Jersey Anesthesia & Pain Management Consultants, LLC

PATIENT INFORMATION

Today's Date _____ **SS#** _____

Name: _____ Date of Birth: _____

Home Address: _____ City/State/Zip_____

Home Telephone: _____ Work Telephone: _____ Cell #:_____

Name of Employer/Address_____

Name/Phone # of Emergency Contact: _____

Sex: M F Marital Status _____
Ethnicity:_____ Race:_____ Prefered Language:_____
Are you currently serving in the Armed Forces : Y or N

REASON FOR VISIT (Chief Complaint) _____

REFERRED BY: _____

OTHER TREATING DOCTORS:

Name: _____ Address/Phone: _____

Name: _____ Address/Phone: _____

INSURANCE INFORMATION:

Primary Insurance
Insurance Company _____

Policy Holder _____ Policy # _____

SS # (if different from pt)_____ Date of birth _____

Do you have any other health coverage? _____

Secondary Insurance
Insurance Company _____

Policy Holder _____ Policy # _____

SS # (if different from pt) _____ Date of birth _____

Employer: _____

Address: _____

Phone: _____

Do you:

Smoke tobacco	N	Y _____ packs/day for _____ years
Drink alcohol	N	Y _____ drinks/day
Use recreational drugs	N	Y _____

Do you have any problems with your (circle all that apply)

Heart	Lungs	Liver	If yes please list:
Kidneys	Blood pressure	Diabetes	_____
Arthritis	Excessive bleeding or bruising		_____

Allergies Yes or No

List all previous surgeries with year

_____

_____

_____

_____

List all current prescription medications you are taking (and doses)

_____

_____

Please list all over the counter medications/vitamins/herbs you are currently taking:

_____

_____

_____

When did you first notice the pain for which you are being treated? _____

What time of the day is your pain the worst? _____

Where is your pain located? _____

Do you take any medicines for pain relief?

Never	Yes, 1 or 2 times/day
Yes, less than 1x/wk	Yes, 3 or 4 times/day
Yes, several times/wk	Yes, 5 or more times/day

Pharmacy Name_____

Phone Number_____ Address_____

Jersey Anesthesia & Pain Management Consultants, LLC

1. CONSENT

I authorize Jersey Anesthesia & Pain Management Consultants, LLC to provide the medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include pathology, radiology, physical therapy, or emergency and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance that are capable of transmitting disease and I am unable to consult timely with my physician prior to testing, I consent to limited testing to determine the presence, if any, of antibodies to hepatitis A, B, and C and HIV.

Signature Date

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of patient health information. I hereby authorize my treating physician to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. Any third party billing company

b. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.

c. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring

d. Any continuing care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

Signature Date

3. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided to the above-named patient by Jersey Anesthesia & Pain Management Consultants, LLC, the undersigned agrees, whether he/she signs as patient or guarantor, to pay Jersey Anesthesia & Pain Management Consultants, LLC for all services ordered by the attending physician, or requested by the patient and/or the patient's family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

Signature Date

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Jersey Anesthesia & Pain Management Consultants, LLC I authorize direct payment to Jersey Anesthesia & Pain Management Consultants, LLC of all insurance benefits applicable to these medical and other services, which are now or which shall become due and payable to me. Should payment be sent to me, I understand that I am responsible to immediately remit payment to Jersey Anesthesia & Pain Manangement Consultants, LLC

Signature Date

HIPAA – Notice of Privacy Practices Acknowledgement

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared. I acknowledge that Jersey Anesthesia & Pain Management Consultants, LLC & staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Jersey Anesthesia & Pain Management Consultants, LLC operations and responsibilities.

Initials of patient or person authorized to sign HIPAA Notice for patient _____

Signature Date

_____

Name of person authorized to consent (if not patient) Date

Patient's relationship to person _____

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I hereby authorize Jersey Anesthesia & Pain Management Consultants to obtain copies of any necessary medical records regarding my current condition/ treatment on my behalf.

Patient Signature_____ Date _____

Jersey Anesthesia & Pain Management Consultants, LLC

Financial Policy Statement

Please Read Carefully:

- We do not participate with many insurance plans. But we will bill your insurance carrier solely as a courtesy to you.
- It is your responsibility to furnish our office with copies of your insurance card(s) and give us any changes in your benefit plan(s) that will assist us in obtaining reimbursement from your carrier(s).
- It is your responsibility to notify us whether your claim is a Workers' Compensation or a Motor Vehicle accident, and provided all necessary documents in order for us to file claims on your behalf.
- We require that arrangements for payment of your share (i.e., co-payments and/or deductibles) of our bill be made at the time of visit.
- Should our claim be denied because you provided incorrect/inaccurate/out-dated insurance information, you will be expected to remit payment in full, and file claims on your own behalf.
- If your insurance carrier (other than WC and/or MVA) does not remit payment on a correctly submitted claim within (60) days of submission, the balance will be due from you. Frequently a call from you resolves delays immediately.

If any payment is made directly to you, for services billed by us, you recognize an obligation to promptly remit it to Jersey Anesthesia & Pain Management Consultants, LLC. If we make a call to the carrier and discover that payment was indeed made to you more than 14 days previously, you will be responsible for our charges IN FULL. In addition, you may also be liable for insurance fraud, a federal offense.

Acknowledgement:
I UNDERSTAND MY RESPONIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____

Parent/Guardian/Responsible Party Date