MARKBRIETER ORTHOPEDICS, PC-NEW PATIENT INFORMATION FORM

NAME_____ OFFICE:

ADDRESS _____ AGE _____ SEX Male Female

_____ ZIP CODE _____

TELEPHONE_____ CELL# _____ DATE OF BIRTH _____

SOCIAL SECURITY # _____ MARITAL STATUS_____ RIGHT HANDED ____ LEFT HANDED

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ ZIP CODE _____

TELEPHONE_____ CAN WE CONTACT YOUR WORK? YES NO

YOUR PRIMARY CARE PHYSICIAN (NAME & ADDRESS) _____

YOUR REFERRING PHYSICIAN (NAME & ADDRESS) _____

EMERGENCY CONTACT (NAME, PHONE. & RELATIONSHIP) _____

HOW DID YOUR INJURY HAPPEN? (PLEASE CIRCLE ONE)

AUTO WORK RELATED SLIP & FALL OTHER:_____

DATE OF ACCIDENT _____ ACCIDENT LOCATION (CITY/TOWN) _____

ATTORNEY'S NAME _____ TELEPHONE_____

PLEASE CIRCLE ONE: I AM MEDICARE BENEFICIARY: YES NO

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
NAME _____	NAME_____
ADDRESS _____	ADDRESS_____
_____	_____
TELEPHONE_____	TELEPHONE _____
CLAIM # _____	CLAIM / ID # _____
POLICY #_____	POLICY / GROUP #_____
ADJUSTER _____	SUBSCRIBER _____
INSURED_____	EFFECTIVE DATE _____

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO PHYSICIAN: I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO MARKBREITER ORTHOPEDIC, PC. ALL FEES OUT OF ANY BENEFIT OR INDEMNITY DUE ME UNDER THE TERMS OF MY POLICY, AND RECOGNIZE THAT PAYMENT IN THIS MANNER IS THE SAME AS PAYMENT TO ME. PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THIS ITEMIZED STATEMENT FOR SERVICES RENDERED TO ME. THIS POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME THAT SERVICES WERE RENDERED. PAYMENT OF THIS AMOUNT IS HEREIN DIRECTED IN WHOLE OR IN PART, SHALL BE CONSIDERED THE SAME AS IF PAID BY YOUR COMPANY DIRECTLY TO ME. THIS ALSO AUTHORIZES MARKBREITER ORTHOPEDICS, PC. TO RELEASE INFORMATION REGARDING MY ILLNESS TO MY REFERRING PHYSCIAN, ATTORNEY, AND INSURANCE COMPANY. I ASSIGN ALL MY RIGHTS, TITLE, AND INTEREST IN ANY SUCH BENEFIT TO MARKBREITER ORTHOPEDICS, PC. AND THIS ASSIGNMENT IS IRREVOCABLE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO MARKBREITER ORTHOPEDICS, PC. FOR MEDICAL SERVICES RENDERED TO ME BY MARKBREITER ORTHOPEDICS, PC.

Signature:_____ Date:_____

List any previous surgeries and dates (Not necessarily related to present problem)

Date	Surgery	Date	Surgery

List All Medications and Vitamins you are Currently Taking

List any Allergies to Medications

Please Complete the following to the best of your ability

Height:_____ Weight:_____ Blood Pressure:_____

Do You Smoke: ☐Yes ☐No How Much?_____ Do you drink?: ☐Yes ☐No Frequency:_____

List All Present Medical Problems

Have you ever had problems with

Asthma	☐Yes	☐No
Bladder	☐Yes	☐No
Bleeding Tendencies	☐Yes	☐No
Bowels	☐Yes	☐No
Breathing Difficulties	☐Yes	☐No
Cancer	☐Yes	☐No
Circulation	☐Yes	☐No
Coordination	☐Yes	☐No
Diabetes	☐Yes	☐No
Digestion	☐Yes	☐No
Dizziness	☐Yes	☐No
Emotional Problems	☐Yes	☐No
Epilepsy	☐Yes	☐No
Gall Bladder	☐Yes	☐No
Gout	☐Yes	☐No
Hearing Problems	☐Yes	☐No
Heart Problems	☐Yes	☐No
• Chest Pains	☐Yes	☐No
• Palpitations	☐Yes	☐No
Hepatitis	☐Yes	☐No
Hiatal Hernia	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Kidneys	☐Yes	☐No
Liver Disease	☐Yes	☐No
Lungs	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Prostate Problems	☐Yes	☐No
Shortness of Breath	☐Yes	☐No
Substance Abuse	☐Yes	☐No
Thyroid	☐Yes	☐No
Ulcer Disease	☐Yes	☐No
Vision	☐Yes	☐No
Water Retention	☐Yes	☐No

Other:_____

Markbreiter Orthopedic, P.C.

145 Wycoff Road, Suite 303
Eatontown, NJ 07724
P: (848) 208-2748
F: (848) 208-2745

ASSIGNMENT OF BENEFITS AND RIGHTS FORM
LIMITED POWER OF ATTORNEY FORM
NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT FORM

(TWENTY ONE DAY NOTICE)

FROM: _____
(NAME OF PATIENT)

TO: _____
(NAME OF INSURANCE COMPANY)

RE: _____ _____
(CLAIM NUMBER) (DATE OF ACCIDENT)

PATIENT AUTHORIZATIONS:

ASSIGNMENT OF BENEFITS: I am the above named Patient (or Guardian if minor) and I authorize and direct the above named Insurance Company, or any other company, to pay directly any of the above named medical providers, as well as Markbreiter Orthopedic,P.C., medical expense benefits otherwise payable to me for services provided to me (or a minor for whom I am the guardian) for their services.

I understand that any of the above named medical providers, as well as Markbreiter Orthopedic, P.C., may each bill for services rendered independently.

I authorize any of the above named medical providers, as well as Markbreiter Orthopedic, P.C., to submit their bill to the above named Insurance Company, or any other company, with which I (or my spouse) have an insurance policy against which I may proceed for medical expense benefits.

ASSIGNMENT OF RIGHTS: In the event any of the above named medical providers, as well as Markbreiter Orthopedics, P.C., elects to bring a lawsuit or arbitration against the above named Insurance Company, or any other company, I assign my rights, title and interest under the medical expense section and/or PIP section of the applicable insurance policy under which I am entitled to proceed for medical expense benefits. This Assignment of Rights shall allow any of the above named medical providers, as well as Markbreiter Orthopedics, P.C., to retain an attorney of their choice to file litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against the above named Insurance Company, or any other company, against which I may proceed for medical expense benefits.

LIMITED POWER OF ATTORNEY: In the event this Assignment of Benefits and Rights Form is held invalid by the above named Insurance Company, or any other company, I hereby authorize any of the above named medical providers, as well as Markbreiter Orthopedic, P.C., to execute any document on my behalf required by the above named Insurance Company, or any other company, to effectuate the intent of this Assignment of Benefits and Rights Form.

RELEASE FOR MEDICAL RECORDS: It is understood that certain privacy rights attach to my medical records as created by federal and/or state legislative bodies and/or federal and/or state regulatory bodies. In order to prove the medical necessity, reasonableness and/or casual relationship of the treatment rendered to me, and/or proposed to Demand For Arbitration (PIP). A photocopy of this document shall serve as an original.

RELEASE FOR IME REPORT: I authorize the Release of any IME Report and/or any Paper Review, prepared by any examining doctor, and/or any reviewing Medical Director, to any of the above named medical providers, as well as Markbreiter Orthopedic, P.C., described above.

RELEASE FOR DECLARATION PAGE AND POLICY: I authorize the Release of my applicable Declaration Page and/or Policy to any of the above named medical providers, as well as Markbreiter Orthopedic, P.C., described above.
RELEASE FOR PIP MEDICAL EXPENSE LEDGER: I authorize the Release of my applicable PIP Medical Expense Ledger to any of the above named medical providers, as well as Markbreiter Orthopedic, P.C., described above.
ACCEPTABILITY OF REPRODUCED COPY: Any reproduction (i.e. Photocopy, Facsimile, Scan, etc.) of this Assignment of Benefits and Rights Form shall be deemed as valid as the original.

I have read the above provisions. I understand the above provisions and agree to be bound by the above provisions.

_____

(Signature of Patient, or Guardian if minor) Date

TREATING HEALTH CARE PROVIDER REPRESENTATIONS (PIP):
I am the Treating Health Care Provider and provide the following representations to the above named Insurance Company in order for this Assignment of Benefits and Rights Form executed by the above named Patient (or Guardian if minor) to be honored. Specifically:

- All requirements of the Decision Point Review Plan and/or Pre Certification Plan of the above named Insurance Company, or other company, that are in accordance with the regulations promulgated by the Department of Banking and Insurance (DOBI) shall be complied with; and
- In the event of a failure to comply with the aforementioned requirements, the Patient described above will not be held financially liable for any additional imposed penalty; and
- In the event of any dispute with the above named Insurance Company, or other company, resolution of the dispute shall be adjudicated by the filing of a Demand For Arbitration (PIP) through the administrator appointed by DOBI.

It is understood that an Insurer may apply to DOBI pursuant to N.J.A.C. 11:3-4.9 (a) for "approval policy forms that include reasonable procedures for restrictions on the assignment of personal injury protection benefits, consistent with the efficient administration of coverage." As such, please provide me within ten days of receipt of this Form with any documentation required to effectuate the intent of the Patient described above. Failure to provide any documentation will be construed as a constructive acceptance of this Form and the intent of the above named Patient.

_____

(Signature of Provider) Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice Privacy Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

*Fellow of the American Board of Orthopaedic Surgeons

OWNERSHIP DISCLOSURE STATEMENT

This is to advise you that the doctors have ownership interests in treatment of Surgery Centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include, but are not limited to: Lakewood Surgery Center.

I have read and under the above.

_____
(Patient Signature)

_____
(Date)

IF YOUR WORKERS COMPENSATION INJURY, PLEASE COMPLETE THIS FORM

DATE OF INJURY: _____

DESCRIBE THE INJURY: _____

DESCRIBE YOUR TREATMENT SO FAR:

1ST DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? ☐ YES / ☐ NO
TREATMENT PROVIDED: _____

2ND DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? ☐ YES / ☐ NO
TREATMENT PROVIDED: _____

3RD DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? ☐ YES / ☐ NO
TREATMENT PROVIDED: _____

4TH DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? ☐ YES / ☐ NO
TREATMENT PROVIDED: _____

HAVE YOU HAD PHYSICAL THERAPY? ☐ YES OR ☐ NO HOW LONG? _____ STILL GOING? Y / N HELPFUL? Y / N

DID YOU HAVE AN MRI? ☐ YES / ☐ NO WHICH BODY PART? _____

DID YOU HAVE ANY INJECTIONS? ☐ YES / ☐ NO WHAT KIND? _____

OTHER TREATMENT: _____

HOW MUCH TIME DID YOU TAKE OFF FROM WORK FOLLOWING THE ACCIDENT? _____

WERE YOU ABLE TO RETURN TO WORK? ☐ YES / ☐ NO WHEN? _____

ANY DOCTORS RESTRICTIONS? _____

ARE YOU ON SHORT TERM DISABILITY? ☐ YES / ☐ NO ARE YOU ON LONG TERM DISABILITY? ☐ YES / ☐ NO

WHAT IS YOUR OCCUPATION? _____

EMPLOYER: _____

HOW LONG HAVE YOU BEEN AT THIS JOB? _____

LIST PRIOR EMPLOYMENT AND HOW LONG YOU WERE THERE

_____ _____
_____ _____

DESCRIBE YOUR CURRENT JOB AND ANY PHYSICAL DEMANDS:

HOURS/DAY: _____ DAYS A WEEK: _____ LENGTH OF COMMUTE: _____

ANY LIFTING? ☐ YES / ☐ NO HOW MANY POUNDS? _____ HOW FREQUENTLY? _____

REACHING? ☐ YES / ☐ NO PULLING? ☐ YES / ☐ NO PUSHING? ☐ YES / ☐ NO OVERHEAD ACTIVITY? ☐ YES / ☐ NO

KNEELING? ☐ YES / ☐ NO BENDING? ☐ YES / ☐ NO CROUCHING? ☐ YES / ☐ NO DRIVING? ☐ YES / ☐ NO

OTHER PHYSICAL DEMANDS: _____

DESCRIBE ANY PRIOR ACCIDENTS OR INJURIES. GIVE DATES, BODY PART INJURED, TREATMENT AND WHETHER OR NOT IT RESOLVED.

_____
_____

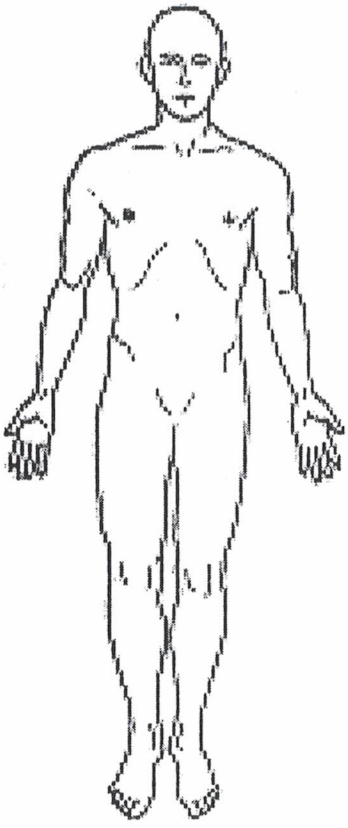
PATIENT PAIN DRAWING

NAME: _____ DATE: _____

Where is the pain now? _____

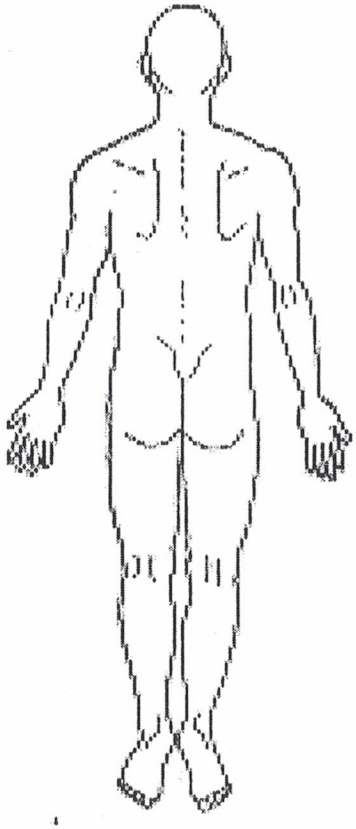
Mark the area on your body where you feel the sensations described below using:

Aching	Numbness	Pins & Needles	Burning	Stabbing
▽▽▽	=========	OOOOOOOO	xxxxxxx	////////



RIGHT LEFT

FRONT



LEFT RIGHT

BACK

How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line below how bad your pain is now:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Imaginable)