

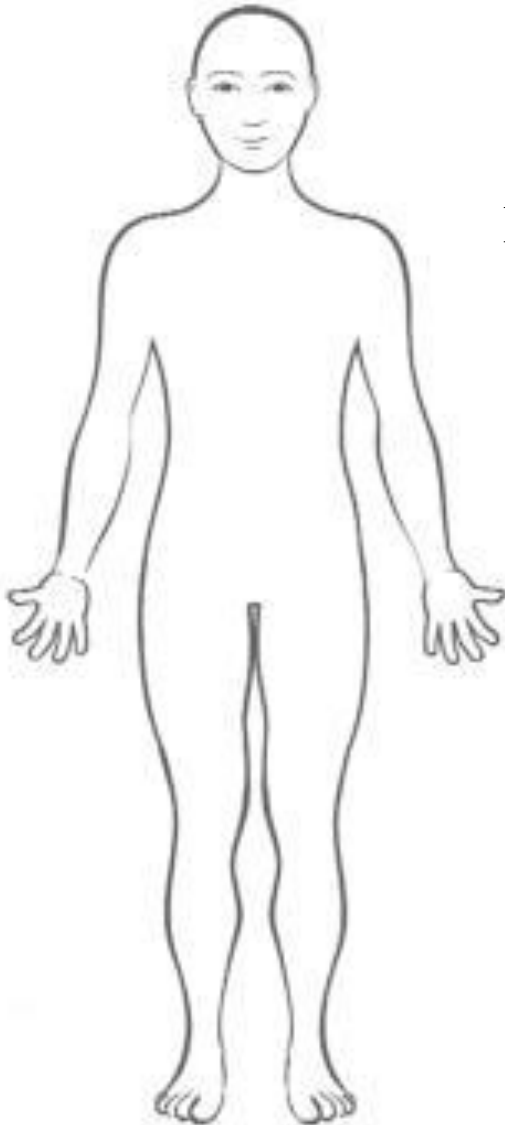
Patient Name: _____

Date: _____ DOB: _____

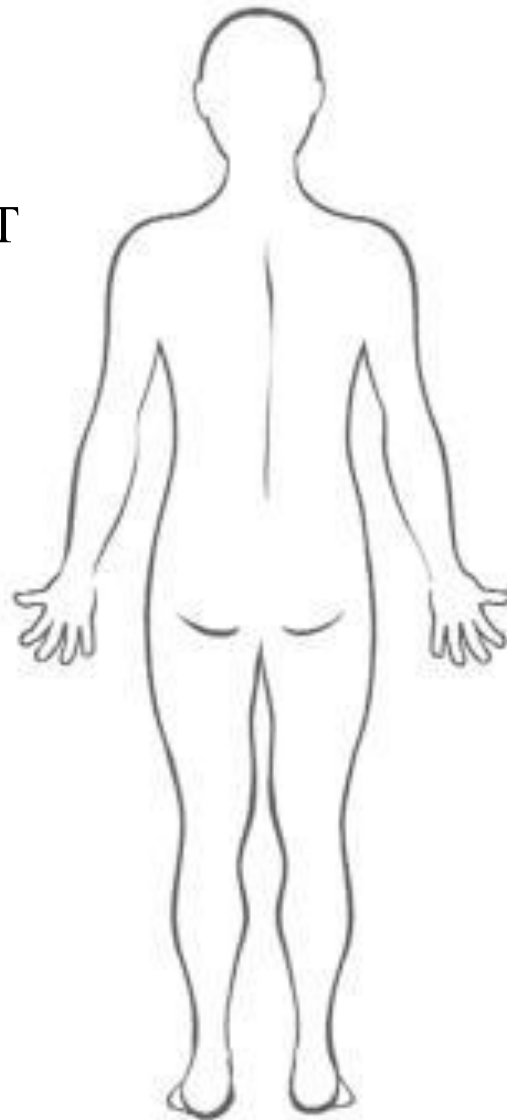
Height: _____ Weight: _____

Please circle injured area(s). DO NOT circle entire body.

RT



LT



RT

Today's Date: _____

Mid Atlantic Orthopedic Associates, LLP

Kenneth S. Klein, MD • Lewis J. Levine, MD • Richard A. Klein, MD

Patient Last Name: _____ First Name: _____ Middle: _____ Suffix: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email Address: _____ Fax#: (____) _____ - _____

Date of Birth: _____ Age: _____ SS#: _____ - _____ - _____ Sex: Male Female Marital Status: **S M W D**

Emergency Contact Name: _____ Tel#: (____) _____ - _____ Relationship to you: _____

May we leave info on your answering machine or voicemail? Yes No Occupation: _____

Employer Name, Address & Phone: _____

Nature of Present Problem: _____ Date of First Symptom: _____

Primary Doctor Name/Referring Doctor, Address and Tel#: _____

PRIMARY HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____ Phone: (____) _____ - _____

Identification Number: _____ Group#: _____ Subscriber's SS#: _____ - _____ - _____

Subscriber's Last Name: _____ First Name: _____ Relationship to Patient: _____

Subscriber's Address if different from Patient: _____

Subscriber's Home Phone: (____) _____ - _____ Sex: Male Female Subscriber's DOB: _____

Subscriber's Employer: _____ Work Phone: (____) _____ - _____

SECONDARY HEALTH INSURANCE INFORMATION

Name of Insurance Company: _____ Phone: (____) _____ - _____

Identification Number: _____ Group#: _____ Subscriber's SS#: _____ - _____ - _____

Subscriber's Last Name: _____ First Name: _____ Relationship to Patient: _____

Subscriber's Address if different from Patient: _____

Subscriber's Home Phone: (____) _____ - _____ Sex: Male Female Subscriber's DOB: _____

Subscriber's Employer: _____ Work Phone: (____) _____ - _____

If Accident or Injury, Date of Injury: _____

Type of Injury: AUTO WORK RELATED OTHER

Name of Insurance Company: _____ Phone: (____) _____ - _____

Address of Insurance Company: _____

Claim Number: _____ City & State of Accident: _____

Adjuster Name & Tel#: _____ Insured's Name: _____

Attorney Name, Address & Tel#: _____

Describe the Accident: _____

Signature of Patient/Guardian: _____

(Parent if under the age of 18)

Print Name: _____

Date: _____

PATIENT HISTORY

Patient Name: _____

Date: _____

Current Medications	Dosage	Review of System: Are You Experiencing Any Problems Regarding	YES	NO					
		1. NEURO							
			<i>Dizziness</i>						
			<i>Light-Headedness</i>						
			<i>Fainting</i>						
			<i>Weakness of arms/legs</i>						
Past Medical History	Patient		Family		2. CARDIAC				
	YES	NO	YES	NO		<i>Chest Pain</i>			
1. Heart Disease						<i>Chest Pressure</i>			
2. Hypertension						<i>Chest Tightness</i>			
3. Diabetes						<i>Chest Squeezing</i>			
4. Seizures or Strokes						<i>Palpitations</i>			
5. Tumors or Cancer						<i>Angina</i>			
6. Lung Disease						3. RESPIRATORY	<i>Shortness of Breath</i>		
7. Liver Disease							<i>Coughing</i>		
8. Ulcers							<i>Chest Pain</i>		
9. Kidney Disease							<i>Fevers</i>		
10. Tuberculosis							<i>Shortness of Breath While Lying Flat</i>		
11. Phlebitis or Blood Clots						4. GI	<i>Nausea</i>		
12. Thyroid Disease					<i>Vomiting</i>				
13. Other					<i>Vomiting Blood</i>				
Past Surgical History							<i>Black Stool</i>		
Operations			Date				<i>Diarrhea</i>		
							<i>Abdominal Pain</i>		
							<i>Weight Loss</i>		
					5. GU	<i>Burning While Urinating</i>			
						<i>Frequent Urination</i>			
						<i>Urinating at night frequency</i>			
Social History					6. OTHER	<i>Swelling of Legs</i>			
1. Tobacco		YES	NO			<i>Swelling of Joints</i>			
How many packs per day?		How many years?				<i>Inflammation of the Joints</i>			
Have you stopped?		YES	NO			<i>Pain While Walking</i>			
2. Alcohol		YES	NO		7. SKIN RASHES				
How many drinks per day?		How many years?							
3. Allergies to Medications: (IMPORTANT) *** <input type="checkbox"/> Yes *** <input type="checkbox"/> No If yes, please list:					Comments:				

MID ATLANTIC ORTHOPEDIC ASSOCIATES, LLP

557 Cranbury Road Suite# 10
East Brunswick, NJ 08816
Phone: 732.238.8800
Fax: 732.238.8246

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient: _____ Date: _____

Signature of Patient: _____ SSN: _____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative: _____ Date: _____

Signature of Personal Representative: _____ Relationship to Patient: _____

The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions. Please provide the following information:

Appointment Reminders/Test Results (laboratory, X-rays, etc)

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all items below that apply to you.

May we call to remind you of an appointment or regarding test results? (circle) Yes No

If we get an answering machine/voice mail, may we leave a message? (circle) Yes No

If we get a family member, may we leave a message? (circle) Yes No

If so, can we discuss your treatment/ progress/ results with them? Yes No

() Spouse _____

() Parent(s) _____

() Child(ren) _____

() Sibling(s) _____

() Other(s) _____

PATIENT AGREEMENT

In order to establish and maintain a physician-patient relationship with our practice, the following terms must be acknowledged by the patient or responsible party (parent, guardian, etc):

Authorization for release of information:

I authorize Mid Atlantic Orthopedic Associates, LLC to release to any medical insurance company, health plan, affiliated entity, or pharmaceutical company records needed to determine responsibility for medical benefits and to obtain reimbursement for professional services rendered or needed.

Signature: _____ Date: _____

Professional Fees

I understand that I am financially responsible for any and all charges for professional services, whether or not paid by an insurance carrier or health plan. Exceptions are when patient financial responsibility is limited by statutory regulation (such as an authorized Workers' Compensation claim, Medicare fee schedule, Motor Vehicle fee schedule) or by managed care (HMO, PPO, etc.) contract.

In those instances in which the Doctor is to be paid by my insurance carrier, I

- a) Understand that it is my responsibility to pay, in a timely manner, any deductible, co-payment, and "non-covered" services (i.e.: items which may not be covered by particular insurance plans, such as crutches, braces, etc)
- b) Request that payment of authorized medical be made on my behalf and assigned to Mid Atlantic Orthopedic associated, LLC.
- c) Understand that in the event my insurance carrier issues payment directly to me it is my responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to Mid Atlantic Associates, LLC.

Signature: _____ Date: _____

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports, or other paperwork may require a fee, paid in advance, related to the amount of the preparation involved. Please allow 5 business days for completion of any disability forms.

Medical-Legal Reports/Testimony

I acknowledge this office's policy regarding medical-legal reports and testimony. Upon proper written authorization and pre-paid copying/clerical/postage fees, copies of medical records will be provided. The doctors do not testify, nor make court appearances. Permanency evaluation and narrative reports are prepared at their discretion. If this policy is unacceptable to me or my attorney, I am aware that I should seek further orthopedic treatment elsewhere. Records will not be released until patient's balance is paid in full, unless essential for medical care.

Initials: _____ Date _____

Managed Care

In order for any Managed Care agreement/fee schedule to be applicable and valid,

- a) The patient must provide proof of coverage (valid insurance ID card) at the time of service
- b) Any required written authorization/referral must be provided at the time of service
- c) Any managed care co-payment is due at the time of each office visit

Initials: _____ Date _____

Workers' Compensation/No Fault Accidents

It is the patient's responsibility to clearly identify those medical injuries/conditions, which he/she believes are due to a motor vehicle accident, or are work related at the time of the initial visit.

Workers' Compensation Claims

In order for this office to submit a claim for medical services to be covered by Workers' Compensation, we must receive written (letter or fax) authorization from the employer or it's Workers' Compensation Insurance Carrier prior to the initial office visit. The patient is responsible for any charges for professional services, which are denied due to lack of proper authorization.

Insurance claims for work related injuries and conditions must be submitted via Workers' Compensation and cannot be billed to the patients' private insurance (managed care or otherwise) unless Workers' Compensation coverage has been denied, does not exist or your case has been settled.

Motor Vehicle (PIP) Claims

Insurance claims resulting from Motor Vehicle accidents must be submitted to you Motor Vehicle (PIP) carrier and cannot be billed to patient's private insurance unless PIP coverage has been denied, does not exist or private insurance was selected as primary carrier. The patient is responsible for any deductibles or co- payments, under their PIP coverage. I agree to have a lien placed against any settlement I receive due to this accident to pay any open balances due to Mid Atlantic Orthopedic Associates, LLC

Initials: _____

Date _____

X-Rays

The x-rays performed in our office constitute an integral part of the medical records. Fees for x-rays are for the professional services rendered and medical information obtained, and are not to be misconstrued as a purchase of the films. Our practice reserves the right to keep all original films, and in such cases will arrange for the patient to pick-up and sign out films. We do not have the ability to copy films in this office. If you need your films please allow a minimum of 48 hours for your request to be processed.

Cost of Collection

If this account becomes delinquent, I may be responsible for additional billing cost; and if this account is assigned to a collection agency or attorney for collection, **I agree to the addition of a collection surcharge of \$50.00 or 19% of the balance owed**, whichever is greater. I acknowledge a fee of \$30.00 or the actual bank charge, whichever is greater, for any returned check.

A photocopy of this form shall be considered as valid as the original.

Missed Appointment Policy

We ask you to show consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor.

This letter serves as a notice that if you fail to give us a 24-hour notice of cancellation in the future, there will be a cancellation fee billed to your account that is non-covered by your insurance. The fee will be \$25.00 for an established patient and \$50.00 for a new patient. You will bear complete financial responsibility for this fee.

Date

Signature of patient (or parent/guardian)

Print name of patient (or parent/guardian)

MEDICAL RECORDS RELEASE
MID ATLANTIC ORTHOPEDIC ASSOCIATES, LLP.

557 Cranbury Road Suite# 10

East Brunswick, NJ 08816

Phone: 732.238.8800

Fax: 732.238.8246

Date: _____

I, _____ authorize the office of

_____ to release my records to Mid Atlantic

Orthopedic Associates, LLP. Please fax records to 732-238-8246.

Patients Name: _____

Address: _____

DOB: _____

Phone: _____

Patients Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

MID ATLANTIC ORTHOPEDIC ASSOCIATES, LLP.

557 Cranbury Road Suite# 10

East Brunswick, NJ 08816

Phone: 732.238.8800

Fax: 732.238.8246

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.

OUR COMMITMENT TO PROTECTING YOUR PERSONAL HEALTH INFORMATION

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.

1. 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 related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 your 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.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, 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.

Other Uses and Disclosure We Can Make Without Your Written Authorization or Opportunity to Agree or Object:

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as 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; Workers 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 Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke your 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.

2. YOUR RIGHTS

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 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.

You have the right to request a restriction of your protected 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 protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the 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. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

3. 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 contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer, Sue Dalton, in person or by phone at 732.238.8800.