



PREMIER

Orthopaedic Spine Associates

Patient Information Form

Patient's Legal Name _____ DOB _____ SS# _____

Address _____ Apt/Lot _____ City _____ State _____ ZIP _____

Email Address _____ Home Phone _____ Cell Phone _____

Pharmacy Name _____ Pharmacy Address _____

Payment Type: Self Pay ___ Insurance ___ Insurance Company _____

Subscriber name _____ Relationship to patient _____ DOB _____

Address _____ SS# _____ Phone _____

Responsible party name _____ Relationship to patient _____ DOB _____

Address _____ SS# _____ Phone _____

Employer _____ Address _____

Emergency Contact _____ Phone _____ Relationship to Patient _____

Referring Physician _____

PAST MEDICAL 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 _____
Cerebrovascular 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	

How did your injury occur? **At work?** Yes No **Motor vehicle accident?** Yes No Date of injury _____

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): _____

Please present insurance card and driver's license with form.
Thank you for helping us to keep your personal information current.



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: _____



OPIOID PAIN MEDICATION AGREEMENT

Patient Legal Name: _____ Date of Birth: _____ Date: _____

I understand that _____ (clinician name) may prescribe opioid medication to assist me in managing chronic pain. I understand the risks, side effects, and benefits, and I agree to the following conditions of opioid treatment.

1. The medication must be safe and effective and help me to function better. The goal is to use the lowest dose that is both safe and effective. If my activity level or general function gets worse, the medication will be changed or discontinued by my clinician.

2. I will participate in other treatments that my clinician recommends and will be ready to taper or discontinue the opioid medication as other effective treatments become available.

3. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my clinician's approval.

4. I will keep regular appointments and will call at least 24 hours in advance if I have to reschedule.

5. One clinician. All opioid and other controlled drugs for pain must be prescribed by the clinician who is named above. I will not obtain medications from other clinicians or pharmacies unless I am hospitalized. I will tell any hospital or emergency room clinicians that I receive pain medications from my provider. In the event of an emergency, if I am given a prescription for pain medication, I will notify my primary clinician as soon as I am able.

6. One pharmacy. I will designate one pharmacy where all my prescriptions will be filled. I am responsible for prescriptions being filled on time. To avoid running out of my medications, I will contact my provider's office at least 3 business days in advance for refills. I understand that prescriptions generally will not be sent by mail or faxed.

7. I understand that lost or stolen prescriptions will not be replaced, and I will not request early refills.

8. I agree to abstain from excessive alcohol use and all illegal and recreational drug use and will provide urine or blood specimens at the clinician's request to monitor my compliance.

9. I understand that my health information may be exchanged with other health care practitioners and pharmacists to assist in my treatment, including pain management and utilization of pain medications.

10. I understand that clinic staff (nurses, receptionists, lab staff, etc.) is very important in my success with this treatment plan. I will treat them respectfully and abide by their decisions regarding my care and the enforcement of this agreement.

11. If I am unable to follow the conditions of this agreement, I understand it may not be safe for me to continue the medication.

Patient Signature: _____ Date: _____ Time: _____

Clinician Signature: _____ Date: _____ Time: _____

Pharmacy: _____



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



**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