Mid Atlantic Orthopedic Associates, LLP

Today's Date:_____

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/Pager: (_____)_____-_____

Email Address: _____ Home Fax tel#: (_____)_____-_____

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: _____

Referring/Primary Doctor Name, Address & tel#: _____

_____

PRIMARY HEALTH INSURANCE INFORMATION

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

Identification Number: _____ GRP#: _____ 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: _____ GRP#: _____ 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, 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: _____

Even though an insurance claim might be filed, you remain the financially responsible party for services rendered to you by Mid Atlantic Orthopedic Associates, LLP. Payment is expected upon receipt of this bill. This office cannot accept responsibility for negotiating a settlement on disputed claims. You are responsible for payment of your account within the limits of our credit policy. If a payment from your insurance company results in an overpayment on your account, this overpayment will be refunded to you immediately. If you have any questions regarding your account, please feel free to contact us and we will do our best to help you.

Accounts 30 days past due will be considered in default and it may become necessary to refer your account to an attorney for collections. If your account is referred to an attorney for collections, you are responsible to pay all amounts, including attorney's fees in the amount of 30% of the default amount placed for collections. The attorney's fees in the above amount shall become due and owing at the time the account is placed for collections and will be assessed and added to the balance due at that time.

I request that payment of authorized benefits be made to Mid Atlantic Orthopedic Associates, LLP for any services rendered to me by that physician. I guarantee payment of all charges not covered by my insurance company. I authorize any holder of medical information about me to release to my insurance company, my attorney, or my employer and their agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient/Guardian: _____ Print Name: _____ Date: _____

(Parent if under age of 18)

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*				

Past Surgical History

Operations	Date

Social History

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

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

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:_____

For Practice Use Only:

_____

Signature of Practice Employee:_____ Date:_____

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 send an appointment reminder card to your home address? (circle) Yes No

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

Please call me at the following number(s):

Home phone:_____ Cell Phone:_____

Work phone:_____ Email address:_____

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

Policy for Discussing Your Medical Information with Family Members

Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

( ) Spouse_____

( ) Parent(s) _____

( ) Child(ren) _____

( ) Sibling(s) _____

( ) Other(s) _____

MID ATLANTIC ORTHOPEDIC ASSOCIATES, LLP.
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 21% 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)

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, Peggy Kolb, in person or by phone at 732.238.8800.