NEUROSURGICAL ASSOCIATES OF CENTRAL JERSEY, P.A.

When you arrive	When you arrive, please come to the window at the front desk and sign in with the receptionist. At that time, please have your insurance card and photo ID available. It is essential that you bring films and reports that have been made concerning your condition. Without these films and reports, we will likely reschedule your appointment until you are able to bring them. Please call our office if you do not understand what is needed.
Refilling Prescriptions	Our patients are required to utilize only one local pharmacy for all prescription medications. Please complete and return the enclosed Medication Request Policy form. If you have unexpected reactions to your medication or if the medication does not help you, please call our office immediately.
Office Visit, Billing and Insurance	Please review your insurance card or contact your insurance carrier to determine the amount of your co-insurance or deductible for visits to a medical specialist. Coinsurance and deductibles not met are due at the time of your visit. Work related or Motor vehicle injuries will be billed directly to the appropriate carrier. If you are involved in a legal dispute, payment is due when services are rendered regardless of any pending legal action.
Check – Off List	The following are items necessary for your initial visit □ **Films and reports (MRI, CT Scan, X-rays, Myelogram)** □ **Completed Patient Information Form** □ **Completed Patient History Form** □ **Completed Medication Request Policy** □ **Completed Financial Agreement** □ **Use and Disclosure of Protected Health Information Form** □ **Insurance Card** □ **Photo ID**

NEUROSURGICAL ASSOCIATES of Central Jersey, P.A.
Diplomates American Board of Neurological Surgery

James M. Chimenti, MD, FAANS
Jay More, MD, FAANS

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **SSN:** _____

Gender: Male ☐ **Female** ☐ **Language:** _____ **Email:** _____

Race: White ☐ **Black** ☐ **Asian** ☐ **Other** ☐ **Ethnicity: Hispanic** ☐ **Non-Hispanic** ☐

Address: _____ **City, State, ZIP** _____

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

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Patient's Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Emergency Contact Phone:** _____ **Relation:** _____

Is your visit related to a motor vehicle accident? **Y** ☐ **N** ☐
If yes, please notify receptionist.

Is your visit related to a worker's comp accident? **Y**☐ **N** ☐
If yes, please notify receptionist.

PRIMARY INSURANCE (Payment required at time of service unless prior arrangements have been made.)

Subscriber: _____ **Relationship to Patient:** _____

Subscriber DOB: _____ **Subscriber SSN:** _____

Address (if different from patient): _____

Subscriber Employer: _____ **Phone:** _____

Insurance Company: _____ **ID#:** _____ **Group #:** _____

SECONDARY INSURANCE

Subscriber: _____ **Relationship to Patient:** _____

Subscriber DOB: _____ **Subscriber SSN:** _____

Address (if different from patient): _____

Subscriber Employer: _____ **Phone:** _____

Insurance Company: _____ **ID#:** _____ **Group #:** _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage with _____ and assign directly to Neurosurgical Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that if I am using out-of-network benefits, I am responsible for any deductibles and/or co-insurance. I authorize the use of my signature on all insurance submissions. The above-named physician group may use my healthcare information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I understand that I am responsible for any non-covered services.

_____ _____
Signature **Date**

Medicare/Medigap Authorization ***Medicare #*** _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits be made on my behalf to Neurosurgical Associates of Central Jersey for any services furnished to me by that physician group. I authorize any holder of information about me be released to the Centers for Medicare and Medicaid Services, my Medigap insurer, and its agents any information needed to determine these benefits. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature **Date**

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PATIENT FINANCIAL AGREEMENT

COMMERCIAL INSURANCE: Neurosurgical Associates of Central Jersey, PA will bill your insurance provided that your deductible is met and your carrier will make payments directly to our office. We will attempt to bill your insurance company in an effort to collect payment. **In the event that your insurance company makes payment directly to you, payment will need to be sent to this office immediately along with the explanation of benefits.**

MEDICARE: If you are enrolled in Medicare, we are obligated by law to attempt to collect your co-insurance. Medicare has a fee schedule by which we must abide. Medicare reimburses us 80% of the allowable amount and requires you to pay the remaining 20%. If you have a Medigap or supplemental plan, the secondary may pay your 20%. You are also expected to pay your deductible at the beginning of the year.

PROOF OF COVERAGE: At the time of service, you must provide a copy of your most recent insurance card and a photo ID. If your insurance changes please notify us before your next visit so that we can make the necessary changes.

INSURANCE RELEASE: I authorize Neurosurgical Associates of Central Jersey PA to release to my insurance company and to communicate with hospitals and other medical providers any required information regarding services provided including: medical, psychiatric, laboratory studies, imaging, HIV testing and other medical data related to my care. **I authorize any insurer or payer to make payment directly to Neurosurgery Associates of Central Jersey, PA. A photocopy of this authorization shall be considered as effective and valid as the original. The authorization is considered valid until written notice of termination is received.**

DEDUCTIBLES: It is your responsibility to understand any deductibles / coinsurances that may apply to your policy.

PATIENT BILLING: If you do not have insurance, you will be expected to pay at the time of service. Our billing department will send out statements for outstanding balances. If the balance is still unpaid after three statements, you account will be sent to our outside collection agency. Please discuss financial hardship with our billing staff as soon as possible so that we may make arrangements for payment. If we do not participate with your insurance plan we will negotiate the best possible reimbursement. We will submit the claim to your insurance, however if the claim remains unpaid after 90 days, you will be responsible for any open balance. It is recommended that you contact your insurance company periodically regarding payment.

FINANCIAL AGREEMENT: I understand that my insurance contract is between me and my insurance company. I agree that I am responsible for any and all services in excess of my insurance limits as well as any non covered charges. I understand that failure to pay my account or make suitable financial arrangements may result in my account being turned over to an outside collection agency. If this becomes necessary, I will be responsible to pay all collection fees which include but are not limited to collection agency fees, court fees, attorney fees and any other fees incurred for the collection of my account in addition to the original charges. We believe it is our obligation to inform patients of our financial policy before services are provided in an effort to avoid any miscommunication at a later date.

I have read, understand and agree to the provisions of this financial policy.

Signature: _____ Date: _____

Spouse/Guarantor:_____ Date:_____

PATIENT HISTORY **DATE: _____/_____/_____**

NAME: _____ AGE: _____ DATE OF BIRTH:_____

REASON FOR VISIT: _____

PAIN ASSESSMENT: On a scale of **1 – 10** please rate your pain today (with "0" being no pain and "10" being the worst pain imaginable) _____

REVIEW OF SYSTEMS: (problems you have with other body parts and functions may be important to your neurological problem; please describe below any current problem you may have with the following):

GENERAL:	___ recurrent fevers	___ fatigue	___ weight change
SKIN:	___ rash	___ ulceration	___ jaundice
HEMATOLOGIC:	___ bruising	___ bleeding tendency	___ enlarged glands
ENDOCRINE:	___ diabetes	___ thyroid disease	___ hormonal / glandular
EYES:	___ blurred or double vision	___ glaucoma	___ flashing lights
ENT:	___ trouble swallowing	___ nose bleeds	___ ringing ears
CARDIOVASCULAR:	___ chest pain	___ palpitations	___ heart disease
RESPIRATORY:	___ frequent coughing	___ asthma	___ shortness of breath
GASTROINTESTINAL:	___ ulcer	___ acid reflux	___ constipation
GENITOURINARY:	___ frequent urination	___ blood in urine	___ kidney stones
ALLERGIC / IMMUNOLOGIC:	___ HIV	___ low white blood count	
MUSCULOSKELETAL:	___ back pain	___ neck pain	___ joint swelling
NEUROLOGICAL:	___ dizziness	___ recurrent headaches	___ gait changes
PSYCHIATRIC:	___ depression	___ anxiety	___ mood swings

PAST HISTORY (do you have or have you had any of the following and when?):

☐**I have had no medical problems in the past**

_____ high blood pressure
_____ heart attack
_____ heart bypass surgery
_____ heart failure
_____ emphysema / COPD
_____ asthma
_____ seizures
_____ blood disorders
_____ brain hemorrhage
_____ brain tumor
_____ convulsions
_____ other _____

_____ tuberculosis
_____ diabetes mellitus
_____ cancer (type) _____
_____ neurofibromatosis
_____ stroke
_____ aneurysm
_____ arthritis
_____ bleeding / clotting disorders
_____ blood transfusion
_____ hepatitis
_____ drug / alcohol addiction

FAMILY HISTORY (please check any medical problems that run in your family):

☐**I have had no family history in the past**

___ bleeding disorder relationship: _____
___ cancer (type)_____ relationship: _____
___ diabetes relationship: _____
___ heart disease relationship: _____
___ hypertension relationship: _____
___ mental illness relationship: _____
___ stroke relationship: _____

SOCIAL HISTORY (please check all that apply):

I drink alcohol: ___ often ___ sometimes ___ occasionally ___ rarely ___ never ___ prior history

I currently use or have previously used recreational drugs: ___ yes ___ no ___ prior history

___ I have never smoked cigarettes or used any tobacco products

___ I currently smoke cigarettes ___ < ½ pack per day (PPD) ___ ½ - 1 PPD ___ 1 – 2 PPD ___ > 2 PPD

___ I have smoked for _____ years ___ I quit smoking (when?) _____ ___ I chew tobacco ___ I smoke cigars

What is your current occupation: _____

MARITAL STATUS: ___ Married ___ Domestic Partnership ___ S/O ___ Divorced ___ Widowed ___ Single ___ Separated

Number of Children: _____

SURGICAL HISTORY (please list any surgery you have had in the past and the approximate date of your surgery):

___ I have never had surgery

DATE	PROCEDURE

MEDICATION HISTORY (include dosage, supplements and over-the-counter drugs):

___ I am not on any medications.

MEDICATION	DOSAGE

ALLERGIES: ___ I do not have any known allergies.

MEDICATION ALLERGY OR INTOLERANCE	REACTION

OTHER ALLERGIES	TYPE	REACTION
___ Latex		
___ Food		
___ Contrast Material		
___ Environmental		
___Other		

NEUROSURGICAL ASSOCIATES of Central Jersey, P.A.
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James M. Chimenti, MD, FAANS
Jay More, MD, FAANS

Medication Request Policy

Neurosurgical Associates of Central Jersey, PA can only provide pain medication for patients who require a surgical procedure. Our practice does not provide long-term pain management services. The following outlines our pain medication prescription policy:

- Patients **may** be prescribed pain medication during our initial evaluation and surgical preparation period, if it is felt that surgery will be likely required. If surgery is not required, the patient will be referred back to his or her primary care physician to manage pain or make additional referrals.
- Pain medication may also be prescribed for a predetermined period of time after the procedure is performed. During the recovery process, the amount of medication will be gradually reduced to help the patient avoid dependency on the drug, potential overdose, or harmful drug interactions.
- Pain medication is to be taken as prescribed. Patients are not to increase medication dosage without consulting a nurse or physician of Neurosurgical Associates of Central Jersey, PA. **Lost, stolen or prematurely completed prescriptions will NOT be rewritten.**
- If it is found that you have obtained controlled medications from another physician / practice or you have used these medications improperly, Neurosurgical Associates of Central Jersey, PA will no longer order these medications. THERE ARE NO EXCEPTIONS TO THIS POLICY.
- All medications require physician approval, and several medications used by this practice require the prescription written on a “hardcopy” and cannot be called in or faxed to the pharmacy. So that we may carefully review all patient records, the office requires a 72 (business) hour advance notice for prescription refills.
- Requests for prescription refills received on Friday will not be filled until the following Monday.
- Our patients are required to utilize only ONE pharmacy for all prescriptions.

Local Pharmacy:_____ **Phone:** _____

Town:_____

I have read and understand the above stated pain medication and prescription policy for Neurosurgical Associates of Central Jersey, PA.

_____ _____
Signature **Date**

_____
Print Name

NEUROSURGICAL ASSOCIATES of Central Jersey, P.A.
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James M. Chimenti, M.D.
Jay More, M.D.

E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program.

These include:

- **Formulary and benefit transactions**
  Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**
  Provides the physician with information about medications the patient is already taking to maximize the number of adverse drug events.
- **Fill status notification**
  Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Neurosurgical Associates of Central Jersey, P.A. can request and use your prescription medication history from other healthcare providers and / or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Neurosurgical Associates of Central Jersey, P.A. to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Representative Date

1200 U.S. Highway 22 East, 2nd Floor, Bridgewater, New Jersey 08807
Tel. 732.302.1720 Fax. 732.302.1724 www.neurosurgerycnj.com

NEUROSURGICAL ASSOCIATES of Central Jersey, P.A.
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Jay More, MD, FAANS

Standard Authorization of Use and Disclosure of Protected health Information

Information to Be Used or Disclosed
This authorization does not cover the information disclosed in our Privacy Policy. It is meant to give you more specific information and option regarding the use of your protected information.

Persons Authorized to Use or Disclose Information

- Neurosurgical Associates Providers & Staff

Persons to Whom Information May Be Disclosed

I hereby authorize the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Expiration Date of Authorization
This authorization is effective from the signature date on this document and will self renew annually unless revoked or terminated earlier by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Neurosurgical Associates Of Central Jersey, P.A. You should contact the Privacy Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Neurosurgical Associates Of Central Jersey, PA discloses it to another party.

Standard Authorization of Use and Disclosure of Protected health Information

Rights of the Individual

- You may inspect or request a copy of information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Effect of Refusing Authorization: If you refuse to sign this authorization, Neurosurgical Associates of Central Jersey , PA will not deny you any treatment. PLEASE KEEP IN MIND THAT THE MINIMUM DISCLOSURES (PAYMENT, TREATMENT, LEGAL,AND HEALTH DEPT) CAN NOT BE REFUSED IF YOU WISH US TO PROVIDE CARE TO YOU.

PRIVACY POLICY

By signing the bottom of this page, I acknowledge that I have reviewed a copy of Neurosurgical Associates of Central Jersey, PA's notice of privacy policies and authorize the designees above. I understand that a complete copy of the policy is available at Neurosurgical Associates of Central Jersey, PA's website (www.neurosurgerycnj.com) or by print in the office upon request.

Signature

Name of Patient (Print or Type)	Signature of Patient or Patient Representative	Date

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage and, if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

RIGHT TO AMEND OR SUPPLEMENT: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as it is.

If we do deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) of Section A of this Notice of Privacy Practices or disclosures for purpose of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official that providing this accounting would be reasonably likely to impede their activities.

RIGHT TO A PAPER OR ELECTRONIC COPY OF THIS NOTICE: You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

D. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice. The revised policies and practices will be applied to all protected health information we maintain.

E. COMPLAINTS:

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our privacy officer.

NEUROSURGICAL ASSOCIATES of Central Jersey, P.A.

NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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.

This medical practice collects health information about you and stores it in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical records belongs to you. The law permits us to use or disclose your health information for the following purposes:

TREATMENT: We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

PAYMENT: We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

HEALTH CARE OPERATIONS: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff.

Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our collection service and answering service that perform administrative services for us.

APPOINTMENT REMINDERS: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

SIGN IN SHEET: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

NOTIFICATION AND COMMUNICATION WITH FAMILY: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

REQUIRED BY LAW: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

PUBLIC HEALTH: We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

HEALTH OVERSIGHT ACTIVITIES: We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure or other proceedings, subject to the limitations imposed by law.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court of administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

LAW ENFORCEMENT: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

CORONERS: We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

ORGAN OR TISSUE DONATION: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

WORKERS' COMPENSATION: We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

CHANGE OF OWNERSHIP: In the event that this medical practice is sold or merged with another organization, your health information / record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

BREACH NOTIFICATION: In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. WHEN THIS MEDICAL PRACTICE MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do not authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. YOUR HEALTH INFORMATION RIGHTS

RIGHT TO REQUEST SPECIAL PRIVACY PROTECTIONS: You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose the information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

NEUROSURGICAL ASSOCIATES of Central Jersey, P.A.
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James M. Chimenti, MD, FAANS
Jay More, MD, FAANS

WORKER'S COMPENSATION INFORMATON

Name:_____ DOB:_____ SSN:_____

Gender: Male ☐ Female ☐ Language: _____ Email: _____

Race: White ☐ Black ☐ Asian ☐ Other ☐ Ethnicity: Hispanic ☐ Non-Hispanic ☐

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

Home Phone: _____ Work: _____ Cell:_____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

EMPLOYER

Employer Name: _____ Phone: _____

Employer Address: _____

WORKER'S COMPENSATION INFORMATION

Worker Compensation Carrier: _____

Carrier Address: _____

Carrier Phone:_____ Claim #: _____

Adjuster Name: _____ Adjuster Phone: _____

Attorney Name:_____ Address:_____ Phone: _____

INJURY INFORMATION

Date of Injury:_____ Time: _____ □ am □pm Place of Injury:_____

Please provide full description of how accident happened: _____

_____

Have you lost time from work? □ yes □ no If yes, how much: _____

Any previous accidents: □ yes □ no Dates of previous accidents:_____

Briefly describe previous injuries: _____

_____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible in the event that my claim is denied. I understand that filing for PIP benefits does not relieve me from any responsibility for the payment of all charges.

_____ _____
Signature of Patient/Parent/Personal Representative Date

_____ _____
Print name of Patient/Parent/Personal Representative Relationship to patient