New Patient Information

Patient Name: ____ **Date of Birth:** ____ / _____ / ______
Last First Middle I.

Race: ☐ **White**
☐ **Black/African American**
☐ **American Indian/Alaska Native**
☐ **Asian**
☐ **Native Hawaiian/Pacific Islander**
☐ **Other** ______________________

Primary Language: __________________________________ **Email Address:** ________________________

Home #: ________________________ **Cell #:** _______________________ **Work #**:____________________________

Address: ____________________________ **City:** ____________________ **State**: _________ **Zip:** _________

Referring Physician: ____ **Phone:** ________________________

Primary Care Physician: _____________________________________ **Phone:** ________________________

Pharmacy: _________________________________ **Phone:** ____________________________

Emergency Contact: ___________________ **Relationship:** ____________________ **Phone:** __________________________

EMPLOYMENT STATUS:
1. Job Title/Occupation: ____

2. Employer: ____

3. Please check current work status:

☐ **Working Full Time** ☐ **Working Part Time** ☐ **Working Light Duty:** ☐ **Retired/Not Working** ☐ **Off Duty Due to Injury**

Hours worked per day_________ **Days worked per week**________

Appointment Reminders and Information

The following is how we will notify you for all appointment information and confirmations. ***Please check off your preferred method of contact. If you do not opt in for any options, appointment information will automatically default to all options possible.***

☐ **Remind me via Home Phone Call (Include Auto Call)**

☐ **Remind me via Cell Phone Call (Include Auto Call)**

☐ **Remind me via Cell Phone Text**

Is This a Work / Auto Related Injury ☐ **YES** ☐ **NO** **(If Yes Go To Page 4)**

Acknowledgement of HIPAA Privacy Notice and Designation of Disclosure

Acknowledgement of Practice's Notice of HIPAA Privacy:

I have received a copy of the Notice of HIPAA Privacy for The Orthopedic Institute of New Jersey

Designation of Certain Relatives, Close Friends, and Other Caregivers:

I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I designate the following person listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list any time in writing.

Print Name________________________________**Relationship**________________________ **Phone Number**____________________

Print Name________________________________**Relationship**_______________________ **Phone Number**____________________

Print Name________________________________**Relationship**_______________________ **Phone Number**_____________________

The following person(s) are **NOT** authorized to receive my patient health information:

Print Name:____

Print Name:____

Print Patient Name ____

Patient Signature ______________________________ **Date** _____ / _____ / _______

Insurance Information

Primary Insurance Company: ____

Insurance ID #: _____________________________________ **Group #:** ___________________________________

Policyholder's Name: ____ **Date of Birth:** ______ / ______ / ______
Last First Middle I.

Patient's Relationship to Insured: __________________________________

Address: ___________________________ **City:** ____________________ **State:** _________ **Zip:**___________

Home Phone___________________________ **Work Phone**______________________________________

Employer: ________________

Secondary Insurance Company: ____

Insurance ID #: _____________________________________ **Group #:** ___________________________________

Policyholder's Name: ____ **Date of Birth:** ______ / ______ / ______
Last First Middle I.

Patient's Relationship to Insured: __________________________________

Address: ____

City:
_______________________ **State:** __________ **Zip:** _______________

Home Phone___________________________ **Work Phone**______________________________________

Employer: ____________________

Assignment Of Benefits

For consideration received, I do hereby assign to THE ORTHOPEDIC INSTITUTE OF NEW JERSEY. all my rights and interests in the personal injury protection portion of any and all applicable automobile insurance policies under which I may be entitled to benefits including but not limited to Personal Injury Protection Benefits.

This assignment is given with respect to all treatment, care, and diagnostic testing provided by THE ORTHOPEDIC INSTITUTE OF NEW JERSEY. By assigning my benefits I expressly agree that the following rights are assigned to THE ORTHOPEDIC INSTITUTE OF NEW JERSEY.

1. The right to collect from the insurer directly payment for any services rendered by THE ORTHOPEDIC INSTITUTE OF NEW JERSEY with respect to Personal Injury Protection Benefits.
2. The right to file a lawsuit or arbitration as provided by applicable law against the insurance company in the name of THE ORTHOPEDIC INSTITUTE OF NEW JERSEY as assignee and to designate an attorney of THE ORTHOPEDIC INSTITUTE OF NEW JERSEY's choosing for the purpose of filing said lawsuit.
3. I agree to fully cooperate with the Assignee in the prosecution of the personal injury protection claim against the applicable insurance carrier, including full cooperation with the attorney chosen by including but not limited the appearance at any deposition and appearance at trial and/ or EUO.

Voluntary Physician's Lien

I hereby agree to provide an irrevocable Lien to THE ORTHOPEDIC INSTITUTE OF NEW JERSEY against any settlement, judgment or verdict arising out of my automobile accident for which I am receiving treatment.

I agree that pursuant to the terms of this agreement I may not rescind this document and that a recession will not be honored by my attorney. I further instruct that in the event another attorney is substituted in this matter, my new attorney shall honor this Lien.

Upon settlement, judgment, verdict and prior to the disbursement of any funds to myself, I hereby direct my attorney to pay to THE ORTHOPEDIC INSTITUTE OF NEW JERSEY any and all sums of money that may be due and owing THE ORTHOPEDIC INSTITUTE OF NEW JERSEY.

Furthermore, I fully understand that I am primarily responsible for all treatment rendered to me by THE ORTHOPEDIC INSTITUTE OF NEW JERSEY and all bills which I may incur.

Patient Signature: ________________________________ **Date:**_____/_______/________

PLEASE COMPLETE THIS SECTION IF THIS IS A WORKER'S COMP INJURY OR AUTO ACCIDENT:

☐ **Worker's Comp** ☐ **Auto Accident**

Patient Name: ____
Last First Middle I.

Date of Injury:________ / ________ /__________ **Body Part** ________________________________

Auto Insurance Carrier____

Claim #: ____

Address: ____

City: ______________________ **State:**____________ **Zip:**________________

Phone: ______________________

Contact Name:__________________ **Phone:**____________________________

(Please attach auto insurance card if applicable)

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Upon settlement, judgment, verdict and prior to the disbursement of any funds to myself, I hereby direct my attorney to pay to THE ORTHOPEDIC INSTITUTE OF NEW JERSEY any and all sums of money that may be due and owing THE ORTHOPEDIC INSTITUTE OF NEW JERSEY.
Furthermore, I fully understand that I am primarily responsible for all treatment rendered to me by THE ORTHOPEDIC INSTITUTE OF NEW JERSEY and all bills which I may incur.

Patient Signature: ______________________ **Date:**_____/_______/________

Medical Information

Patient Name: ____ **Date of Birth:** __________ / _________ / __________

PAST MEDICAL HISTORY:

HISTORY: Please check any applicable diseases/disorders. If these diseases/disorders run in your family, indicate below.

- **Heart disease**: ☐ Yourself ☐ Relative
- **Arthritis:** ☐ Yourself ☐ Relative
- **Hypertension**: ☐ Yourself ☐ Relative
- **Alcohol Abuse:** ☐ Yourself ☐ Relative
- **Diabetes:** ☐ Yourself ☐ Relative
- **Drug Abuse:** ☐ Yourself ☐ Relative
- **Cancer:** ☐ Yourself ☐ Relative
- **Other:** ______________________________

Current Medication
____
____
____
____
____

Allergies
____
____
____
____
____

Height ________ (Verbal / Actual)
Weight ________ (Verbal / Actual)

Are you on a blood thinner? ☐ Yes ☐ No

Please List surgeries you have had:

Procedure: ____ Date: ______________________

Procedure: ____ Date: ______________________

Procedure: ____ Date: ______________________

Procedure: ____ Date: ______________________

SOCIAL HISTORY:

Marital Status: ☐ Married: Name of spouse: ______________________ ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. **Do you Smoke?**
   ☐ No ☐ Yes If yes: Packs/Day____ Quit When? _______
2. **Do you drink alcoholic beverages?**
   ☐ No ☐ Yes If yes, per week? _________
3. **Do you consume caffeinated beverages**
   ☐ No ☐ Yes If yes, per week? _______
4. **Do you use or have you used street drugs?**
   ☐ No ☐ Yes If yes, what kind and when? _________________

Reason for Today's Visit____

Body Part_________________________ Any Trauma? ☐ Yes ☐ No If yes, explain: _____________________________________

When did your symptoms first appear? ____

Have you tried Physical Therapy? ☐ Yes ☐ No

Have you tried an anti-inflammatory? ☐ Yes ☐ No

Financial Policy for TOINJ Patients and Commercial Insurance Companies

Thank you for selecting The Orthopedic Institute of New Jersey as your health care provider. It is our sincere desire to provide you with the best possible medical care. This involves mutual understanding among the patients, healthcare providers and staff. We encourage you, our patient, to discuss any questions you may have regarding our professional fees, this financial policy and your responsibility.

Patient Responsibility:

1. Your insurance company makes final determinations as to coverage and sets the terms and conditions that govern your relationship with the insurance company and our relationship with that same insurer as well. We do not make the rules.
2. Payments that your insurance company deems are your responsibility, such as office visit co-pays, deductibles and co-insurance become your patient responsibility and these amounts are due and payable to TOINJ and constitute an important source of revenue to support the practice.
3. **We do not participate with ANY Medicaid Insurance Plan. If you have Medicaid as a secondary Insurance Plan (Except to Medicare) You will be held financially responsible for any and all charges.**
4. Patient responsibility is due on demand and we take cash, check and all major credit cards. Upon request, we will make short-term payments plans to satisfy balances but only if you provide a valid credit card on file and within the expiration date of that credit card. All returned checks will be subject to $50.00 return reprocessing and administrative fee.
5. We will send you a statement every month and phone call reminders detailing charges. If you have any questions, please call our office **at (908) 684-3005 Extension 269**, we will be happy to assist you.
6. If we are forced to start collection proceedings, we will charge your account a collection fee of up to $160.00. We will also charge your account attorney fees of 33.33% of your outstanding balance if your account is placed with an attorney for legal collections.
7. You are responsible to notify us of any Insurance changes **IMMEDIATLY, PRIOR TO ANY SERVICES** or you will be held financially responsible for any and all charges not paid by your Insurance Company.
8. In the event we need to Appeal a claim to your Insurance Company and / or The New Jersey State Department of Banking and Insurance, you give us permission to do so on your behalf.

Other Matters:

If your plan requires a primary physician referral, please provide same at the time of visit, most primary physicians will provide you with a referral letter or they may even be able to send the referral electronically.

Please inform the office of ANY secondary coverage. Insurers may not pay a claim at all or you may end up liable for the charges if the coordination of benefits is not complete, we are trying to help you.

We are unable to change diagnosis codes and/or procedure codes to meet the reimbursement requirements of your plan for a medical service specifically excluded by your policy.

I authorize payment of benefits be made on my behalf to The Orthopedic Institute of New Jersey for any services furnished me by the provider. Additionally, I authorize TOINJ to furnish information from my medical records pertaining to my treatment as requested by other healthcare providers for my continued care and treatment. I have been presented with a copy of TOINJ's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I have read the above and agree that I am ultimately responsible for the balance on my account for any services plus reasonable collections costs including attorney fees, court costs and interest on the balance as allowed by law.

Patient Name (Please Print) ____

Responsible Party Name: (Please Print) ____

Responsible Party Signature: ____

Responsible Party Relationship to Patient: ______________________________________

Date _____ / _____ / _______