



# ORTHO CENTER

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## PATIENT INFORMATION

(Please note the information being requested is for the PATIENT)

Patient Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Home Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: S M W D

Email Address: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

## IF PATIENT IS UNDER 18 YEARS OF AGE, Responsible Party Information

Responsible Party Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Billing Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Subscriber Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_

Subscriber Home Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

**PLEASE TURN OVER.....**

Patient Information Continued...

**SECONDARY INSURANCE INFORMATION**

Subscriber Name: \_\_\_\_\_ Sex: M F DOB: \_\_\_\_\_

Subscriber Home Address: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Group #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

First & Last Name of Primary Care Physician: \_\_\_\_\_

First & Last Name of Referring Physician: \_\_\_\_\_

Do you have an Advanced Directive:  Yes  No

If yes, please select one from the following options:

- Do not intubate     Do not resuscitate     Full code     Health proxy on file  
 Durable Power of Attorney for healthcare     Living will     Organ or Tissue Donor  
 Surrogate decision make

Please complete if your visit today is a result of an accident. Type of Accident:

- Auto Accident                       Workers Comp Accident  
 Slip and Fall Accident             Sports Related Accident             Assault/Battery

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Location of Accident (City & State): \_\_\_\_\_

If Sports Related Accident, name of school you attended: \_\_\_\_\_

Name of Attorney representing you: \_\_\_\_\_

How did you hear about us?

Referral:

- Doctor     Family/Friend     Other Professional

Online:

- Google/Online Search     Social Media     Website Ad     Signage  
 Other: \_\_\_\_\_

I authorize the release of any information required in the processing of my health claims

I authorize my insurance benefits to be paid directly to the health care provider

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**CONSENT TO NAME AN AUTHORIZED REPRESENTATIVE TO  
PURSUE AN APPEAL OF AN ADVERSE BENEFITS DETERMINATION  
INVOLVING MEDICAL JUDGEMENT  
&  
AUTHORIZATION TO RELEASE INFORMATION RELATING TO THE  
APPEAL**

I, <sup>1</sup> \_\_\_\_\_, by signing below, agree to representation by the following authorized representative, \_\_\_\_\_, to act on my behalf in an appeal of an adverse benefits determination involving medical judgement as allowed by the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, and Section 2719 of the Public Health Services Act (PHS Act) which PPACA has incorporated into the Employment Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code), making those provisions applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. I also agree to the release of my personal health information to my appointed authorized representative named herein, to Horizon BCBSNJ and its independently contracted Independent Review Organization (IRO) that will review my appeal. My consent to this appointment of this authorized representative and my authorization of release of my personal health information expires 24 months, but I may revoke both sooner.

Signature: \_\_\_\_\_ Ins. ID#: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient:  I am the patient  I am a personal representative

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<sup>1</sup> If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete this form.



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**HIPAA/PRIVACY PRACTICES ACKNOWLEDGEMENT FORM**

The Orthopaedic Center is very concerned about the protection of your health information. Federal Law requires all physician offices to have a signed privacy statement on file for every patient. In order to serve you, we must have an existing Privacy Acknowledgement form on file. The law is intended to protect the privacy of your medical records. –Thank you.

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I have been given the opportunity to review the Notice of Privacy Practices.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Personal Representative & Relationship: \_\_\_\_\_

Any and all situations can be discussed with: \_\_\_\_\_

In case of emergency, please contact:

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

[ ] I do, [ ] I do not give permission to The Orthopaedic Center to leave detailed messages on my answering machine, mail to my home or fax any information regarding appointments, instructions for surgery, test results, billing and/or insurance issues or other pertinent information.

Fax #: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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**FINANCIAL POLICY AND INSURANCE AUTHORIZATION**

I authorize Orthopaedic, Sports Medicine and Rehabilitation Center, PA (“OSMRC”) to release to the Social Security Administration and Centers for Medicare & Medicaid Services, its intermediaries or carriers, or to any other insurance company for which I or my dependents or insurance beneficiaries is/are covered insureds, any information, including protected health information, needed for processing of claims for payment for services rendered to me or my dependents or insurance beneficiaries, as applicable. I request that payment of Medicare and/or other third-party insurance company benefits for services rendered to me (or my dependents or insurance beneficiaries, as applicable) be made directly to OSMRC. If my insurance carrier will not assign benefits to OSMRC, then I understand that I am responsible for payment of all charges, regardless of whether or not I am later reimbursed by my insurance plan.

We are providers for some insurance plans and we will bill your insurance company directly. Most plans require co-payments and/or deductibles and co-insurance that are due at the time of service.

If we are not a participating provider with your insurance plan, or you do not have insurance, payment is expected in full at the time of service.

If your visit is a result of a work injury or motor vehicle accident, you must provide us with the following information prior to your visit: insurance carrier, claim number, adjuster’s full name and phone number, and date of accident. If your visit is not authorized by this insurance carrier, you will be fully responsible for service rendered.

I understand that I am responsible for all deductible, co-payment, co-insurance and/or charges for all non-covered services. It is customary to pay for services when rendered unless other arrangements have been made. Acceptable forms of payment are cash, check, Visa, MasterCard, Discover or American Express. There is a \$20 administration fee for any returned check. In the event I fail to pay for services rendered, when payment is due, my account will be turned over to collection.

Please feel free to contact our Billing Office if you have any questions. We are happy to answer your questions or to provide additional information.

I understand and acknowledge the financial policy and insurance authorization terms stated above.

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Patient’s Name

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Date

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Signature (Patient/Guardian)



**ORTHO**  
C E N T E R

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**CANCELLATION AND NO-SHOW POLICY**

**Please be aware that if for any reason you need to cancel your appointment for an EMG, Fluoroscopic Procedure and/or Spinal Procedure (Epidural, RFA, Nerve Block, etc.) you must call at least 24 hours prior to your appointment.**

**If you do not cancel the appointment with 24 hours' notice you will be subject to a no-show fee of \$50.00**

**To cancel your appointment, please call our office: 732-741-2313**

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**Patient Name**

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**DOB**

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**Patient Signature**

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**Date**