Patient Information

Appointment Date: _____

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

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, a division of OrthoNJ.

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, a division of OrthoNJ 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, a division of OrthoNJ 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

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

Pursuant to the Privacy Rule regulations established by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended and supplemented, we are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose your health information for many different reasons. For some of these uses and disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures of your PHI.

A. Uses and Disclosures That Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the reasons set forth below. In the event other applicable law, such as the regulations at 42 CFR Part 2, require your authorization prior to our use or disclosure of certain types or portions of your information, we will first obtain your authorization.

1. **For treatment.** We may use and disclose your PHI for the provision, coordination, or management of your health care, including consultations between doctors, nurses, and other health care personnel regarding your care, and referrals for care from one provider to another. For example, if you are being treated by a specialist or are referred for a test, we may communicate with such other providers to coordinate your care.

2. **To obtain payment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We also may disclose PHI to another provider involved in your care for the other provider's payment activities. Note that certain state or federal laws governing specialized or highly sensitive health information may require your written authorization prior to our disclosure of PHI for payment purposes. In this event, we will ask you to sign an authorization form so that we may disclose your PHI to obtain payment.

3. **For health care operations.** We may use and disclose your PHI as necessary to operate our business. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may provide your PHI to our accountants, attorneys, consultants, and others as needed for their services. We also may use your PHI for data aggregation purposes or to de-identify your PHI (that is, remove your personal identifiers) in accordance with applicable law, including through our business associates. We and others may use such de-identified data for legally-permitted purposes. We may use your PHI to create a "limited data set" by removing certain identifying information. We may use and disclose the limited data set for research, public health, or health care operations purposes, and any third party who receives a limited data set must sign an agreement to protect your health information.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** We may use or disclose your PHI for such purposes. For example, we may disclose your PHI when a law requires that we report certain information to government agencies or to law enforcement personnel about victims of abuse, neglect, or domestic violence (for adults, we will make the disclosure of adult abuse only if the person agrees or when required by law); when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** We may use or disclose your PHI for public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events, and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted or required by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. **For health oversight activities.** We may use or disclose your PHI for health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners, funeral directors, and for organ donation.** We may disclose to coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants.

8. **For research purposes.** We may disclose PHI in order to conduct medical research where permitted by applicable law. When required by applicable law, we will obtain your written authorization prior to disclosure of your PHI for such purposes.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. **For workers' compensation purposes.** We may disclose PHI in order to comply with workers' compensation laws.

12. **Inmates.** If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official, provided that such disclosure is necessary for the provision of health care to you, to protect your health and safety or the health and safety of other inmates, or for the safety and security of the correctional institution.

13. **Lawsuits and disputes.** If you are involved in a lawsuit or dispute, we may disclose your PHI subject to certain limitations.

14. **Appointment reminders and health-related benefits or services.** We may use your PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer. We may disclose your PHI to our business associates so that they may perform these functions on our behalf. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

15. **Health Information Exchanges.** We and other health care providers may participate in certain Health Information Exchanges (HIEs) as we and they may determine from time to time. These HIEs allow patient information to be shared electronically through a secured connected network. HIEs give your health care providers who participate in the HIE networks immediate electronic access to your pertinent medical information for treatment, payment and certain health care operations. If you do not opt out of a HIE, your information will be available through such HIE network to your authorized participating providers in accordance with this notice and applicable law. If you opt out of a HIE, this will prevent your information from being shared electronically through the HIE network; however, it will not impact how your information is otherwise typically accessed, used, and disclosed in accordance with this notice and applicable law. Any exception that denies an individual from opting out of having their information transmitted through an HIE will be in accordance with applicable federal and state law. In the event we participate in a HIE, you may opt out by contacting our Privacy Officer as provided in Section VI.

16. **Use of unsecure electronic communications.** If you choose to communicate with us, including our providers and staff, via unsecure electronic communications, such as regular email or text messages that are not encrypted, we may respond to you in the same manner in which the communication was received and to the same email address or phone number from which you sent your original communication. In addition, if you provide your email address or cell phone number to us, we may send you emails or text messages related to appointment reminders, surveys, or other general informational communications. For your convenience, these messages may be sent unencrypted.

    Before using or agreeing to use any such unsecure electronic communication technology, note that there are certain risks, such as, but not limited to, interception by others who are not authorized to have your information, shared accounts, misdirected/misaddressed messages, or messages stored on unsecured devices. By choosing to correspond with us via unsecure electronic communications, you are agreeing to accept these risks.

    You should understand that the use of email, text message or other electronic communication methods is not intended to be a substitute for professional medical diagnosis, advice, or treatment. Emails, text messages, and other electronic communications should never be used in urgent situations.

B. Uses and Disclosures Where You May Have the Opportunity to Object.

1. **Disclosures to family, friends, or others.** We may disclose your PHI to a family member, friend, or other person that you indicate is involved in your health care or the payment for your health care, to the extent related to their involvement in your care or payment for your care. We may use or disclose your PHI to notify others of your general condition and location at our premises. We may allow friends and family to act for you and pick up prescriptions and other documents when we determine, in our judgment, that it is in your best interests to do so. If you are available, we will give you the opportunity to object to these types of disclosures, and then we will not make the disclosures for which you have objected.

2. **Disaster relief.** When permitted by applicable law, we may coordinate our uses and disclosures of PHI with other organizations authorized by law or charter to assist in disaster relief efforts. For example, a disclosure may be made to the American Red Cross or similar organization in an emergency.

C. Uses and Disclosures That Require Your Authorization. Other than as stated otherwise in this notice, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance on the authorization.

1. **Psychotherapy notes.** In the event we maintain psychotherapy notes relating to you, in most circumstances we must obtain your written authorization prior to disclosing such psychotherapy notes outside our organization. You do not have a right under HIPAA to receive copies of psychotherapy notes relating to you.

2. **Genetic information.** Except under certain circumstances permitted or required by law, we may use or disclose your genetic information (for example, your DNA sample or DNA test results) only with your written authorization.

3. **HIV, AIDS, and certain sexually transmitted diseases.** Except under certain circumstances permitted or required by law, we may use or disclose diagnosis and treatment information about HIV, AIDS or sexually transmitted diseases only with your written authorization.

4. **Substance use disorder treatment information.** Records received from federally-funded substance use disorder (SUD) treatment facilities are protected by federal regulations at 42 CFR Part 2, which provides certain protections to such records in addition to HIPAA. In the event we receive information or records about you from a federally-funded SUD treatment facility, we will not disclose such information or records to outside third parties for purposes of other than treatment, payment and health care operations unless (i) we have received your written authorization, (ii) we have received a court order accompanied by a subpoena or other legal mandate compelling disclosure that was issued after you and we were given written notice and an opportunity to be heard, as required under federal regulations at 42 CFR Part 2, (iii) the disclosure is made to medical personnel in a medical emergency and we were not able to obtain your prior written authorization, (iv) the disclosure is to qualified medical personnel of the Food and Drug Administration who assert a reason to believe that the health of any individual may be threatened by an error in the manufacture, labeling, or sale of a product under FDA jurisdiction, and that the information will be used for the exclusive purpose of notifying patients or their physicians of potential dangers; or (v) the disclosure is to qualified personnel for research purposes. 42 CFR Part 2 strictly limits use of SUD records in legal proceedings, and the content of such records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or under a court order after notice and an opportunity is provided to the individual or the holder of the SUD records. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

D. Marketing Communications. We may contact you as part of our marketing activities without obtaining your written authorization, for the following purposes: to provide you with marketing materials in a face-to-face encounter; to give you a promotional gift of nominal value, if we so choose; and, as long as we are not paid to do so, to communicate with you about products or services relating to your treatment, case management, or care coordination, or alternative treatments, therapies, providers, or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products. We will obtain your written authorization for certain other marketing activities when we are legally required to do so.

E. Sale of PHI. We will disclose your PHI in a manner that constitutes a sale of PHI only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI for public health purposes; for research; for treatment and payment purposes; relating to the sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; to the individual; required by law; for any other purpose permitted by and in accordance with applicable law.

F. Fundraising Activities. We may use certain information (name, address, telephone number, dates of service, age, and gender) to contact you for the purpose of various fundraising activities we may undertake. You may opt out of such communications by providing notice to us of your opt-out. In the event we create or maintain records subject to 42 CFR Part 2, we will first provide you with a clear and conspicuous opportunity not to receive any fundraising communications. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

G. Incidental Uses and Disclosures. We may disclose your PHI incident to a use or disclosure that is otherwise permitted as described in this notice. For example, discussions about you within our offices might be overheard by persons not involved in your care. We have implemented reasonable safeguards as well as policies and procedures regarding minimum necessary uses and disclosures of PHI in an effort to minimize such incidental uses and disclosures and to protect your PHI.

H. Business Associates. We may engage certain individuals or entities (business associates) to provide services to us or perform certain functions on our behalf, and we may disclose your PHI to these business associates for such purposes. For example, we may share PHI with our computer consultant or our billing company to facilitate our health care operations or payment for services provided in connection with your care. We will require our business associates to enter into a written agreement to keep your PHI confidential and to abide by certain terms and conditions.

I. Data Breach Notification. We may use or disclose your PHI to provide legally-required notices of unauthorized access to or disclosure of your PHI.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but we are not legally required to accept it except in the following circumstance: You have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested. You may make your request our front office staff or in writing. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may

deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

If you request a copy of your information, we may charge reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request, in accordance with applicable law. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. You have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the electronic copy directly to a third party. We may charge for the labor costs to transfer the information and charge for the costs of electronic media if you request that we provide you with such media, in accordance with applicable law.

Please note, if you are the parent or legal guardian of a minor child, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent on the minor's own behalf (without your consent) may be restricted unless the minor provides an authorization for such disclosure.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations (unless we are required by applicable law to include such disclosures), those made pursuant to your written authorization, those made directly to you or your family, or permitted incidental disclosures. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or for timeframes beyond 6 years prior to the date of your request. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

We will respond within 60 days of receiving your written request. Except as otherwise provided by applicable law, the list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their addresses, if known), a description of the information disclosed, and the reason for the disclosure. If you make a request for a list of disclosures, we will provide one list during any 12-month period without charge, but if you make more than one request in the same year, we may charge you an administrative fee for each additional request.

E. The Right to Receive Notice of a Breach of Unsecured PHI. You have the right to receive notification of a breach of your unsecured PHI, including any breach of SUD records or information.

F. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your written request. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

F. The Right to Get a Copy of this Notice. This notice is posted in public areas of our offices and on our website at https://orthonj.org. We may provide you with a copy of this notice by email. In addition, you have the right to get a paper copy of this notice by contacting our office by phone or in writing. ***Send written requests to: OrthoNJ, 2 Worlds Fair Drive, Somerset, NJ 08873, Attn: HIPAA Privacy Officer***.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will take no retaliatory action against you if you file a good-faith complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices or violation of your privacy rights, please contact our Privacy Officer as follows:

OrthoNJ, LLC
2 Worlds Fair Drive
Somerset, NJ 08873
Attn: HIPAA Privacy Officer
Email: compliance@orthonj.org
Phone: (862) 217-6900

VII. CHANGES TO THIS NOTICE. We have the right to change the terms of this notice at any time. Any changes to the terms of this notice will apply to the PHI we already have. If we change this notice, we will post the new notice in public areas of our offices and on our website. You also may obtain a copy of any new notice by contacting the Privacy Officer listed above.

VIII. NON-DISCRIMINATION NOTICE. We comply with applicable federal civil rights laws requiring that we do not discriminate on the basis of race, color, national origin, sex, age, or disability.

IX. EFFECTIVE DATE OF THIS NOTICE.

Effective Date: February 16, 2026

Acknowledgment

ORTHONJ, LLC

Patient Name: _____

I acknowledge receipt of the above organization's Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

-OFFICE USE ONLY-

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained.

Reason: _____

Signature of Staff Member: _____

Printed Name: _____ Date: _____

HIPAA Authorization for Disclosure of PHI Form

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, a division of OrthoNJ 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) ☐ _____

Signature: _____ Date: _____

Automobile (No Fault) Insurance Assignment of Benefits

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, a division of OrthoNJ, TIN# 82-4413259 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, a division of OrthoNJ.

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

Witness _____

PERSONAL INJURY PROTECTION BENEFITS
CONDITIONAL ASSIGNMENT OF BENEFITS

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**