	❏ None	❏ Yes	List:
Fractures / Injuries	❏ None	❏ Yes	List:
Significant Accidents / Falls	❏ None	❏ Yes	List:
Medications / Vitamins	❏ None	❏ Yes	List:

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Patient Consent

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFROMATION: By signing this form, you are granting consent to the office to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND CONSENT TO RELEASE INFORMATION: I certify that the information given by me in applying for payment under Title XVIll and /or Title of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim. VERIFICATION OF NON-PREGNANCY (Female Patients only): By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period ____________________________

PRINT PATIENTS' NAME: ____

PATIENT'S SIGNATURE: ____

OTHER THAN PATIENT, PRINT NAME AND RELATIONSHIP (WITNESS): ____

SIGNATURE ON FILE:

PATIENT NAME: ____

ADDRESS: ____

SSN#: ____

I authorize use of this form on all Medicare/private and secondary insurance submissions.

I authorize releases of any information to Medicare/private and secondary insurance companies to determine the benefits payable for this service.

I understand that I am responsible for my bill if I am not covered by insurance.

I understand that I am responsible for my co-pay and deductible not covered by Medicare/primary and secondary Insurance.

I authorize payment direct to service provider.

I permit a copy of this authorization to be used in place of original.

PATIENT SIGNATURE: ____

PATIENT GAUDRIAN(WITNESS): _______________________________________

DATE: ____________________________

By signing below, I acknowledge that I have been provided a copy of Notice of Privacy Practices.

Signature of Patient or Representative: ____

Print name of Patient or Representative: ____

Date: ____________________

Description of Personal Representative's Authority: ____

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OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefit directly to us. This policy reduces you're out of pocket expense and allows you to place your family under care.

1. If You Don't Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Speak to our representatives to set up a payment plan.
2. If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule or fees beating no relationship to the current standard and in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance an authorize u to use your credit card to collect full payment.

The undersigned agrees, whether signing as agent or patient, that she/he individually obligates himself/herself to pay for services rendered in accordance with the regular rates and terms of Pain X Ortho Specialists. The practice will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/ patient is responsible for any co-payment, deductible, co-insurance and amounts identified by the insurer as the patient's responsibility. A fee of 33% will be added to the outstanding balance if the outstanding balance will be referred to collection. This information will be used for the purpose of evaluating and administering claims of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name: _______________________________________

Signature: ____ Date: ____________________________

Witness: ____ Date: ____________________________

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PATIENT HEALTH HISTORY			
Do you have any of the following symptoms?	☐ Headaches/Migraines ☐ Chills ☐ Night Sweats ☐ Fainting/ Dizziness ☐ Numbness/Pain in Arms/Hands ☐ Numbness/Pain in Legs/Feet ☐ Fatigue ☐ Nervousness ☐ Loss Weight ☐ Chest Pain ☐ Coffee _____ cups/day	☐ Lower Back Pain ☐ Pain Between Shoulders ☐ Painful tailbone ☐ Foot Troubles ☐ Weakness ☐ Swollen Joints ☐ Neck Pain ☐ Backache ☐ Nausea/Fever ☐ Difficulty Breathing ☐ Smoking _____ pks/day	☐ Urination Problems ☐ Digestive Problems ☐ Bowel Problems ☐ Anxiety/Panic Attacks ☐ Depression ☐ Insomnia ☐ Acid Reflux/Ulcers ☐ Blood urine ☐ Allergies ☐ Chronic Cough ☐ Alcohol _____ drks/week
Do you, or have you ever had?	☐ Osteoporosis ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Ankylosing Spondylitis ☐ Spinal Infection ☐ Diabetes ☐ Cancer ☐ Epilepsy	☐ Heart Attack ☐ Heart Disease/Pacemaker ☐ High Cholesterol ☐ High Blood Pressure ☐ Stroke/TIA/Aneurysm ☐ Blood Clots ☐ Abdominal Aortic Aneurysm ☐ Angina	☐ Respiratory Disease ☐ Asthma/Chronic Bronchitis ☐ Thyroid disease/problems ☐ Kidney disease/problems ☐ Liver disease/problems ☐ Skin problems ☐ Psychological disorder ☐ Fibromyalgia/Chronic Fatigue

Do you have a family history of any of the following?	☐ Cancer ☐ Obesity ☐ Diabetes ☐ Osteoporosis ☐ Arthritis	☐ Heart disease ☐ High blood pressure ☐ High cholesterol ☐ Stroke ☐ Blood disorders	☐ Depression ☐ Anxiety disorders ☐ Alzheimer’s ☐ Parkinson’s ☐ Huntington’s	☐ Kidney disease ☐ Liver disease ☐ Digestive disorder ☐ Thyroid disorder ☐ Mental illness

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ACCIDENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Name: ____ DOB: _________________ Date: ___________________

Address: ____________________________ City: ____________________ State: ______________ Zip Code: _____________

SS# ________________ Sex: ☐ Male ☐ Female Marital Status: ________________ How did you hear about us? ___________

Home Phone: ______________________ Cell Phone: __________________________ Email: ________________________

Employer: ____ Occupation: ______________________________________

Have you missed and days of work? ☐ Yes ☐ No Dates Missed: ____

Date of the accident: ______________________________ Time of accident: ______________________________________

Please describe the accident in your own words: ____

____

____

Where you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian ☐ Cyclist

ACCIDENT SITE

Road/Street Name: ________________________

City/State: _______________________________

Driving Conditions: ☐ Dry ☐ We t ☐ Icy ☐ Other

Visibility: ☐ Poor ☐ Fair ☐ Good ☐ Other

Was your vehicle moving: ☐ Yes ☐ No

Speed of your vehicle: _____________ mph

YOUR VEHICLE

Make/Model of your car: ___________________

Were you wearing a seatbelt: ☐ Yes ☐ No

Were shoulder harnesses worn: ☐ Yes ☐ No

Did the airbag inflate: ☐ Yes ☐ No

Did your seat have a headrest: ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Top of headrest even with the bottom of head

☐ Top of headrest even with top of head

☐ Top of headrest even with middle of head

OTHER VEHICHLE

Make/Model other vehicle: _________________

Speed of other vehicle: _________________ mph

IMPACT

Did your car impact another vehicle: ☐ Yes ☐ No

Did your body strike anything inside the vehicle? ☐ No ☐ Yes

If yes, explain: ____________________________________

Type of impact: ☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other

How were you sitting before the impact?

☐ Head straight forward ☐ Body straight

☐ Head up/down ☐ Body rotatd right/left

☐ Head turned right/left ☐ Other ____________________

Did you see the accident coming: ☐ No ☐ Yes

Did you brace for impact: ☐ No ☐ Yes

Was your car braking: ☐ No ☐ Yes

ILLUSTARATION OF THE ACCIDENT

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PATIENT CONDITION

Were you unconscious after the accident? ☐ Yes ☐ No If yes, for how long? ______________________________

Could you move all parts of your body ☐ Yes ☐ No If no, which parts couldn't you move and why? _____________

____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No If no, why not? ________________________

Did you get any bleeding cuts? ☐ Yes ☐ No If yes, where? ____

Did you get any bruise? ☐ Yes ☐ No If yes, where? ____

Please describe how you felt 1. Immediately after the accident? _______________________________________

2. Later that day? ____

3. The next day? ____

TREATMENT

Did you go the hospital immediately after the accident? ☐ Yes ☐ No

How did you get there? ☐ Ambulance ☐ Police ☐ Someone else drove me ☐ Drove my own car

When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 Days or more after the accident

Hospital Name: _______________________________________ Name of Doctor: ___________________________

Treatment received: ____

Medications given: ____

X-rays/MRI taken: ____

Did you seek any additional treatment? ☐ Yes ☐ No If yes, who did you see? ______________________________

Date of visit? ____________________ Treatment received: ____

SYMPTOMS

If you have had an of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

- ☐ Arm/Shoulder Pain ____
- ☐ Low back pain ____
- ☐ Neck pain ____
- ☐ Upper back pain ____
- ☐ Chest pain ____
- ☐ Leg pain ____
- ☐ Hand/Finger numbness ____
- ☐ Foot/Toe numbness ____
- ☐ Neck stiffness ____
- ☐ Headaches ____
- ☐ Irritability ____
- ☐ Nausea ____
- ☐ Stomach upset ____
- ☐ Painful tailbone ____
- ☐ Dizziness ____
- ☐ Ear ringing ____
- ☐ Memory loss ____
- ☐ Jaw problems ____
- ☐ Sleep difficulty ____
- ☐ Blurred vision ____
- ☐ Shortness of breath ____

Past health history: ☐ None related to current complains ☐ Hospitalized ☐ Surgery
☐ Other auto accident(s) ☐ Work accident ☐ Illness

Describe condition and treatment: ____

____

____

____

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ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

Patient's Name: ___________________________

Accident Date: ____________________________

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment of services rendered to me. I authorized you to file insurance claims on my behalf for services rendered to me and his specifically includes filing arbitration/litigation in your name on my behalf against PIP carrier/health 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 payment goes directly to you, my medical provider. I authorize you to act on my behalf. I 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" set forth in NJ Administration Code.

In the event the insurance carrier responsible for making medical payments in the matter does not accept my assignment is deemed invalid. I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical service directly against the carrier in this case including filing an arbitration demand or my name or in your name as a medical provider rendering services to me and designate your collection attorney in fact. I further grant limited power of attorney 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 obtain medical information regarding my physical condition for any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about m, including medical reports, x-ray reports, narrative reports, and any other report or information regarding any physical condition.

Patient Signature: ____ Date: _________________________

Pain X Ortho Specialists

TO: *ATTORNEY:* ____

RE: *PATIENT* ____

DATE OF ACCIDENT: ____

MEDICAL REPORTS AND DOCTOR'S LIEN

I do hereby authorize the above clinic to furnish to you my attorney a full report of examination, diagnosis, prognosis, etc. pertaining to myself in regards to my personal injury cause of action.

I hereby authorize and direct you, my attorney, to pay direct to said doctor/clinic such sums as may be due to said doctor/clinic for medical services rendered to me for reason of this personal injury cause of action and for any other bills to said doctor/clinic and withhold such sums from my settlement, judgment, or verdict be necessary to adequately protect said doctor/clinic. I hereby further irrevocably create a lien on my judgment or verdict which may be paid to you, my attorney, o r myself as a result of the injuries for which treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor/clinic for all medical bills submit clinic for ser vices rendered to me and that this agreement is made solely for said doctor/clinic's additional protect consideration of said docto r/clinic awaiting payment and in the event this case is assigned by me to another not a signatory hereto. I understand that all money s due said doctor/ clinic will be due and payable to me.

I UNDERSTAND THIS IS AN IRREVOCABLE LIEN AND ASSIGNMENT

DATE: ____

PATIENT'S SIGNATURE: ____

PATIENT'S NAME AND ADDRESS: ____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms and agrees to withhold any pay over such sums from any settlement, judgment or verdict as may be adequately protect said doctor/ clinic abo ve named.

In addition, I agree to notify said clinic within ten (10) days in the event the patient (my client) assigned to other counci l.

DATE: ____________________ ATTORNEY SIGNATURE: ____________________

ATTORNEY'S NAME AND ADDRESS: ____

____

TO THE ATTORNEY: Please date and return one copy to the above stated doctor/clinic at once, treatment can continue on the herein contain lien basis.

Pain X Ortho Specialists

Notice of Commencement of Medical Treatment
(21 "Day Notice Letter")
Assignment Consent Request

Please accept this document as our formal request for your consent to our attached assignment of benefits/rights executed by our patient in this matter. If we do not hear from you to the contrary within 3 business days, we will assume that we have your consent. We agree to comply with your insurance policy terms, including the requirements of your pre-certification plan, and we will not balance bill the patient where coverage is appropriately denied or charges appropriately reduced in accordance with NJ law and any valid provision of your pre-certification plan.

Name and address of patient:
____
____
____
____

Name and address of insured (If Different):
____
____
____
____

Insurance Carrier Name and Address: ____
____
____
____

Date of first treatment: ___________________

Date of accident/injury: __________________

Policy Number: _________________________

Claim Number: _________________________

TAX ID# ________________________________

New Jersey Application for Benefits
Personal Injury Protection

Date:	Type of Claim:	Date of Accident:	Claim Number:

Your Name:	Gender:	Phone Nos.: Home: Mobile:
Your Address:	Date of Birth:	Social Security No.:

Your Previous Address:

Date of Accident:	Time of Accident:	Place of Accident:

Brief Description of Accident:

Do you or any member of your household own a vehicle? Yes ☐ No☐
Name of Insurance Company: **«F19»**
Do you have health insurance? Yes ☐ No☐
Name of Insurance Company: **«F20»**

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

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 Inpatient? ☐ Outpatient? ☐	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?

Date Disability from work began:	Date you returned to work:

Have you received or are you eligible for benefits under:

	Yes	No
(1) Any Worker's 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 Address 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," please explain:

Signature: ______________________________ Date: ______________________________

Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or Treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the Personal Injury Protection Benefit Law.

Signature: ______________________________ Date: ______________________________

Authorization for Medical Information

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 prove this information in accordance with the Personal Injury Protection Benefits Law.

Signature: ______________________________ Date: ______________________________
Social Security Number: **«F13»**

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."