Premier Brain & Spine

a division of **PREMIER BRAIN AND SPINE**

□Health Insurance □Workers' Comp □MVA

PATIENT INFORMATION -- PLEASE PRINT

Last Name: _____
First Name: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Patient email: _____
Home Phone: _____
Mobile Phone: _____
Sex: □Female □Male
Social Security No.: _____
(Required by government mandate [although you may refuse].)
Language: _____
Race: _____
Ethnicity: _____
Marital Status: _____

Guarantor Information (to whom statements are sent):

Name: _____
Address: _____
Relationship to patient: _____
Date of Birth: _____
Phone: _____

Emergency Contact Information

Name: _____
Relationship: _____
Phone: _____

Employer information

Employer: _____
Address: _____
Phone: _____

Other

Patient Referred by: _____

Primary Care Provider: _____

Pharmacy Information:

Name: _____
Address: _____

Primary Insurance Information

Insurance Plan Name: _____
Policy Holder Last Name: _____
Policy Holder First Name: _____
Policy ID Number: _____
Insurance Address / PO Box: _____
Insurance City: _____ State: _____ Zip: _____

Sex: □ Female □ Male

Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name: _____
Policy Holder Last Name:
Policy Holder First Name:
Policy ID Number: _____
Insurance Address / PO Box: _____
Insurance City: _____ State: _____ Zip: _____

Sex: □ Female □ Male

Patient's relationship to policy holder:

Designated Person to/with Whom My Medical Information May be Disclosed/Discussed:

I designate the following persons as being involved with my healthcare and/or payment thereof as persons to/with whom the practice may disclose/discuss my otherwise protected healthcare information. I understand that I am not required to list anyone and that I may change this list at any time in writing.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

RECLAIMABILITY
PAIN SERVICES

a division of **PREMIER BRAIN AND SPINE**

****Please read each statement and initial for understanding.****

ACKNOWLEDGEMENT AND AUTHORIZATION:

_____ To the best of my knowledge, my insurance and demographic information is complete and accurate.

_____ I have read and understand the HIPAA/Privacy Policy and am aware that I can access at the HIPAA online at our website, on the patient portal, or directly in the office.

_____ I acknowledge the notification of Provider Interest in other facilities.

_____ I authorize my provider's office to contact me by mobile phone.

_____ I acknowledge that I may receive text messages to the mobile phone number I provide.

Signed_____ **Date:** _____

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NEW PATIENT CLINICAL INTAKE INFORMATION

Name:_____ **Age:** _____ **Date of Birth:** _____

Gender: ☐ Male ☐ Female **Dominance:** ☐ Right-Handed ☐ Left Handed **Height:** _____ **Weight:** _____

☐ **Motor Vehicle Accident** ☐**Workers' Compensation** ☐ **Other:** _____

Chief Complaint

Reason for Today's Visit:_____

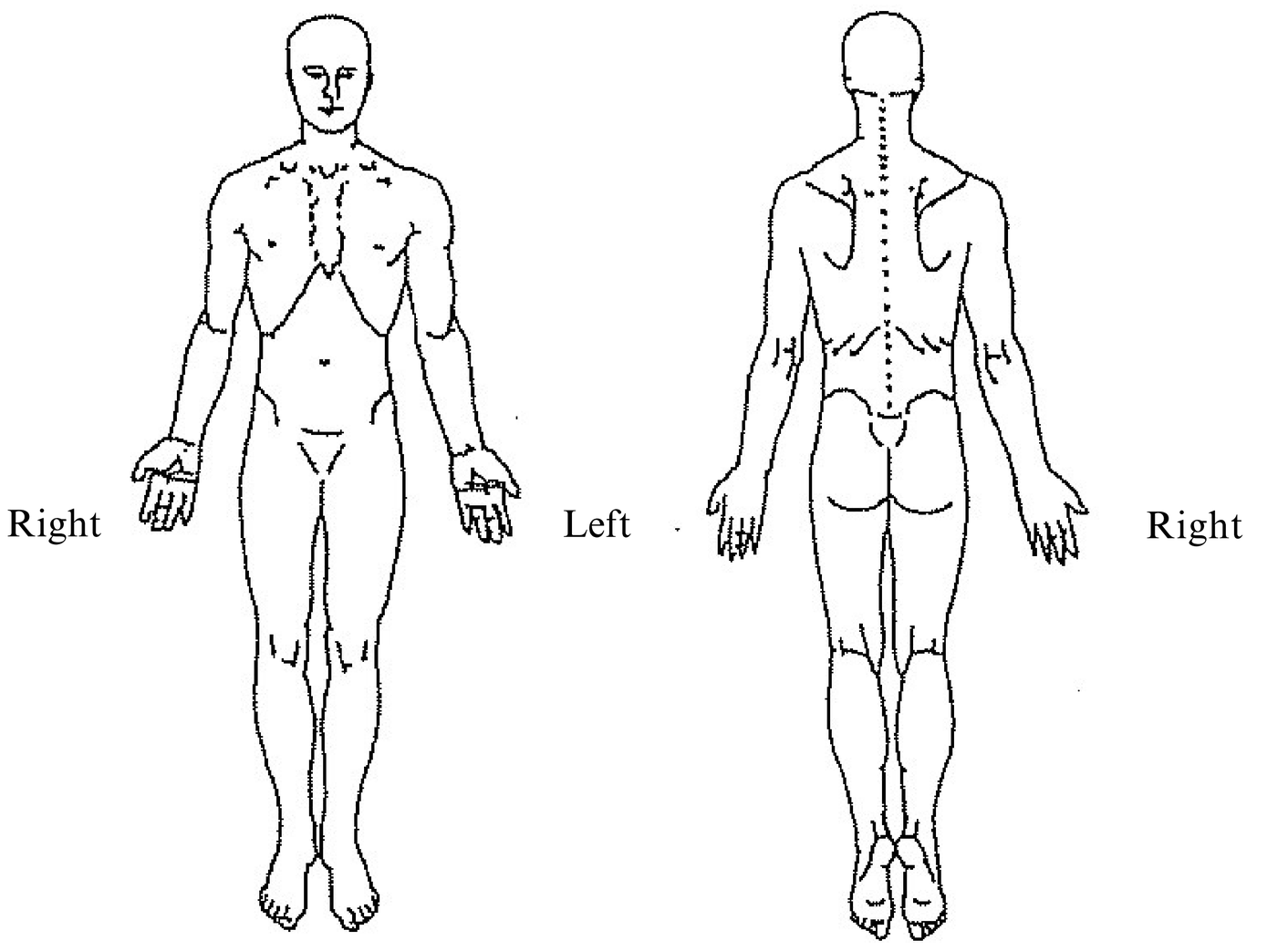
When did your complaint(s) begin? _____

Briefly describe how the accident/injury occurred: _____

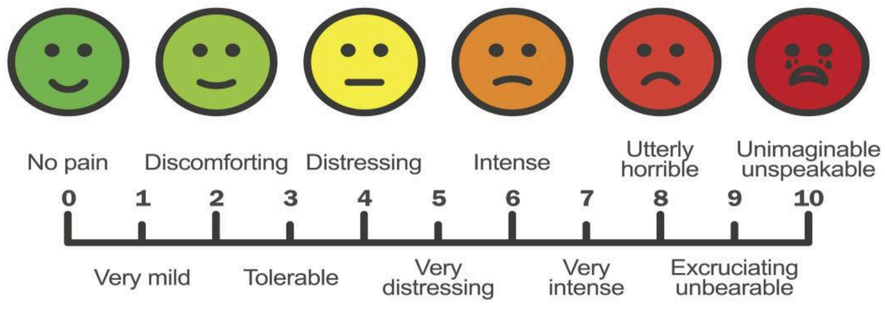
Have you had any of the following done relating to your present complaint?

☐ **Imaging** ☐**EMG** ☐**Surgery** ☐**Injections** ☐**Physical Therapy** ☐**Chiro**

If "yes", please specify where and when:_____



Please Indicate Pain Level



Factors that improve your pain:

☐ Nothing helps	☐ Position Change	☐ Exercise	☐ Injections
☐ Sitting	☐ Heat	☐ Stretching	☐ Surgery
☐ Standing	☐ Cold/Ice	☐ Narcotics	☐ Brace/Sling
☐ Lying down/rest	☐ Rest	☐ NSAIDs	☐ Other:

Factors that worsen your pain:

☐ Cannot identify	☐ Walking	☐ Exercise	☐ Morning
☐ Stretching	☐ Bending forward/back	☐ Changing clothes	☐ Nighttime
☐ Sitting	☐ Lifting/Carrying	☐ Going from sit to stand	☐ Cold weather
☐ Standing	☐ Twisting	☐ Getting out of bed	☐ Damp weather
☐ Lying down	☐ Pushing/Pulling	☐ Gripping/Grasping	☐ Other:

Medical History

Please list all current medications you are taking: ☐ None

Please list all drug allergies: ☐ No Known Drug Allergies

Drug Name	Describe Reaction

Pharmacy Name & Address:- _____

Please indicate your family history:

Illness/Problem	Relative	Onset (Age)	Deceased {Age)

☐ First-degree relatives have no current problems or disabilities

☐ Unknown

Please check off the following if it applies:

Tobacco use?	☐ Yes	☐ No
Vape use?	☐ Yes	☐ No
Alcohol consumption?	☐ Yes	☐ No
Illicit drug use?	☐ Yes	☐ No
History of addiction?	☐ Yes	☐ No
Medicinal THC use?	☐ Yes	☐ No

Please list your <u>surgical history</u> below:

Surgery	Surgery Date

Surgery	Surgery Date

Please indicate any past or present medical problems:

☐ Anxiety/Depression
☐ Asthma
☐ Blood Disorder (specify):
☐ Cancer (specify):
☐ Diabetes
☐ Glaucoma
☐ Heart Attack
☐ Heart Disorder (specify):
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDs
☐ Pacemaker
☐ Thyroid Disorder (specify):
☐ Ulcers
☐ Stroke
☐ Lung Disorder:
☐ Osteoporosis
☐ Seizures
☐ Kidney Disease (specify):
☐ Other (specify):

I am aware that Premier Brain & Spine is relying on the information I have provided as part of the safe and effective decision making process regarding my treatment and I certify that the information is true and complete.

Patient Signature: _____ Date Signed: _____

Print Name: _____ *DOB:* _____

a division of **PREMIER BRAIN AND SPINE**

GENERAL MEDICAL AND FINANCIAL POLICIES

Medical Policy It is important to your health that you carefully follow your provider's care plan. It is equally important for you to keep us informed about all medications (prescription and over the counter) that you are taking, as well as any changes in your health status. Please note that we cannot and will not refill controlled substance medications in advance of their refill date, that we cannot and will not call in a controlled substance medication to your pharmacy, and we do not mail prescriptions. Medication refills are provided at the time of your appointment. In some instances, requests for prescription refills of noncontrolled substance medications may be requested by phone. In those cases, a 3-business day notice is required from the time of your request until the refill request will be processed (e.g., if you call on Wednesday, your prescription will be processed by Monday).

Financial Policy

If you have medical insurance, our goal is to help you receive your maximum allowable benefits. It is your responsibility, however, to know and understand the terms and benefits of your own insurance policy, including need for referrals and the application and amounts of your deductible, co-pay, and co-insurance.

If your insurance coverage is with one of the plans with which we participate, we will bill your insurance company directly in accordance with the guidelines of our contract with your provider for your plan. Please keep in mind that **co-pays are due at the time services are rendered** . If your insurance coverage is with a plan that with which we do not participate, we will still submit a claim to your insurance company on your behalf, however payment in full must be made at the time services are rendered. We accept credit cards and debit cards only. We will gladly answer any questions relating to your insurance, but we ask you to keep in mind that your insurance coverage is a contract between you and the insurance carrier, and we are not a party to that contract.

You will be required to show a copy of your insurance card at the time services are rendered. If you do not have your insurance information or if we are unable to verify your coverage, you will be required to pay up-front for the services rendered that day or you will have to reschedule your appointment. It is your responsibility to notify us of changes or termination of your insurance policy.

Consent to Receive Text Messages You may receive text messages to the mobile phone number you provide. The text messages may be from your treating provider or their office staff, health EMR, or other vendors on behalf of the health system. The text messages may be for appointment reminders, patient paperwork, education, feedback, any other healthcare services related to any lawful purposes. You understand that data usage and other charges from my cellular provider may apply. You may stop text messages by replying STOP or contacting the office directly.

Missed Appointments

The care of our patients is important to us. Missed appointments without appropriate notification will result in a "no-show" fee of $25.00. If you are more than 15 minutes late for your scheduled appointment, you will be considered a "no-show".

Account Balances

Any account balance that become 90 days overdue will be sent to collection unless you are enrolled in a payment plan with the practice and are meeting the terms of that agreement.

Form Fees

There is a fee of $20.00 for completion of third-party/private disability, FMLA, work-related, or other forms. (Exception: no charge for completion of NJ State Temporary Disability forms or Social Security Disability forms). The fee is due and payable when you pick up your completed forms. No forms will be faxed to any third party. (Exception: Social Security Disability). It is necessary that you bring your forms to our office and allow two (2) weeks for them to be completed and ready for pick-up.

Patient Name	Patient/Responsible Party Signature	Date

a division of **PREMIER BRAIN AND SPINE**

Assignment of Benefits

I authorize and direct my insurance carrier or payor to pay directly to **PREMIER BRAIN AND SPINE** and its affiliated health care providers any and all benefits that would otherwise be payable to me (or the patient, if this form is being signed by the responsible party or representative of the patient) up to the full amount of my bill, accruing to me in connection with my treatment at **PREMIER BRAIN AND SPINE.**

I request that payment of authorized Medicare, Medigap, and/or other health insurance policy benefits for services furnished to me by **PREMIER BRAIN AND SPINE** be made on my behalf to **PREMIER BRAIN AND SPINE**.

I agree to cooperate with **PREMIER BRAIN AND SPINE** to ensure that it receives all amounts due.

I hereby authorize **PREMIER BRAIN AND SPINE** and its affiliated providers to pursue any means necessary to collect all charges on my account, including follow-up calls, appeals, arbitration, and civil suit, as allowable by law.

In the event **PREMIER BRAIN AND SPINE** brings an appeal, lawsuit, or petition for arbitration against the insurance carrier, I hereby assign to them my rights, title, and interest under any insurance policy under which I am entitled to benefits.

This assignment shall allow an attorney chosen by **PREMIER BRAIN AND SPINE** to bring suit or submit to arbitration **PREMIER BRAIN AND SPINE** claims of any unpaid or underpaid bills for treatment rendered to me and/or my dependents or those for whom I am the financial responsible party.

I understand that even though I have signed this Assignment of Benefits, the insurance company may send payment of services rendered by **PREMIER BRAIN AND SPINE** to me rather than sending it to **PREMIER BRAIN AND SPINE**.

In such event, I agree to immediately forward payment to **PREMIER BRAIN AND SPINE** of the amount received by me from the insurance company.

I authorize **PREMIER BRAIN AND SPINE** to release to my insurance carrier(s) and/or their representatives, the Health Care Financing Administration, or other entity, any and all medical information necessary for the purpose of determining benefits and collecting payment for claims for services rendered to me (or my dependent or person for whom I am financially responsible).

_____

Patient Name

_____ _____

Signature of Patient or Responsible Party Date

a division of **PREMIER BRAIN AND SPINE**

Notice of Privacy Practices

I. Introduction

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights. This Notice further states the obligations we have to protect your health information.

"Protected health information" means health information (including identifying information about you) we have collected from you or received from your health care providers, health plans, disability plans, your employer, or a health care clearinghouse. It may include information about your past, present or future physical or mental health or condition, the provision of your health care, and payment for your health care services.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are also required to comply with the terms of our current Notice of Privacy Practices.

II. Permitted Uses & Disclosures

We will use and disclose your health information as described in each category listed below. For each category, we will explain what we mean in general, but not describe all specific uses or disclosures of health information.

A. Uses and Disclosures for Treatment, Payment and Operations

1.**For Treatment.** We may use and disclosure your health information without your further authorization in order to provide your health care and any related services. This information will only be shared with employees and agents of Premier Brain & Spine. We will use your health information to coordinate and manage your health care and related services. We may disclose your health information among our clinicians and other staff. In addition, we may disclose your health information without your authorization to another health care provider (e.g., a pharmacy or a laboratory) working outside of Premier Brain & Spine for purposes of your treatment. We would only disclose sufficient information for them to provide necessary services to you. For example, an authorization for laboratory tests may require a diagnosis.

2. **For Payment.** We may use or disclose your health information without your further authorization so that the treatment and services you receive are billed to, and payment is collected from, your health plan or other third party payer. By way of example, we may disclose your health information to permit your health plan to take certain actions before your health plan approves or pays for your services. We may also disclose your health information to another health care provider so that provider can bill you for services they provided to you, for example an ambulatory surgery center where we perform a procedure.

3. **For Health Care Operations.** We may use and disclose health information about you without your further authorization for our health care operations. These uses and disclosures are necessary to run our organization and make sure that our consumers receive quality care. These activities may include, by way of example, quality assessment and improvement, reviewing the performance or qualifications of our clinicians, training in clinical activities, licensing, accreditation, business planning and development, and general administrative activities. We may combine health information of many of our clients to decide what additional services we should offer, what

services are no longer needed, and whether certain treatments are effective. We may also provide your health information to other health care providers or to your health plan to assist them in performing certain of their own health care operations. We will do so only if you have or have had a relationship with the other provider or health plan. For example, we may provide information about you to your health plan to assist them in their quality assurance activities. We may also use and disclose your health information to contact you to remind you of your appointment. Finally, we may use and disclose your health information to inform you about possible treatment options or alternatives that may be of interest to you.

B.Other Uses & Disclosures

1.Disclosures may be made to persons designated to participate in your care in accordance with an advance directive validly executed under state law, your guardian or other fiduciary if one has been appointed by a court, or if applicable, the state agency responsible for consenting to your care. In limited circumstances, we may disclose health information about you to a friend or family member who is involved in your care. If you are physically present and have the capacity to make health care decisions, your health information may only be disclosed with your agreement to persons you designate to be involved in your care.

If you are in an emergency situation, we may disclose your health information to a spouse, a family member, or a friend so that such person may assist in your care. In this case we will determine whether the disclosure is in your best interest and, if so, only disclose information that is directly relevant to participation in your care.

If you are not in an emergency situation but are unable to make health care decisions, we will disclose your health information to:

Report to public health authorities for the purpose of preventing or controlling disease, injury or disability;

Report vital events such as birth or death;
Conduct public health surveillance or investigations;
Report child abuse or neglect;
Report certain events to the Food and Drug Administration (FDA) or to a person subject to the jurisdiction of the FDA including information about defective products or problems with medications;
Notify consumers about FDA-initiated product recalls;
Notify a person who may have been exposed to a communicable disease or who is at risk of contracting or spreading a disease or condition;
Notify the appropriate government agency ifwe believe you have been a victim of abuse, neglect or domestic violence. We will only notify an agency if we obtain your agreement or if we are required or authorized by law to report such abuse, neglect or domestic violence.
A court order, warrant, summons or similar process requires us to do so or the information is needed to identify or locate a suspect, fugitive, material witness or missing person, or we report a death that we believe may be the result of criminal conduct, or we report criminal conduct occurring on the premises of our facility, or we determine that the law enforcement purpose is to respond to a threat of an imminently dangerous activity by you against yourself or another person, or the disclosure is otherwise required by law.

2.**Persons Involved in Your Care.** We may provide health information about you to someone who helps pay for your care. We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may also use or disclose your health information to an entity assisting in disaster relief efforts and to coordinate uses and disclosures for this purpose to family or other individuals involved in your health care.

C.Special Situations

1.Emergencies. We may use and disclose your health information in an emergency treatment situation. By way of example, we may provide your health information to a paramedic who is transporting you in an ambulance. If a clinician is required by law to treat you and your treating clinician has attempted to obtain your authorization but is unable to do so, the treating clinician may nevertheless use or disclose your health information to treat you.

2.Research. We will obtain a written authorization from you prior to using your health information for research. We may then disclose your health information to researchers when their research has been approved by an Institutional Review Board or a similar privacy board that has reviewed the research proposal and established protocols to protect the privacy of your health information. For example, a research project may involve comparisons of the health and recovery of all clients who received a particular medication. All research projects are subject to a special approval process, which balances research needs with a client's need for privacy.

3.As Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

4.To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious and imminent threat to your health or safety or to the health or safety of the public or another person. Under these circumstances, we will only disclose health information to someone who is able to help prevent or lessen the threat.

5.Organ and Tissue Donation. If you are an organ donor, we may release your health information to an organ procurement organization or to an entity that conducts organ, eye or tissue transplantation, or serves as an organ donation bank, as necessary to facilitate organ, eye or tissue donation and transplantation.

6.Public Health Activities. We may disclose health information about you as necessary for public health activities including, by way of example, disclosures to:

7.Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. Oversight agencies include government agencies that oversee the health care system, government benefit programs such as Medicare or Medicaid, other government programs regulating health care, and civil rights laws.

8.Disclosures in Legal Proceedings. We may disclose health information about you to a court or administrative agency when a judge or administrative agency orders us to do so. We will not disclose health information about you in legal proceedings without your permission or without a judge or administrative agency's order. If we receive a subpoena for your health information, we will not provide this information in response to a subpoena without your written authorization.

9.Law Enforcement Activities. We may disclose health information to a law enforcement official for law enforcement purposes. We may also disclose health information about a client who is a victim of a crime, without a court order or without being required to do so by law. However, we will do so only if the disclosure has been requested by a law enforcement official and the victim agrees to the disclosure or, in the case of the victim's incapacity, the following occurs:

10.Medical Examiners or Funeral Directors. We may provide health information about our consumers to a medical examiner. Medical examiners are appointed by law to assist in identifying deceased persons and to determine the cause of death in certain circumstances. We may also disclose health information about our consumers to funeral directors as necessary to carry out their duties.

11.Military and Veterans. If you a member of the armed forces, we may disclose your health information as required by military command authorities. We may also disclose your health information for the purpose of determining your eligibility for benefits provided by the Department of Veterans Affairs. Finally, if you are a member of a foreign military service, we may disclose your health information to that foreign military authority.

12.National Security and Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We may also disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or so they may conduct special investigations.

13.Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official.

14.Workers' Compensation. With your consent we may disclose health information about you to comply with the state's Workers' Compensation Law.

III.Uses and Disclosures of Your Health Information with Your Permission.

Uses and disclosures not described in Section II of this Notice of Privacy Practices will generally only be made with your written permission, called an "authorization." You have the right to revoke an authorization at any time. If you revoke your authorization we will not make any further uses or disclosures of your health information under that authorization, unless we have already taken an action relying upon the uses or disclosures you have previously authorized.

A.Right to Request Restrictions.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment or health care operations. To request a restriction, you must request the restriction in writing.

B.Right to Request Confidential Communications.

You have the right to request that we communicate with you about your health care only in a certain location or through a certain method. For example, you may request that we contact you only at work or by e-mail. To request such a confidential communication, you must make your request in writing.

IV.Confidentiality of Substance Abuse Records

You authorize the disclosure in writing, or the disclosure is permitted by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation purposes, or you threaten to commit a crime either at the drug abuse or alcohol program or against any person who works for our drug abuse or alcohol programs.

The confidentiality of drug or alcohol abuse records is protected by federal law and regulations. Federal law and regulations governing confidentiality of drug or alcohol abuse permit us to report suspected child abuse or neglect under state law to appropriate state or local authorities

V.Changes to this Notice

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We will post a copy of the current Notice of Privacy Practices at our main office and at each site where we provide care. You may also obtain a copy of the current Notice of Privacy Practices on the Premier Brain & Spine website at www.premierspinenj.com, by calling us at 732-258-0190 and requesting that a copy be sent to you in the mail, or by asking for one any time you are at our offices.

I, patient _____ or guarantor_____ agree to sign consent forms electronically.

Signature: _____ Date: _____

If not signed, reason why acknowledgment was not obtained: _____

Staff Witness seeking acknowledgement: _____ ***Date:*** _____

Privacy Officer Premier Brain and Spine
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