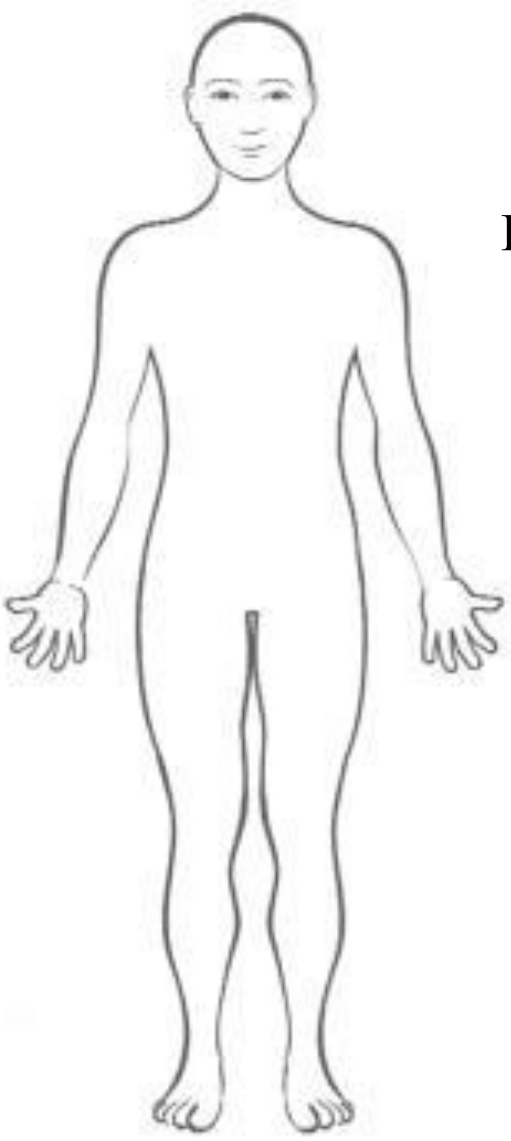
Patient Name: _____

Date: _____ **DOB:** _____

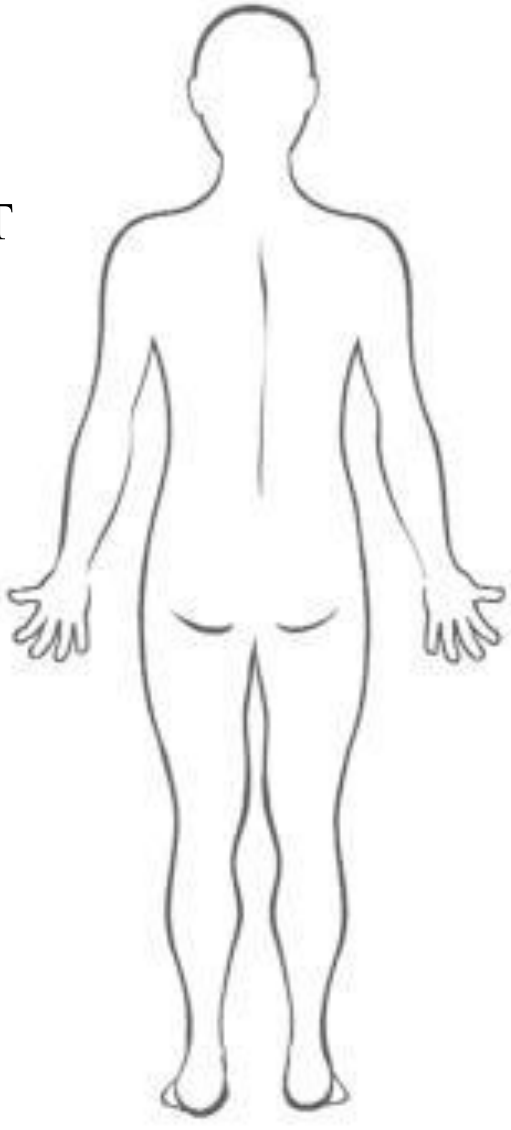
Height: _____ Weight: _____

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

Past Medical History	Patient		Family	
	YES	*NO*	*YES*	*NO*
1. Heart Disease				
2. Hypertension				
3. Diabetes				
4. Seizures or Strokes				
5. Tumors or Cancer				
6. Lung Disease				
7. Liver Disease				
8. Ulcers				
9. Kidney Disease				
10. Tuberculosis				
11. Phlebitis or Blood Clots				
12. Thyroid Disease				
13. Other				

Past Surgical History

Operations	Date

Social History

1. **Tobacco**	**YES**	**NO**
How many packs per day?	How many years?	
Have you stopped?	**YES**	**NO**
2. **Alcohol**	**YES**	**NO**
How many drinks per day?	How many years?	

3. **Allergies to Medications:** ***(IMPORTANT)***

*****□ Yes** ***** □ No**

If yes, please list:

Review of System: Are You Experiencing Any Problems Regarding		YES	NO
1. NEURO	*Dizziness*		
	Light-Headedness		
	Fainting		
	Weakness of arms/legs		
2. CARDIAC	*Chest Pain*		
	Chest Pressure		
	Chest Tightness		
	Chest Squeezing		
	Palpitations		
	Angina		
3. RESPIRATORY	*Shortness of Breath*		
	Coughing		
	Chest Pain		
	Fevers		
	Shortness of Breath While Lying Flat		
4. GI	*Nausea*		
	Vomiting		
	Vomiting Blood		
	Black Stool		
	Diarrhea		
	Abdominal Pain		
	Weight Loss		
5. GU	*Burning While Urinating*		
	Frequent Urination		
	Urinating at night frequency		
6. OTHER	*Swelling of Legs*		
	Swelling of Joints		
	Inflammation of the Joints		
	Pain While Walking		
7. SKIN RASHES			

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 t 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)

HIPPA COMPIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: _____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

_____
Street Address

_____
City, State and Zip Code

RE: Patient Name: _____

Date of Birth: _____ Social Security Number: _____-_____-_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclosure full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, r ports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All disability, Medicaid or Medicare records including claim forms and record of denial benefits.

☐ All employment, personnel or wage records.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial benefits for the period of _____ to _____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: _____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which has been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____

Name of Representative

_____

Representative Capacity (e.g. attorney, records requestor, agent, etc.)

_____

Street Address

_____

City, State and Zip Code

I understand the following: See CFR § 164.502(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative (See 45CFR § 164.508(c)(1)(vi)) Date

_____

Name and Relationship of Legally Authorized Representative to Patient (See 45CFR § 164.508(c)(1)(vi))

_____ _____

Witness Date

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.