Edison Spine and Pain Management, pc

1692 Oak Tree Road Edison, NJ 08820
Phone: (732)-343-6542
Fax: (732)-906-3675

Patient Information Sheet *(Please Print neatly)(Por Favor escribe cuidadosamente)*

Last Name (Apellido) _____ First (Primer Nombre) _____ Middle Name (Segundo Nombre) _____

Date of Birth:_____/_____/_____ (Fecha de Nacimiento) Soc. Sec. #:_____/_____/_____ (Seguro Social) Gender:☐ M ☐ F (Genero)

Race: ☐ White Black/African ☐American Indian/Alaska native ☐Asian ☐ Native Hawaiian/other Pacific Islander ☐ Spanish/Hispanic ☐Other _____ (Raza/Etnicidad)

Primary Language: _____ (Lenguaje primario)

Home #: _____ (Telefono de casa) Cell #:_____ (Cellular)

Address: _____ (Domicilio)

City: _____ (Ciudad) State: _____ (Estado) Zip:_____ (Codigo Postal)

Referring Physician: _____ (Referido por) Phone: _____ (Telefono)

Primary Care Physician: _____ (Doctor Primario) Phone: _____ (Telefono)

Emergency Contact Name_____ (Contacto de Emergencia) Phone: _____ (Telefono)

Relationship to Patient _____ (Relación con el paciente)

Primary Insurance Company Name: _____ (Nombre de la aseguranza)

Insurance ID #: _____ (Numero de Poliza o identificacion) Group #:_____ (Numero de grupo)

Please enter the policyholder's information below. *(Por favor ingrese la información del titular de la póliza a continuación.)*

Policyholder's Full Name: _____ (Nombre de la persona asegurada) Date of Birth:_____/_____/ (Fecha de Nacimiento)

Relationship to Patient: _____ (Relación con el paciente) Soc. Sec. # _____/_____/

Address: _____ (Direccion)

City: _____ (Ciudad) State: _____ (Estado) Zip:_____ (Codigo Postal)

Home #: _____ (Telefono de casa) Cell #:_____ (Cellular)

Employer:_____ (Empleador)

Edison Spine and Pain Management PC
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Assignment of Benefits & LTD. Power Of Attorney

Patient:_____ **Date of Loss:** _____

I hereby irrevocably authorize "Edison Spine and Pain Management, PC" and/or its designees to provide treatment and/or examination, and release any pertinent information to my physician, insurance company, adjuster or attorney if applicable, and to apply for Medicare/Medicaid, and other health insurance benefits if applicable, (No Fault, Personal injury Protection & Workers Compensation) on my behalf and to take all necessary steps to collect such benefits, including but not limited to filling for arbitration as provided by statues. I hereby authorize payment of any/all medical benefits and insurance proceeds made on my behalf to the above. I certify that the information I have reported with regard to my insurance carriers is correct. I authorize the release of medical information about me to my physician, health insurance carrier and the center of Medicare & Medicaid Services (CMS) agents, and any and all other information needed to determine the benefits payable for related services(s).

If medical insurance is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are fully reimbursed by your insurance and are indicated on your insurances Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement. Also, please be aware that this center will not forgive patient deductibles, patient co-payments, and patient co-insurance payments. It is against the law.

If you do not have medical insurance, financial arrangements will be made prior to services being rendered. Otherwise, full payment will be expected at the time of services.

By signing below, I hereby attest that I have provided all insurance coverage applicable for services performed at this time; I attest that the policy was in full force and effective at the time services were rendered. In the event that there is insurance coverage requiring pre-certification and it is not disclosed at the time of service I will be held personally responsible for any outstanding balance due to lack of pre-certification.

In the event the insurance carrier responsible for making medical payments in this matter does not accept the assignment, or my assignment is deemed invalid, I execute this limited power of attorney and authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect some sums due if such sums are not paid within the legally prescribed, or within a reasonable period of time or if denied by the carrier per N.J.A.C. 113-5.1 do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider for any expenses not covered by the responsible insurance carrier.

I realize that I am financially responsible for charges not covered by this assignment. Payment in whole or part shall be considered as if paid by your company directly to me. A photocopy of this assignment shall be valid as original.

Insured:_____

Claim #: _____

Patient Signature:_____

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Authorization of Disclosure of Protected Health Information by another Covered Entity for Use by Edison Spine and Pain Management PC

Information to Be Used or Disclosed

Information to be obtained under this authorization includes: Medical Records

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

- Third party billing and/or collection services
- Transcription services
- Interpreters for translation

Persons Authorized to Use or Disclose Information

Information described above may be disclosed to:
Legal representatives of Edison Spine and Pain Management PC and their associates

Expiration Date of Authorization

This authorization unless revoked or terminated 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 Edison Spine and Pain Management PC

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual

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

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

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Medical Records Release Form

Doctor's name and/or Hospital _____

Address _____

I hereby authorize and request you to release to Edison Spine and Pain Management PC complete medical records in your possession concerning my illness and/or treatment during period:

From _____ to _____

Patient Name: _____

Patient Address: _____

_____

Signature: _____

Witness: _____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list ALL medications taken on a daily basis, including vitamins, herbals and over-the-counter medications. Please list all medication allergies.

Please list pharmacy name and telephone number.

Medication Name	Dose/Strength	Times taken per day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

MEDICATION ALLERGIES: _____

Pharmacy Name: _____ **Phone Number:** _____

Pharmacy Address: _____

Edison Spine and Pain Management PC
1692 Oak Tree Road Edison, NJ 08820
Phone: (732)-343-6543
Fax: (732)-906-3675

Date: _____

Attorney: _____

Patient Name: _____

D/A: _____

Dear Sir or Madam:

I hereby authorize the above doctor to furnish you my attorney, with a full report of his examination, diagnosis treatment, prognoses, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for professional services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may necessary adequately to protect said doctor. I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all professional bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment, and I further understand that such payment is not contingent on any settlement judgement or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Date: _____ **Patient Signature:** _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary adequately to protect the said doctor named above. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded fees and costs.

I hereby consent to honor the terms of the above agreement in its entirety. I further agree to dispense all fees to my client's provider pursuant with R.P.C. 1.45 in NJ, and DR9-102 in NY.

Date: _____ **Attorney's Signature** _____

Attorney: Please acknowledge this letter by returning a copy to the doctor's office at once.

Keep one for your records.

PATIENT CONSENT FORM

Edison Spine and Pain Management, PC
1692 Oak Tree Road, Edison, NJ 08820
TEL: (732) 343-6543 FAX: (732) 906-3675

PATIENT NAME: _____
PATIENT DOB: _____
DATE OF SERVICE: _____

1. **CONSENT FOR MEDICAL AND SURGICAL TREATMENT**: the undersigned consents to the procedures which may be performed during on an outpatient basis, including emergency treatment or services, and which may be included but are not limited to laboratory procedures and testing, X-Ray examination, medical or surgical treatments or procedures, anesthesia, pharmaceutical products, blood or blood derivatives and intravenous medication, or other diagnostic procedures, medical treatments and hospital services rendered to the patient under the general and special instructions of the patients physician or surgeon.
    A. Major procedures are not carried out upon a patient until he or she has discussed them with the physician or health professionals and has agreed to the procedure, except in emergencies or other unusual circumstances.
    B. Each patient has the right to consent or to refuse to conse4nt to any proposed procedure or treatment.
    C. No patient will be involved in any research or experimental procedure without his or her full knowledge or consent.

    I impose no specific limitations or restrictions other than the following: ◯ NONE or

    List: _____
2. **THE UNDERSIGNED UNDERSTANDS THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND THAT DIAGNOSIS AND TREATMENT MAY INVOLVE A RISK OF INJURY OR EVEN DEATH. THE UNDERSIGNED ACKNOWLEDGES THAT NO GUARANTEE HAS BEEN MADE AS TO THE RESULT OF EXAMINATION OR A COURSE OF TREATMENT AT Edison Spine and Pain Management, PC.**
3. **RELEASE OF INFORMATION**: to the extent necessary to determine liability for payment and to obtain reimbursement, Edison Spine and Pain Management, PC may disclose portions of the patients record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of Edison Spine and Pain Management, PC charge, including but not limited to insurance companies, healthcare service plans or workers compensation carriers, public assistance agencies patient's employer or review organizations and agencies.
4. I hereby authorize Edison Spine and Pain Management, PC, all doctors rendering care and treatment to furnish the responsible parties and/or insurance companies with full information regarding treatment rendered. (Including copies of my record). A photocopy of this authorization shall be considered effective as valid as the original.
5. **FINANCIAL AGREEMENT**: the undersigned agrees, whether he/she signs as agents or as patient, that inconsideration of the services to be rendered to the patient he/she hereby individually obligates him/her to pay the account of Edison Spine and Pain Management, PC in accordance with the regular rates and terms of Edison Spine and Pain Management, PC. Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay actual attorney's fees and collection expense.
6. I further consent to the drawing blood and testing for exposure to Syphilis, the Hepatitis B and Human Immune-Deficiency Virus, in the event that any individual at Edison Spine and Pain Management, PC is accidentally exposed to my blood fluids. The result of these tests will remain strictly confidential except as specified by law.
7. **ASSIGNMENT OF BENEFITS**: I hereby assign and transfer to Edison Spine and Pain Management, PC all insurance benefits payable to me by my insurance company as specified above for services performed and costs incurred I connection with this procedure. I understand that the assignment of benefits shall be exclusively for the payment of charges for this procedure. I authorize release of all records required to act on this request. I hereby assign any insurance benefits due to me and authorize payment made directly to the associated anesthesia and laboratory services

The undersigned certifies that he/she has read the foregoing, is satisfied with its consent and significance and is the patient or is duty authorize by the patient as the patient's general agent to execute the form and accept its terms.

_____ _____ _____
PATIENT/RELATIVE/GUARDIAN SIGNATURE **RELATIONSHIP, if other than patient** **DATE/TIME**

_____
WITNESS SIGNATURE