Patient Information

Appointment Date: _____

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First Name: _____ Last Name: _____ Middle Initial: _____

SS#: _____ Birth Sex: ◯ Male ◯ Female Gender Identity: ◯ Male ◯ Female ◯ Other Date of Birth: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Language:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Employer Address: _____

Referring MD: _____ Referring MD Address: _____

PCP: _____ PCP Address: _____

Employment: ◯ Full Time ◯ Part Time ◯ Not Employed ◯ Self Employed ◯ Retired ◯ Military Duty ◯ Permanently Disabled

Current Occupation: _____ and/or **Student:** ◯ Full Time ◯ Part Time

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Parent Information for Minors:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS#: _____ Date of Birth: _____ Birth Sex: ◯ Male ◯ Female Gender Identity: ◯ Male ◯ Female ◯ Other

Employer: _____ Employer Address: _____

Email Address: _____

Primary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Employer Group: _____ Patient's Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID#: _____ Group#: _____

Secondary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Employer: _____ Patient's Relationship to Subscriber: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID#: _____ Group#: _____

Worker's Compensation or Auto Accident Information *(Complete this section, if applicable)*

Coverage Type: ◯ Worker's Compensation ◯ Auto Accident

Insurance Company: _____ Date of Injury: _____

Claim ID#: _____ Body Part Injured: _____

Proceed to 2nd page for Completion and Signature

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Emergency Contact:

Name: _____ Relationship to Patient: _____

Phone: _____

Patient Affirmation:

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize treatment by the providers at University Orthopaedic Associates, LLC.

Signature: _____ Date: _____

Authorization for Assignment of Benefits

Please accept this Assignment of Benefits as a blanket Assignment of Benefits for charges on services rendered and submitted by University Orthopaedic Associates, LLC on my behalf. I, the undersigned, authorize and request that.

_____

Signature

	Initials
Medical-Legal Reports/Testimony: I acknowledge this office's policy regarding medical-legal reports and testimony. The providers do not testify, nor make court appearances. Permanency evaluations and narrative reports are prepared at their discretion. If this policy is unacceptable to me or my attorney, I am aware that I should seek orthopaedic treatment elsewhere.	
Workers' Compensation and Auto Accidents: It is the patient's responsibility to clearly identify those medical injuries/conditions which he/she believes are due to a motor vehicle or work related injury at the time of the initial visit on all required documentation. Failure to do so can result in patient liability.	
Motor Vehicle (PIP) Claims: Injuries involving Motor Vehicle accident/injuries must be submitted to my Motor Vehicle (PIP) carrier and cannot be billed to my private insurance unless PIP coverage has been denied, does not exist or private insurance was selected as the primary carrier. I am responsible for any deductible or co-payments under my PIP coverage. I agree to a promissory note enactment for any open balances owed to UOA, LLC in relation to my accident/injuries.	

Dear University Orthopaedic Associates Patient,

We kindly request your email address so that we can extend to you the opportunity to provide us with feedback regarding your care, and access to information regarding what's new at University Orthopaedic Associates, in the form of patient satisfaction surveys and newsletters.

Your email address will not be sold or made available for use by any other organizations.

PLEASE PRINT CLEARLY:

Name: _____ Email: _____

Signature: _____ Date:_____

Notice Of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

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Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say no to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home, office or cell phone) or to send mail to a different address. • We will say yes to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree to your request, and we may say no if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say yes unless a law requires us to share that information.
Get a list of those whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting our Privacy Officer at 2 World's Fair Drive, Somerset, NJ 08873 OR (732) 537-0909 • You can file a complaint with DHHS Office of Civil Rights. Visit www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. *If you are not able to tell us your preference (for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we never share your information unless you give us written permission	• Marketing purposes. • Sale of your information. • Most sharing of psychotherapy notes.
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

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Our Uses & Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Other Uses & Disclosures

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	**We can share health information for certain situations such as:** • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	**We can use or share health information about you:** • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security and presidential protective services
Respond to law and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our website.

Notice Of Privacy Practices Receipt

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I acknowledge that a Notice of Privacy Practices of University Orthopaedic Associates is posted on the UOA website and available to me upon my request.

Print name of patient: _____ Date: _____

Signature of patient: _____ SSN: _____

For personal representative of the patient (if applicable):

Print name of personal representative: _____ Date: _____

Signature of personal representative: _____ Relationship to patient: _____

For practice use only:

Signature of practice employee: _____ Date: _____

Please provide the following information:

(The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions.)

Appointment Reminders/Test Results (laboratory, x-rays, etc.):

If we need to reach you regarding an appointment or test results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours.

Please complete/check all items below that apply to you:

May we call/text/email to remind you of an appointment or regarding test results? ◯ Yes ◯ No

Please contact me:

Home Phone: _____ Cell Phone: _____

Email: _____ Work Phone: _____

If we get an answering machine/voicemail, may we leave a message? ◯ Yes ◯ No

If we get a family member, may we leave a message? ◯ Yes ◯ No

I understand I have a right to request communication with UOA, LLC through email and by doing so I understand that currently their email is not encrypted. I also understand that non-encrypted email can result in possible public access of my personal information. My initials indicated below show I understand and still will like this type of communication to be possible.

Initials: _____ Date: _____

Policy for discussing your medical information with family members:

Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

Spouse ☐ _____

Parent(s) ☐ _____

Child(ren) ☐ _____

Sibling(s) ☐ _____

Other(s) ☐ _____

Automobile (No Fault) Insurance Assignment of Benefits

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Name of Insurance: _____

Claim/Policy No.: _____ **Date of Accident:** _____

Adjuster: _____

To my auto insurance carrier:

I, _____ *, request that payment of authorized medical benefits for*
Name of Insured

_____ *, who is covered under my automobile policy, be made*
Name of Patient

on my behalf and assigned to University Orthopaedic Associates, LLC, TIN# 26-1257314 for any auto related injuries. In the event my covering insurance carrier pays benefits directly to me, I will be financially responsible to return any and all monies to University Orthopaedic Associates, LLC.

Date _____ Patient's or Parent/Legal Guardian's Signature _____

Witness _____

PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS

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Policy Number:
Claim Number:
Patient's Name:
Medical Provider's Name:

I authorize and request _____ and all of its subsidiaries and affiliates of New Jersey (hereinafter referred to as the "Company") to pay directly to the above-named provider, the amount due me under the terms of the
above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associates with the provider's office.

Date: _____ _____

Patient's Signature or Parent/Legal Guardian

I have read the information sent by the Company concerning the Decision Point Review plan, including any pre-certification requirements (collectively referred to hereafter as the "Plan") and, as a condition precedent to the Company's acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office, to the following:

1) I (we) have complied and will comply with all the procedures identified within the Plan;

2) I (we) will comply with all requests for additional information from the Company concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, casual relationship to the accident and care plan and if necessary submit to Examinations Under Oath;

3) I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the Plan;

4) I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the Plan until there has been a final determination of the Internal Appeal Procedure of the dispute; and

5) In the event that I (we) fail to comply with the requirements of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the Plan.

I (we) understand that the Company has the right to reject this assignment of benefits. The Company does not provide coverage for any insured or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident or loss for which coverage or benefits are sought.

Any person who knowingly files a statement of claim containing any false statement or misleading information is subject to criminal and civil penalties.

Date: _____ _____ _____

Provider's Signature **Printed Name**