PRIME NEURO SPINE
INSTITUTE

Patient Form | HIPPA

Patient Information

Patient First Name	Patient Middle Name	Patient Last Name	Patient Preferred Name
Sex	Social Security Number	Date of Birth	
Primary Phone	Cell Phone	Email Address	
Address	City	State	Zip
Emergency Contact First Name	Emergency Contact Last Name	Emergency Contact Phone	Emergency Contact Reletionship
Occupation	Employment Type	Employer Name	Work Phone
Work Address	City	State	Zip
Position			

New Patients: How did you hear about PRIME NEURO SPINE INSTITUTE?

Family | Friend   Self-Referred   Google Search   Facebook

If the Physician referred or other please explain:

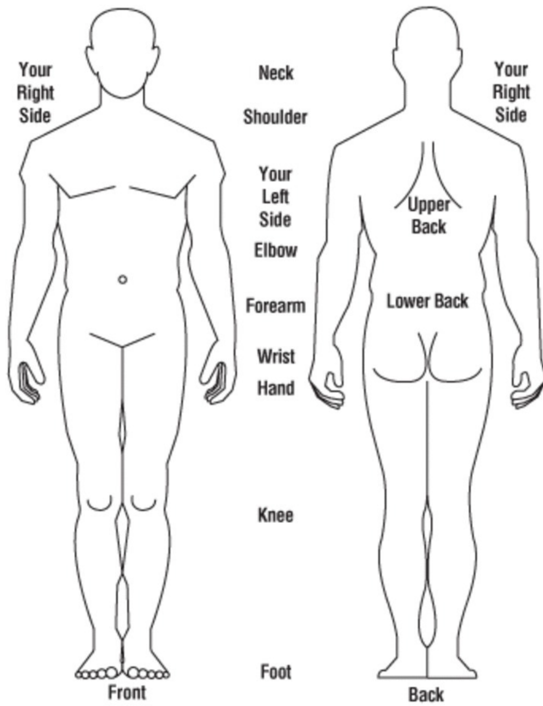
Medication List

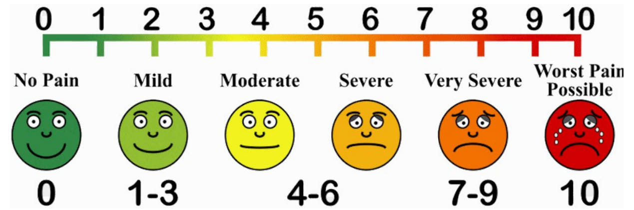
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:
Medication Name:	Dosage:	Frequency:

Will you be bringing with you a SEPARATE MEDICATION LIST?

Patient Form | HIPPA

Please Cirlce Areas of Pain:





Please describe more about the areas you circled:

Conservative Treatment Prior to Office Visit Today

Physical Therapy | Chiropractor — **Was it successful?** — **Did you only get temporary relief?**

Comments

Brace — **Was it successful?** — **Did you only get temporary relief?**

Comments

Injections — **Was it successful?** — **Did you only get temporary relief?**

Comments

Medication — **Was it successful?** — **Did you only get temporary relief?**

Comments

Acupuncture — **Was it successful?** — **Did you only get temporary relief?**

Comments

Allergies:

Social History:	**Never**	**Former**	**Occasionally**	**Frequently**	**Daily**
Alcohol Use	☐	☐	☐	☐	☐
Cigarettes | Cigars	☐	☐	☐	☐	☐
Pipe	☐	☐	☐	☐	☐
Chewing Tobacco	☐	☐	☐	☐	☐
Vape	☐	☐	☐	☐	☐

Past Medical History | Please Check All That Apply

Diabetes Hypertension
High Cholesterol
Cancer
Stroke
Kidney Disease
Renal Failure
Coronary Artery Disease Heart
Arrythmia Myocardial Infraction
Heart Attack
Mitral Valve Prolapse
Cardiac Pacemaker
Pulmonary Embolism
Deep Vain Thrombosis
Depression
Bipolar Disorder
Anxiety
Schizophrenia
Seizure
Disorder
Dementia
Alzheimer's Disease
Hepatitis A,B,C
Turberculosis
Pneumonia
Chronic Obstructive Pulmonary Disease (COPD)
Asthma
Bleeding Disorder
Anemia
Autoimmune Disease
Cataracts
Glaucoma
Thyroid Disease (hypo/hyper)
Rheumatoid Arthritis
Cirrhosis of Liver
HIV
Gout
GI Bleed
Ulcer
Acid Reflux
Diverticulitis
Chron's Disease
Missing Limb Status

Past Surgical History | Please Check All The Apply

Spine
Brain
Spinal Chord
Stimulator
Cardiac Pacemaker
Cardiac Stent
Vascular Stent of arms of legs
Hysterectomy
Vasectomy
Circumcision
Lumpectomy
Mastectomy
Breast Implant
Reduction Joint Replacement
Foot
Knee
Shoulder
Elbow
Hand
Hip
Carpal Tunnel Release
Retina Cataract
C-Section
Gall Bladder Removal
Cardiac Bypass Surgery
Aortic Valve Replacement
Appendectomy
Tonsillectomy
Kidney Transplant
Gastric Bypass
Gastric Sleeve
Limb Amputation
Bladder Sling
Colostomy
Lymph Node
Other Past Medical History:

Family History | Circle if applicable and relationship

Cancer:	Mother	Father	Sister	Brother
Diabetes: **Epilepsy:**	Mother	Father	Sister	Brother
Tuberculosis:	Mother	Father	Sister	Brother
Stroke:	Mother	Father	Sister	Brother
Heart Trouble:	Mother	Father	Sister	Brother
High Blood Pressure:	Mother	Father	Sister	Brother
Other:	Mother	Father	Sister	Brother

Patient Policies

NARCOTICS AND MEDICATIONS:

Please allow 48 hours for a response to medication requests. Narcotics are not prescribed as a general pain treatment. As surgeons, we recommend pain management techniques or surgery to treat pain. Medications are not prescribed prior to surgical intervention. We do prescribe postoperative pain management medications in the form of narcotics for a determined period-of- time and not later than 3 months after surgery. It is our policy to prescribe urinary drug testing on any of our patients that are prescribed narcotic medications by our office. Patients receiving narcotic medications in their postoperative period must contact the office with 72-hour lag time for prescription refills. Prescriptions will not be refilled in a 24-hour time slot or on weekends. Prescriptions may be mailed to the patient's address on file or picked up at the office. A signed Pain Management Agreement may be necessary to continue to provide narcotic medications.

FILM AND DISKS:

Please allow two weeks for our physician to review your films/ disks and contact you with an interpretation. We cannot mail your films/ disks back to you and therefore, must be picked up in person. If you cannot pick them up within three months, they will be destroyed according to our office policy. We kindly ask that all New Patients arrive to the office with imaging CD's or films. The physician requires imaging for review for and appropriate consult and evaluation.

CONTACT:

We may contact you via text message, cell phone, or email unless you provide written notification to opt out.

FORMS AND CLAIMS:

Please allow 10-days for our Physicians to complete paperwork related to our treatment. When you submit claims/ forms please include instruction for their disbursement**.**

INSURANCE BENEFIT INFORMATION:

With exception to Medicare, **PRIME NEURO SPINE INSTITUTE** is **out of network** with all other insurance carriers. This is very commonplace among Neurosurgery practices in our area. Out of Network means we do not participate with most insurance plans. However, many insurance plans provide for Out of Network benefits, which allow us to work with your insurance company. Typically, patients who have Out of Network benefits will have a different responsibility. Each insurance plan is different, and we are here to assist you with understanding your plan.

FINANCIAL ARRANGEMENTS:

PRIME NEURO SPINE INSTITUTE recognizes that all healthcare plans have shifted a greater responsibility to our patients to assist in paying for their care. We are committed to working with you needs not just medically, but financially as well.
By law, we are unable to "write off" co-insurances, copayments or deductibles. Our dedicated billing team works with each patient to create payment plans and assist them through the challenge of understanding their healthcare plans.

FINANCIAL POLICY: Our billing team will work diligently to assure your insurance company meets their obligations to you. If our billing team choses to appeal a decision, we ask you work with them to assist in assuring maximum reimbursement is obtained in order to reduce your out of pocket financial obligations.With your Out of Network Benefits, there are times when the insurance company will send the payment for services directly to the patient, rather than our office. The reason for this is many other practices chose to have the patient pay up front for services and are then reimbursed by the insurance company. We recognize this is a hardship for our patients and do not require payment up-front for our services. In the event that you receive any payment from an insurance carrier relating to services rendered, you agree to hold such payment in trust for the provider and agree to send any such payment to the provider within one week after receipt of same. Failure to submit this payment will result in an additional 18% monthly interest rate until the debt is paid in full. Furthermore, it is the responsibility of the patient to reimburse all attorneys' fees expended in connection with obtaining payment of the debt. Despite our efforts to arrange for payment plans over time after a patient is balanced billed, in the event that your account is turned over to an attorney for collection, you agree to pay a collection fee equal to 33 1/3% of the outstanding balance, plus court costs and attorney's fees.

AUTOMOBILE ACCIDENTS/WORKERS COMPENSATION:
You must have opened a claim with your insurance in order to be seen, Documentation must be provided from an adjuster on billing information. We do not accept letters of representation / protection from an attorney. Once documentation from your adjuster is received and benefits are available, we will file your claim. All patients seen for automobile accidents are required to provide their health insurance information in order to be treated in the practice.
You must have opened a claim with our employer to be seen. Documentation must be provided from adjuster employer on billing information. Once received, we will file your Workers Compensation insurance for you.

Patient Name ____

Signature ____

Permission for office to file complaint/ grievance/ appeal on patient's behalf for payment

To Whom It May Concern:

I authorize PRIME NEURO SPINE INSTITUTE to act as my representative in connection with complaint / grievance/ appeal with my insurance company.
I authorize this group to make any request to present or elicit evidence; to obtain information and to receive any notice in connection with my complaint/ grievance or appeal. I understand that personal health information related to my claim may be disclosed to my representative in the course of complaint/ grievance or appeal.

I have read this consent or have had it read to me and it has been explained to my satisfaction. I understand this information and grant my consent for my representative to file a complaint/ grievance or appeal on my behalf.

Thank you.

Patient Name

Date of Birth:

Signature

Assignment of Benefits

I, the undersigned, hereafter referred to as "The Patient" do hereby assign all of my rights and interests to PRIME NEURO SPINE INSTITUTE, hereafter referred to as "the Medical Provider" to pursue and obtain payment on my behalf**.** This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

I assign, to the Medical Provider, all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my medical bills, I hereby authorize and give the medical provider power of attorney to sign any documents on my behalf to pursue a claim for personal injury protection benefits. However, upon consent of both parties, same shall be revocable.
I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies undue on my account, or, have same deducted from any settlement made on my behalf.
I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/ or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.
I, the patient, do hereby acknowledge that I will not file suit and or arbitration for the payment of above providers medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Signature

Meaningful Use

To All New and Existing Patients:

Based on new healthcare regulations called Meaningful Use, we are required to ask you for the following information and document it in our computer system:

Date

Patient Name

Date of Birth:

Race:

White Black | African American Asian American Indian | Alaska Native
Native Hawaiian | Pacific Islander Other Race Unknown Declined

Ethnicity :

Hispanic or Latino Not Hispanic or Latino Unknown Declined

Preferred Communications: How would you like to be contacted by our office?

Phone Number E-Mail Mail

Phone Number: **Email:**

Mailing Address: **City:**

State: **Zip:**

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _______________________________________ hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations, Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risk.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient Name

Signature

Out of Network Disclosure

Dear Patient:

Please be advised that the **PRIME NEURO SPINE INSTITUTE** only participates with Medicare insurance.

Depending on your specific plan, you may have a financial responsibility for services related to your out-of-network deductible, co-pay and/or co-insurance. Additionally, you may be responsible for the portion of our charges that are not covered by your insurance and we recommend that you contact your insurance carrier for further information regarding the costs under your specific plan.

As a courtesy to our patients, we will bill your insurance company directly for reimbursement for our services. Occasionally, the insurance company will either mail the check or deposit our reimbursement for surgical fees directly to you. In these circumstances, we kindly request that you mail us a copy of the explanation of benefits (EOB) with the check from your insurance company endorsed by you, or in the case of monies being directly deposited, a check from you in the exact amount stated in the EOB made payable to **PRIME NEURO SPINE INSTITUTE**. Failure to comply will force your account to become past due. This may result in the amount owed being turned over to a collection agency and may adversely affect your credit.

We thank you for your cooperation in this matter and we are happy to assist you in any way we can.

I acknowledge that is an out-of-network provider and I elect to obtain services from PRIME NEURO SPINE INSTITUTE. I understand it is my responsibility to remit any funds rendered to me by my insurance carrier as payment for medical services provided to me by PRIME NEURO SPINE INSTITUTE. I hereby authorize PRIME NEURO SPINE INSTITUTE, its providers, or their authorized representatives, to appeal and pursue all other legal rights for any and all unpaid claims on my behalf with my insurance company. I also acknowledge that I have read the above information regarding fee disclosures.

Signature

HIPAA Authorization Form

HIPAA Authorization for Use or Disclosure of Health Information

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient First Name **Patient Middle Name** **Patient Last NamePatient** **Preferred Name**

Date of Birth **Social Security Number**

My Authorization

I authorize the following using or disclosing party:

To use or disclose the following health information.

All of my health information ☐

My health information covering the period from ☐

My health information relating to a specific treatment or condition: ☐

Other ☐

The above party may disclose this health information to the following recipient:

Name (or title) and organization

Address **City** **State** **Zip**

Cell Phone **Work Phone** **Email Address**

The purpose of this authorization is (check all that apply):

- ☐ **At my request**
- ☐ **To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.**
- ☐ **To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.**

This authorization ends:

My Rights as a Patient

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to: Prime Neuro Spine Institute. 115 Horseneck RD. Montville NJ 07045. I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive. The medical information may be used by the person I authorize to receive this information for my medical treatment of consultation, billing or claims payment, or other purposes as I may direct. I understand I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to condense a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient

Signature of Authorized Representative

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

Signature of Patient

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact [*Insert contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: 1-800-985-3059*].

Visit [*Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

Signature of Patient