



SPINE CENTER & ORTHOPEDIC REHABILITATION OF ENGLEWOOD, PC

Today's Date _____

Last Name _____ Middle _____ First _____ Sex: Male _____ Female _____

Street Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____ What is the best way to reach you during the day? _____

Date of Birth _____ Age _____ Social Security # _____ Marital status _____

Employer's name _____

Employer's address _____

Next of Kin _____ Relationship _____ Phone _____

Spouse's Name _____ Date of Birth _____ Age _____ S.S. # _____

Spouse's Employer name _____ Work Phone _____

Patient Emergency contact information

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

HOW DID YOU HEAR ABOUT US? _____

Referred by _____ Phone _____

Family Physician _____ Phone _____

Address _____

PRIMARY INSURANCE

Name of Company _____ Phone _____

Address _____

City _____ State _____ Zip _____

Group # _____ Policy # _____

Subscriber's Name _____ S.S. # _____ Date of Birth _____

Referral Required ___ Yes ___ No Prescription Required ___ Yes ___ No Co-pay ___ Yes ___ No

SECONDARY INSURANCE

Name of Company _____ Phone _____

Address _____

City _____ State _____ Zip _____

Group # _____ Policy # _____

Subscriber's Name _____ S.S. # _____ Date of Birth _____

Referral Required ___ Yes ___ No Prescription Required ___ Yes ___ No Co-pay ___ Yes ___

*****IF YOUR VISIT TODAY IS RELATED TO A MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION PLEASE FILL OUT INFORMATION ON REVERSE SIDE OF THIS FORM*****

MOTOR VEHICLE AND WORKER'S COMPENSATION INFORMATION

Date of Accident _____ Motor vehicle Workers' Compensation

Insurance Company _____ Adjuster _____ Phone _____

Claim# _____ Employer at time of injury _____

Motor vehicle---Have you filled out and submitted your PIP application? Yes No

Workers' Compensation—Has your employer filed an accident report? Yes No

Attorney's Name _____ Phone _____

Attorney's Address _____

Insured's Name (if not the same) _____ Phone _____

Insured's Address _____

Have you had treatment elsewhere for this injury? Yes No If yes, where? _____



DATE _____

NAME _____ AGE _____ HEIGHT _____ WT _____

PAST MEDICAL HISTORY

- High blood pressure, Heart disease, Diabetes Type 1, Type 2, Bleeding ulcer, Reflux, Osteoporosis, Osteopenia, Kidney disease, Hypothyroidism, Lung disease (COPD, emphysema, asthma), Arthritis, Depression/anxiety, High cholesterol, Cancer (type), Other, Neck/Back Pain, Previous Pain Management: spinal injections, physical therapy, medications, chiropractic, acupuncture

PAST SURGICAL HISTORY (PLEASE LIST & PROVIDE DATES)

CURRENT MEDICATIONS AND DOSAGE-----

YOUR PHARMACY NAME TOWN PHONE NUMBER

ALLERGIES TO MEDICATIONS, CONTRAST DYE, LATEX

SOCIAL HISTORY

Marital Status Occupation Physical demands at work Smoking History: Never Quit Current smoker of packs/day Recreational drugs use: Never Quit Hobbies/Sports Exercise routine

FAMILY HISTORY (Note immediate family member with any of the conditions below)

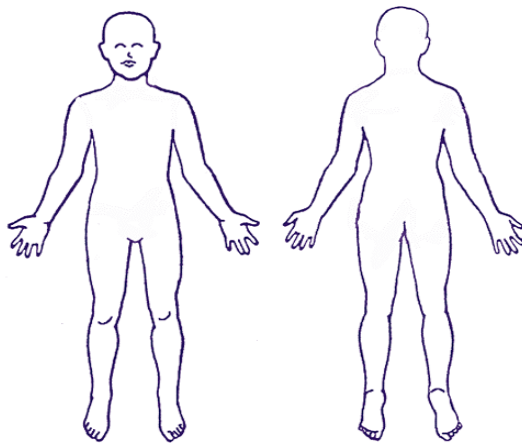
- Heart disease, Diabetes, Cancer, Arthritis, Neurological disorders(Stroke, MS), Osteoporosis

REVIEW OF SYSTEMS (please circle response)

CONSTITUTIONAL: Any recent changes in weight or appetite? Yes No Any fevers, chills, sweats, fatigue? Yes No SKIN: Do you have any rashes, sores, itching, changes in moles? Yes No ENT: Do you have any trouble with your vision or hearing? Yes No RESPIRATORY: Do you have trouble breathing, persistent cough or phlegm? wheeze? Yes No GI: Do you suffer from diarrhea, nausea, vomiting, constipation, bloody or black stools? Yes No GU: Do you have trouble starting or stopping you urine? Yes No Do you lose your urine accidentally? Yes No Do you have frequency of urination, bloody or cloudy urine? Yes No Men: Do you have a discharge from your penis? Yes No

Women: Do you have any lumps, discharges, or pain in your breasts? _____ Yes No
 Do you have any vaginal discharge? _____ Yes No
 If menopausal, age at menopause _____
CARDIAC: Have you had chest pain, shortness of breath, palpitations? _____ Yes No
 Have you had a heart attack? _____ Yes No
 Have you had a stress test? If so, results _____ Yes No
HEMATOLOGIC: Do you bruise or bleed easily? Do you have a low blood count? _____ Yes No
NEUROLOGIC: Do you have frequent headaches or migraines? _____ Yes No
 Do you have any numbness or tingling in your arms or legs? _____ Yes No
 Do you have serious trouble with your memory? _____ Yes No
 Have you had seizures, TIA, or a stroke? _____ Yes No
ALLERGIC: Do you have any allergies or swollen glands _____ Yes No
PSYCHIATRIC: Do you often feel depressed, sad, or anxious? _____ Yes No
 Do you have trouble sleeping? _____ Yes No

On the diagram, shade in the areas where you feel pain. Put an X where it hurts the most.



Please rate your pain by circling the one number that best describes your pain at its **WORST** in the last 24 hours. _____

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain you can imagine

Please rate your pain by circling the one number that best describes the **LEAST** pain in the past 24 hours. _____

No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain you can imagine



PATIENT NAME _____

ASSIGNMENT OF BENEFITS

I irrevocably assign to Spine Center and Orthopedic Rehabilitation of Englewood (SCORE) all of my rights and benefits under any insurance contracts for payment for services rendered to me by SCORE. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by SCORE to be released to SCORE. I irrevocably authorize SCORE to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to SCORE. I irrevocably authorize SCORE to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize SCORE to obtain counsel and enter legal or other action on my behalf and /or in my name, including the arbitration/dispute resolution process, to collect such sums due it, should sums not be paid within the legally prescribed time frame. In the event that SCORE elect to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I irrevocably assign my rights title, and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitle to proceed for benefits. This assignment shall allow an attorney of SCORE choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize SCORE to appoint an attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of SCORE.

The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to SCORE upon receipt of the same.

A photocopy of this agreement shall be valid as the original. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

SIGNATURE _____ **DATE** _____



SCORE SPINE CENTER & ORTHOPEDIC REHABILITATION OF ENGLEWOOD, PC

RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I have received a copy of the Health Insurance Privacy and Portability Accessibility Act (HIPPA).

SIGNATURE _____ **DATE** _____

NOTICE OF PRIVACY POLICIES

This notice describes the privacy practices of The Spine Center and Orthopedic Rehabilitation of Englewood (SCORE) and how SCORE may use and disclose your protected health information to carry out treatment, payment or healthcare operations 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.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with any revised Notice of Privacy Practices by (accessing our website www.SCORENJ.com), calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent You will be asked by SCORE to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in Section A.

Permissible Uses and Disclosures Without Your Written Authorization In certain situations, which we will describe in Section B, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures.

SECTION A:

- Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you and conduct our "health care operations" (e.g. internal administration, quality improvement and customer service) as detailed below:
- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. 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.
- In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. 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 activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities.

- In order to maintain our health care operation we may disclose your protected health information because 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, via phone and leave a message on your answering machine.
- We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.
- **Emergencies:** If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.
- Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
- Victim of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a government authority, including, a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
- Health Oversight Activities. We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare.
- Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
- Law Enforcement Officials. We may disclose PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.
- Decedents. We may disclose PHI to a coroner or medical examiner as authorized by law.
- Organ and Tissue Procurement. We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
- Research. We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.
- Health or Safety. We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person's or the public health or safety.
- Specialized Government Functions. We may use and disclose PHI to units of the government with special functions, such as the U.S. Military or the U.S. Department of State under certain circumstances required by law.
- Workers' Compensation. We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
- As required by law. We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

SECTION B:

- **Use and Disclosures Requiring Your Written Authorization**
- **Use or Disclosure with Your Authorization.** For any purpose other than the ones described in Section A, we only may use or disclose PHI when (1) you give us your authorization on The Spine Institute's authorization form.
- For instance, you will need to execute an authorization form before we can send your PHI to your life insurance company, to your child's camp or school, to your employer, or to the attorney representing the other party in litigation in which you are involved.
- **Special Authorization.** Confidential HIV-related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, HIV-related illness or AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) will never be used or disclosed to any person without your specific written authorization, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances to public health or other government officials (as required by law), to persons specified in a special court order, to insurers as necessary for payment for your care or treatment, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth in New York State law). This special written authorization is a New York State approved form which is a separate document from Your Authorization.

- There is only one type of disclosure of confidential HIV related information which is permitted with Your Authorization, as opposed to Your Special Authorization: disclosure to a third party payor for any reason other than obtaining payment for health care services rendered to you.
- Marketing Communications. We must also obtain your written authorization prior to using your PHI to send you any marketing materials. (We can however, provide you with marketing material in a face-to-face encounter, without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.)
- **Your Individual Rights**
 - For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our Compliance Officer. You may also file written complaints with the Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with us or the Director.
 - Right to Receive Confidential Communications. You may request in writing for someone other than yourself to receive PHI. We will not discuss medical treatment with unauthorized persons.
 - Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the office and submit the completed form to the Office Manager. If you request copies, we will charge you \$0.75 (75cents) for each page.
- You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to venereal disease, abortion, or care and treatment to which the minor is permitted to consent himself/herself (without your consent) such as HIV testing, sexually transmitted disease diagnosis and treatment, chemical dependence treatment, prenatal care, care received by a married minor, and contraception and/or family planning services).
- Right to Revoke Your Authorization. You may revoke Your Special Authorization, or Your Marketing Authorization, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Office Coordinator of The Spine Institute of Southern New Jersey.
- Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Office Coordinator. All requests for amendments must be in writing. The Office Coordinator will give the form to the The Spine Institute of Southern New Jersey Compliance Office for a decision.
- Right to Receive An Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply disclosure that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you \$5.00 per page of the accounting statement.
- Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

Effective Date and Duration of this Notice

A. Effective Date. This notice is effective on April 15, 2003.