PREMIER
Orthopaedic Spine Associates

Workers' Compensation
Patient Information Form

Patient Name _____ SS#_____ Today's Date_____

Address _____Apt/Lot____ City _____State _____ZIP _____

Gender: Male Female Marital Status: Single Married Divorced Widowed DOB_____ Age_____

Email Address _____Home/Cell Phone_____ Work Phone_____

Pharmacy Name _____ Pharmacy Address _____

Employer Name _____ Address _____

Emergency Contact _____ Phone_____ Relationship to Patient_____

Primary Physician _____ Phone_____

PAST MEDICAL HISTORY/SOCIAL HISTORY

MEDICAL CONDITIONS (Circle all that apply):

Migraines	Coronary Artery Disease	Diabetes:	Renal Insufficiency
Alzheimer's / Dementia	Pacemaker/Defibrillator/Heart Stents	Type 1 or Type 2	Liver Cirrhosis
Parkinson's	Hypertension	Anemia	Gastric Ulcers
Anxiety / Depression / Bipolar	Peripheral Vascular Disease	HIV/AIDS	GERD
Atrial Fibrillation	Thyroid Disease-Hypo / Hyper	Hepatitis: Type A / B /C	Cancer:
Mitral valve prolapse	Fibromyalgia	DVT (blood clot):	Type _____
Aortic stenosis	Systemic lupus erythematosus	If yes, where? _____	Osteoarthritis:
Congestive heart failure	Asthma	High Cholesterol	Body part _____
Cerebralvascular accident (Stroke)	COPD / Emphysema	MRSA-Active / Inactive	Osteoporosis
Myocardial Infarction (Heart Attack)	Obstructive Sleep Apnea	End Stage Renal Disease	Other _____
	Use of CPAP Y or N	Dialysis Y or N	

Past Surgical History (please list any since last visit): _____

_____

Medications with Dosages (include Herbs, Vitamins/Supplements, OTC Medications):

_____

_____

Do you take any of the following: Coumadin __ Plavix __ Aspirin __

Allergies (Medications/Food): _____

_____

Thank you for helping us to keep your personal information current.

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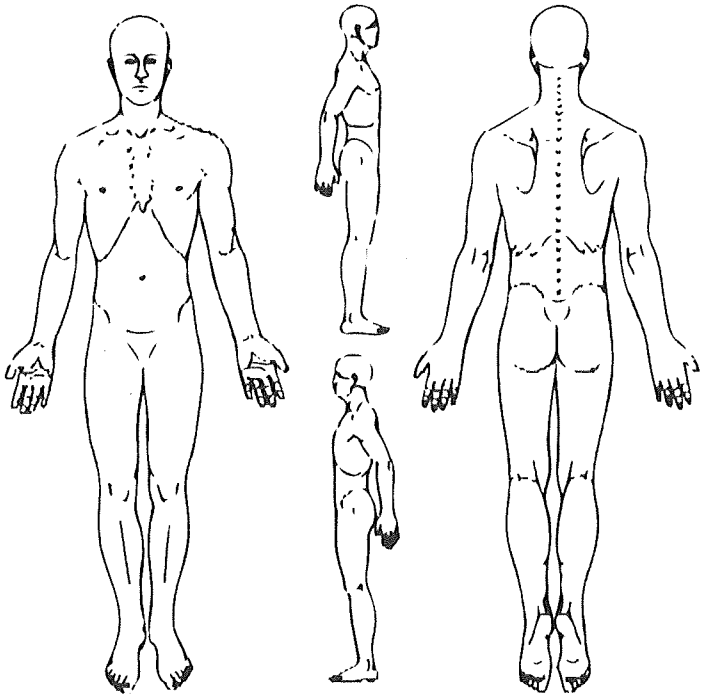
Rahul V. Shah, MD



Name : _____

Date : _____

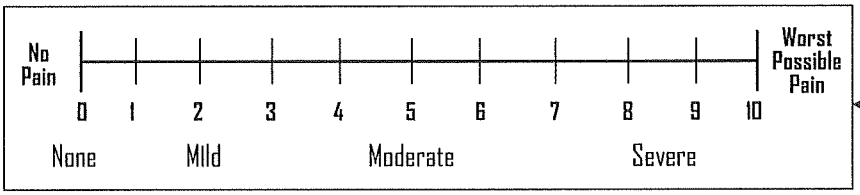
Age: _____

Referring Dr. _____

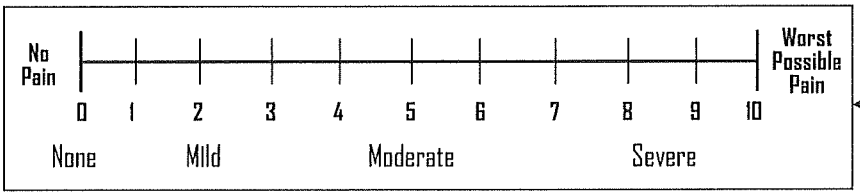
If you feel discomfort, please mark on the drawings with the type of discomfor you feel.

Burning discomfort **xxxxxx**
Deep Ache **ooooo**
Pins and Needles **///////**
Stabbing discomfort **ZZZZZ**
Numbness --------

If you have no discomfort, leave blank and initia l.



Circle your current level of BACK/NECK discomfort



Circle your current level of ARM/LEG discomfort

When and how did your discomfort start?

_____

_____

Is the discomfort getting? (check I box)

☐ better ☐ worse ☐ same

What activities INCREASE your discomfort?

_____

What activities DECREASE your discomfort?

_____

Have you had to miss work because of this?

☐ Yes. How long? _____ ☐ No

Have you had this discomfort before?

☐ Yes. When? _____ ☐ No

Does this discomfort wake you from sleep?

☐ Yes ☐ No

Have you tried?

☐ Medicines ☐ Therapy: ☐ Chiropractor

☐ Injections ☐ Surgery ☐ Other: _____

What studies have you had for this?

☐ X-Rays ☐ MRI ☐ CT ☐ Myelogram

☐ EMG ☐ Other: _____

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Financial Policies

Thank you for choosing Premier Orthopaedic Spine Associates (POSA) for your spine care. We are committed to the success of your medical treatment and care. Please understand that payment of your bills is part of this treatment and care.

Referrals If you have an HMO plan we are contracted with, you need a referral from your PCP authorizing your treatment. If we have not received the referral prior to your arrival at the office, you may use the telephone available to call your PCP to obtain it. **If you are unable to obtain the referral for your visit, you may be rescheduled or required to fill out and sign our responsibility waiver, which makes you financially responsible for all charges incurred at your visit. (*Emergency cases only)**

Your Financial Responsibilities:

Our office will file insurance claims for all reimbursable services, to your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, co-insurance, and non-covered service amounts. We accept payment by cash, check Visa or MasterCard.

You will receive billing statement(s) from our office for account balances that are your responsibility. Balance in full is due within 15 business days. If the patient portion of your account is not paid in a timely manner, legal collection efforts will be made. All legal collection fees incurred to collect the patient balance will be the responsibility of the patient.

HMO, POS and PPO plans that POAS contracts with: If the services you receive are covered by the plan and you have provided any required referral and/or authorization, you are responsible for all applicable copays and deductibles. These are to be paid at the time of service. If the services you receive are not covered by the plan, payment in full is requested at the time of service.

Commercial Insurance or PPO's that POAS does NOT contract with: POAS will submit your claims to your carrier as a courtesy if all current and accurate information is provided. You will be billed for any remaining balance with the total amount due within 15 days of billing. It is the responsibility of the patient to contact your insurance to verify if our office is contracted with your carrier.

Medicare: You will be responsible for any portion of your deductible that is not paid or covered by your secondary insurance. You will be responsible for any service not covered by Medicare. POAS will submit Medicare and secondary claims. All patient balances remaining after Medicare and/or secondary payments will be billed to you and will be due within 15 days of billing by this office.

Medicaid: POAS physicians are **NOT** participating in NJ Medicaid. Payment is required at the time of service. We will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request to speak to a billing representative to discuss a possible self-pay patient discount, and/or payment plan.

NO Insurance: Payment in full is required at the time of service. If you have financial hardships, we will work with you to arrange a payment plan. This will be determined on a case by case basis. Please request to speak to a billing representative to discuss a possible self-pay discount and/or payment plan.

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copays and deductibles, are my responsibility. I authorize the release of any information concerning me or my child's healthcare, for the purpose of evaluating and administering claims for insurance benefits and to my primary care physician.

I authorize my insurance benefits be paid directly to Premier Orthopaedic Spine Associates (POAS).
I authorize Medicare benefits to be paid directly to Premier Orthopaedic Spine Associates (POAS) I authorize any holder of medical information about me to release the centers of Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Name Printed

Orthopaedic Spine Associates

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Premier Orthopaedic Spine Associates, L.L.C's Notice of Privacy Practices. Copies of our policy are available at the front desk.

Please sign below. Thank you.

_____ _____

Signature Date

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Orthopaedic Spine Associates

RELEASE OF INFORMATION AUTHORIZATION FORM

I, _____ give my _____
Patient's Name Relationship to Patient

_____, permission to:
Name of person receiving PHI

PLEASE CHECK ALL THAT APPLY:

_____ MAKE & RECEIVE PHONE CALLS REGARDING MY OR MY LEGAL DEPENDENT'S PHI (Protected Health Information) IN MY ABSENCE.

_____ PICK UP FORMS, PRESCRIPTIONS, REFERRALS, &/ OR SAMPLES FOR ME OR MY LEGAL DEPENDENT IN MY ABSENCE.

_____ RECEIVE BILLING INFORMATION

Please include any additional individuals to be included for the above:

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

I understand that this authorization will remain in effect unless/until I change it in writing. I understand that I may change or rescind this authorization at any time in writing.

By signing this document I also give my authorization for any POASNJ staff member or doctor to leave messages on my answering machine or voice mail.

Signature: _____ Date: _____