INTEGRATED MEDICAL CARE

# Patient Intake Forms

First Name: **M.I:** Last Name:

Address: City: State: Zip:

Phone: Cell Phone: Email

Date Of Birth: Gender: Male / Female **SSN:**

Pharmacy: Location: Phone:

How did you hear of our practice: Referred by:

*Insurance Information:*

Primary Health Insurance Name:

Member ID: Group#:

Name of Insured: DOB:

Employer Name: Employer Phone number:

*Motor Vehicle Accident Info:*

Claim#: Auto Insurance Name:

Policy Limit:

Date of Accident: Adjuster Name: Adjuster Ph#:

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

Were you a pedestrian or cyclist struck by an automobile at the time you were injured? Yes No

Attorney Name:

Attorney Phone:

*Primary Care Doctor/Other Treating Doctors:*

Name Address/Phone:

Name Address/Phone:

Name Address/Phone:

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*Medical History*

Do you have any allergies? NO Yes List:

If "YES" describe allergic reaction:

Are you on any Medications? **NO** Yes List:

Any medical problems? **NO** Yes List:

Family history of medical problems? **NO** Yes List:

Have you had any previous surgeries? **NO** Yes List w/ date:

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

| | | |
|---|---|---|
| Heart | Lungs | Liver |
| Kidneys | Blood Pressure | Diabetes |
| Arthritis | Excessive bleeding or bruising | |

*Social History*

Tobacco Use: Do you smoke cigarettes? **NO** Never Smoked Quit (Date / / )

If Yes packs/day years Other tobacco products used:

Alcohol Use: Do you drink alcohol? **NO** Yes Number of drinks/week:

Drug Use: Do you use recreational drugs? **NO** Yes List:

*Current Condition:*

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

Where is your pain located? When

is your pain the worst?

Do you take any medicines for pain relief?

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## 1. CONSENT

I authorize Integrated Medical Care, tests, procedures, drugs, 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.

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**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. My referring physician, or any other physician or entity with a valid signed authorization d. Any continuing care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

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**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 Integrated Medical Care, LLC the undersigned agrees, whether he/she signs as patient or guarantor, to pay Integrated Medical Care, LLC t 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 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.

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**Signature** **Date**

# Patient Intake Forms

### 4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Integrated Medical Care, LLC I authorize direct payment to Integrated Medical Care, 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 Integrated Medical Care, LLC. If the insurance information is invalid, or my policy has been canceled, I understand that I am liable for all charges incurred by Integrated Medical Care, LLC on my behalf.

**Signature** **Date**

### 5. HIPPA- 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" which explains when, where and how my confidential health Information may be used or shared. I acknowledge that Integrated Medical Care, 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 Integrated Medical Care, LLC operations and responsibilities.

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides the uses and disclosures of my protected health information that may be made by Integrated Medical Care, LLC. Integrated Medical Care, LLC has the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Integrated Medical Care's current Notice of Privacy Practices on request.

**Print Name** **Signature** **Date of Birth**

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

INTEGRATED MEDICAL CARE

# Patient Intake Forms

## ***FINANCIAL POLICY STATEMENT***

***Please read carefully***

- We do not participate with many insurance plans except Clover and Medicare. 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 for Workers' Compensation or a motor vehicle accident, and provide 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 sixty (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 Integrated Medical Care, 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, afederal offense.*

**Acknowledgement:** I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

**Signature** **Date**

INTEGRATED MEDICAL CARE

# Patient Intake Forms

## *ASS/GMENT OF BENIFETS and LIMITED POWER OF ATTORNEY*

Patients Name: _____

Accident date: _____

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 the 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 money 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 fron:i 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.

Signature _____ Date _____

# Patient Intake Forms

## ***Notice***

If you have any new Insurance and do not provide the front desk with this Insurance information you will be held responsible for the entire balance.

Signature Date

_____ am fully aware that I will be made responsible for a $500.00 fee out of my own personal pocket for the cancellation of any type of procedure Without giving Integrated Medical Care, LLC (201-634-9000) and/or New Century Spine and Outpatient Surgical Institute, LLC (201-523-7800) 72 hours' notice.

Signature Date

Witness

INTEGRATED MEDICAL CARE

# Patient Intake Forms

## Conditional Assignment of Rights and Guarantee to Cooperate

This Conditional Assignment of Rights and Guarantee to Cooperate is made between Integrated Medical Care, LLC having offices located at 37 West Century Road Suite 101, Paramus, NJ 07652 hereinafter referred to as the "Provider", and the following individual, hereinafter referred to as the "Patient"

**Name of Patient:** _____

**Address:** _____

In consideration of services rendered, the Patient authorizes this Conditional Assignment of Rights and Guarantee to Cooperate to the benefit of the Provider. The Patient agrees to the following terms and conditions:

1. The Patient assigns directly to the Provider the payment of, and the right to collect payment of, any no fault automobile insurance benefits to which the Patient may be entitled for services rendered by the Provider.
2. Pre-certification: The Patient and the Provider agree to comply with any policy terms concerning pre certification of treatment, which may include a decision point review. The provider agrees to submit a proposed care plan to be approved by the carrier in accordance with N.J.A.C. 11:3-4. The provider shall hold the patient harmless for any co-penalty imposed for the failure to pre-certify treatment.

1. The patient authorizes, assigns, and directs payment of no-fault insurance benefits to the provider for medical invoices upon which payment is due for medical services rendered. Further, the Patient assigns to the Provider the right to prosecute claim(s) against the no-fault insurance carrier (the "carrier") named in this paragraph no. 2, for the payment of no-fault medical benefits to which the Patient is entitled in accordance with the applicable provisions of the following insurance policy:
2. Name of Insurance Carrier: _____
   Policy Number: _____
3. In the event that the Patient fails to file an application for benefits under the New Jersey State no- fault laws, and the Provider has not been paid by the carrier for medical services rendered to the Patient, the Provider is hereby authorized to file an application on the Patient's behalf in order that the Provider may realize payment.
4. Guarantee: The Patient agrees to fully cooperate with the Provider's efforts to prosecute a claim Against the no-fault insurance carrier in the event timely payment of medical benefits is not made to the Provider for services rendered.
5. This Limited Assignment of Rights and Guarantee to Cooperate shall be deemed a "limited assignment" to the Provider solely for the purpose of collecting payment from the carrier for medical services rendered.

**Approved and Agreed By:**

_____

**Patient Signature** **Date**

_____

**Physician** **Witness**

# Patient Intake Forms

## Disclosure of Physician Ownership

**To Our Patients:**

Federal Law Mandates that a physician must inform patients of any financial interest he may have in an ambulatory Surgical Center.

Accordingly, we wish to inform you that the following physician is an owner of **New Century Spine and Outpatient Surgical Institute.**

- **Thomas Ragukonis, MD.**

*This physician has become an owner as result of his commitment to quality health care and to provide better service to his patients. New Century Spine and Outpatient Surgical Institute is licensed by The State of New Jersey, fully accredited by AAAHC and certified by Medicare. You may, of course, seek treatment at a health care service of your own choice. A listing of alternative health care service providers can befound in the classified section of your telephone directory under the appropriate heading.*

**Signature** **Date**

# Patient Intake Forms

I do hereby authorize Integrated Medical Care, LLC to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc. in regard to the accident in which I was involved.

I hereby authorize and direct you my attorney, to pay directly to Integrated Medical Care, LLC such sums as may be due and owing for medical services rendered both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect them. I hereby further give a lien on my case to Integrated Medical Care, LLC against any and all proceeds of any settlement, judgment or verdict which may be paid to you my attorney, or to me as a result of the injuries for which I have been treated.

I fully understand that I am directly and fully responsible to Integrated Medical Care, LLC for all medical bills submitted by them for services rendered me and this agreement is made solely for Integrated Medical Care, LLC additional protection and in consideration of awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I further instruct that in the event another attorney is substituted in this matter, the new attorney, upon notice, shall honor this lien and deem it enforceable as if it were executed by him.

I have been advised that if my attorney does not wish to cooperate in protecting Integrated Medical Care, LLC interests, then Integrated Medical Care, LLC will not await payment but will require me to make payments on a current basis.

**Patient's Signature** **Date**

The undersigned, being attorney(s) of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said above Integrated Medical Care, LLC .

**Attorney's Signature** **Date**

New Jersey Department of Banking and Insurance

# CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

## APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage I: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke} your consent at any time. Your financial obligation, IF **ANY,** does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

## INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

## CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____ by marking I] (or [;]) and signing below, agree to:

0 representation by in an appeal of an adverse UM determination as allowed by N.L.S.A. 26:2S- I 1, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

0 release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: 0 I am the Patient 0 I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

**Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE I has been completed, signed and dated.**

New Jersey Department of Banking and Insurance

# NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance Consumer
Protection Services
Office of Managed Care -Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

**ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!**

## REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

D I hereby revoke my consent to representation by and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medi.cal information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID# _____ Date:_____

Relationship to Patient: D I am the Patient ☐ I am the Personal Representative

## Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information: PRINT

NAME: _____

ADDRESS:_____

_____

**PHONE:** _____ FAX: _____ **EMAIL:** _____

**of this document AFTER PAGE I has been completed, signed and dated.**



**Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages**