Jersey Anesthesia & Pain Management Consultants, LLC
MVA, WORKER'S COMP. AND SLIP AND FALL – INTAKE FORM

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____

Home Phone #: ( ) _____ Business Phone #: ( ) _____

Cell Phone #: ( ) _____ E-Mail Address: _____

Marital Status: _____ Sex: M F
Ethnicity:_____ Race:_____ Preferred Language:_____

Are you now or have you ever served in the armed forces Y or N

Employer Name/Address: _____

Date of Accident: _____ Referred by: _____

Emergency Contact: _____ Relation: _____ Phone: _____

If you were treated at any hospital, name of facility: _____

Reason for Visit – (Chief Complaint):

_____

OTHER TREATING DOCTORS:

Name: _____ Address/Phone: _____

Name: _____ Address/Phone: _____

Name: _____ Address/Phone: _____

ATTORNEY NAME: _____ Phone: _____

Attorney Address: _____

Do you own an automobile: Y or N Make/Model/Year _____

Did you have auto insurance on the date you were injured : Y or N

Insurance Carrier:_____ Address : _____

Claim #_____ Adjuster: _____

Health Insurance: (please provide copy to front desk)

Carrier: _____ ID#:_____

Address/City/Zip :_____

Name of insured: _____ Relationship to patient: _____

If you did not have your own automobile insurance at the time of your injury, did you live in the same household for any part of the year with any person who owns an automobile? Yes or NO

What is your relationship to the owner of the automobile?

_____

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_____

If you were a passenger in an automobile at the time you were injured, what is the name and address of the owner/operator of the automobile?

_____

What is the name of the insurance company that insures this automobile?

_____

Were you a pedestrian or cyclist struck by an automobile at the time you were injured? Y or N

If Yes: What is the name and address of the owner/ operator of the auto that hit you:

_____

What is the name of the insurance company that insures this automobile?

_____

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	Allergies Yes or No
Kidneys	Blood pressure	Diabetes	If yes please list:
Arthritis	Excessive bleeding or bruising		_____
			_____

List all previous surgeries by 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? (circle one)

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 #: _____

Address_____

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

I hereby authorize Jersey Anesthesia & Pain Management Consultants, LLC 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
940 Amboy Avenue Ste. 104-A
Edison, NJ 08527

ASSIGNMENT OF INSURANCE BENEFITS & LIMITED POWER OF ATTORNEY

PATIENT'S NAME _____

DATE OF ACCIDENT _____

I **irrevocably assign** to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case including filing an arbitration demand or lawsuit, I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier to pay you directly any monies due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.
I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

_____ _____

Patients Signature Date

If not patient, relationship: _____

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 Management 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 _____

_____ _____

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, 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