THE
ORTHOPEDIC
INSTITUTE
of New Jersey

New Patient Information

Patient Name: _____ **Date of Birth:** ____/ _____/ _____
Last First Middle 1.

Race:
o White
o Black/African American
o Asian
o Native Hawaiian/Pacific Islander
o American Indian/Alaska Native
o 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:

l . Job Title/Occupation: _____

2. Employer: _____

3. Please check current work status:

o Working Full Time o Working Part Time o Working Light Duty o Retired/Not Working o 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.

o Remind me via Home Phone Call (Include Auto Call)

o Remind me via Cell Phone Call (Include Auto Call)

o Remind me via Cell Phone Text

THE ORTHOPEDIC INSTITUTE of New Jersey

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

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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_____ Phone Number_____

Relationship _____

Print Name_____ Phone Number_____

Relationship _____

Print Name_____ Phone Number_____

Relationship _____

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

Print Name: _____

Print Name: _____

Patient Signature: _____

Print Patient Name: _____

Parent/Legal Guardian (if minor) Signature:_____

Date: _____/_____/_____

THE
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Insurance Information

Primary Insurance Company: _____

Insurance ID: _____ Group #:_____

Policyholder's Name: _____ _____Date of Birth: _____
Last First Middle 1.

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 1.

Patient's Relationship to Insured:_____

Address:_____City: _____State: _____ Zip:_____

Home Phone_____Work Phone_____

Employer: _____

Patient Signature: _____ **Date:** _____

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Assignment of Benefits

By signing below, I hereby authorize North Jersey Sports Medicine & Orthopedic Group, LLC, DBA The Orthopedic Institute of New Jersey and its physicians and staff (each and collectively, the "Practice") to release to the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient (identified below) any information, including without limitation protected health information, needed for the processing of claims for payment for services rendered to the patient.

I hereby authorize the Practice to submit claims to the applicable payor, insurance plan, intermediary, plan administrator, or third party for all services rendered to the patient and to exercise any appeals and other rights on the patient's behalf. I hereby authorize the Practice the right to file suit, obtain counsel, and enter into legal or other actions on the patient's behalf, including arbitration or dispute resolution processes, for any claims against the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient. This authorization includes assignment of the right to pursue declaratory, equitable, and compensatory relief or other legal remedies.

I hereby authorize the Practice to appoint an attorney to represent the patient directly for the collection of all insurance plan or other benefits through the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient. I authorize the Practice to obtain an attorney to represent the patient directly in appealing a claim to the applicable payor, insurance plan, intermediary, plan administrator, or third party.

I hereby authorize the Practice to act on the patient's behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I hereby direct the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient to issue payment for submitted claims directly to the Practice. If payment will not be made directly to the Practice, I hereby authorize and direct the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient to send copies of all payments and Explanation of Benefit forms in connection with the services provided by the Practice to: North Jersey Sports Medicine & Orthopedic Group, LLC, DBA The Orthopedic Institute of New Jersey, 376 Lafayette Road, Suite 202 Sparta, NJ 07871.

I understand and agree that, should I, the patient, my dependents, or my beneficiaries receive funds from the applicable payor, insurance plan, intermediary, plan administrator, or third party for services performed by or at the Practice, that it is my responsibility to endorse the checks and send them to the Practice, and that payment of fees for all services rendered that are not paid directly by the health plan to the are my ultimate responsibility.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Name

THE
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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 pat ients, 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 patient financial consultant at (908) 684-3005 Extension 731, she 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 S 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.
9. If you cancel or reschedule your planned surgery or procedure less than one week prior to the confirmed scheduled date, you will be automatically charged a cancellation/rescheduling fee of $200.00 applied directly to your patient account.

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) _____

Patient Signature: _____

Date: _____/_____/_____

Fill out this section if patient is under 18
Responsible Party Name: (Please Print) Responsible Party Signature: _____

Responsible Party Relationship to Patient: _____

Date: _____/_____/_____

Insurance Disclosure Form 2024

THE ORTHOPEDIC INSTITUTE of New Jersey

MEDICARE
MEDICARE-NJ
MEDICARE-PA
MEDICARE RR
AETNA Medicare Advantage
AETNA MEDICARE - Not All Plans - SOME EXCEPTIONS LIKE DR. WHITE ON NNJ
AETNA MEDICARE PRIME VALUE HMO New 1/1/2021
Clover PPO
TIER 1 INSURANCE COMPANIES
AETNA Traditional/Standard Plans
Narrow Network (AETNA Aexcel) Plans:
AETNA Aexcel
Elec Choice EPO
Select Plan
Plus Elec Choice EPO
Plus AETNA Select
Choice POS/ POS II (Open Access) Atlantic Health Care Employees
Plus POS II
Managed Choice POS
Plus Managed Choice POS
Open Choice PPO
Plus Open Choice PPO
Aetna Premier Care Network and Network Plus - 2019 and 2020
CIGNA (AS OF 1/1/23 TIER TWO)/GREAT WEST
HMO
OAP
PPO
LOCAL PLUS/LOCAL PLUS IN
Horizon BCBS
Horizon NJ Direct
Horizon Direct Access
Horizon Omnia
Anthem BCBS
Empire BCBS
MERITAIN
OSCAR
United Health Care PPO & Commercial Plans
GEHA
Surest

TIER 2 INSURANCE COMPANIES
AMERIHEALTH
EMBLEM HEALTH/GHI (QUALCARE TPA)
MAGNACARE OPERATING ENGINEERS (Local 825 Only)(Closed)
NALC - NATIONAL ASSOCIATION OF LETTER CARRIERS (PANEL CLOSED) - Cigna HealthCare OAP
MHBP - MAIL HANDLERS BENEFIT PLAN (PANEL CLOSED) - Aetna Choice POS II
APWU - American Postal Workers Union High Option - Cigna PPO
CHN (Consumer Health Network)
MILITARY PLANS
TRICARE PRIME - Humana
Tricare for Life - Medicare Supplemental Plan
US FAMILY HEALTH PLAN (FAMILY MEMBERS OF VETERANS MEDICARE REPLACEMENT)
CHAMPVA (Need Pt's SSN as this is used as the ID)
Homestead (POS PLAN- PATIENT CAN GO ANYWHERE)
Workers Compensation Insurances
NEW JERSEY MANUFACTURERS
GALLAGHER BASSETT
PMA
MEDLOGIX
HARTFORD INS
HORIZON CASUALTY SERVICES
FIRST MCO (IN NEGIOATIONS)
SEDGWICK
LIBERTY MUTUAL
QUAL-LYNX
TRAVELERS
AMTRUST NORTH AMERICA
ESIS
CHUBB INSURANCE
BROADSPIRE
SELECTIVE INSURANCE
CORVEL
FRANKLIN MUTUAL INSURANCE
ZURICH

Please sign acknowledging that you're aware of what insurances we are IN-NETWORK with. Thank you!

Signature _____ Date _____