NEXGEN ORTHOPEDICS

PATIENT REGISTRATION

Patient Name: _____ **Sex**: ☐ M ☐ F **Date of Birth**: __/__/____

Home Phone #: _____ **Cell Phone #**: _____ **Email Address**: _____

SSN: _____-_____-_____ **Marital Status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____

Occupation: _____ **Employer:** _____

Employers Address/Tel. #: _____

Emergency Contact: _____ **Relationship**: _____ **Phone #**:_____

Primary Care Provider (PCP) _____ **PCP Phone:** _____

Referring Provider: _____ **Referring Phone**: _____

IS THIS VISIT A RESULT OF: ☐ Work Injury ☐ Auto Accident ☐ Slip & Fall ☐ Other_____

Please list all active treating physicians (i.e pain management, cardiology, physical therapist, chiropractor, etc.)

Doctors Name: _____ Specialty: _____

Doctors Name: _____ Specialty: _____

Doctors Name: _____ Specialty: _____

Desired Pharmacy

Pharmacy Name: _____ Phone Number: _____

Address: _____

MEDICAL INSURANCE INFORMATION

(*Policy holder information (even if other than patient)*)

Primary Insurance: _____ ID# _____ Group/Policy# _____

Insured Name: _____ Insured SSN: _____-_____-_____ DOB: ___/___/_____

Secondary Insurance: _____ ID# _____ Group/Policy# _____

Insured Name: _____ Insured SSN: _____-_____-_____ DOB: ___/___/_____

NEXGEN ORTHOPEDICS

Dr. Lloydine Jacobs
Tel: (844) 724-6735 **Fax:** (855) 72302174

Today's Date: _____

Patient Name: _____ **Date of Birth**: _____ **Gender**: ☐ M ☐ F

Current Age: _____ **Height**: _____ **Weight**: _____

Where is your pain located: _____

How long have you been having this pain? ___ weeks _____ months _____ years

Date of Injury: _____ Date you **first received treatment** for this injury:_____

Cause of Injury: ☐ car accident? ☐ car vs, pedestrian? ☐ injured on the job? ☐ slip/trip and fall?

Describe how the accident or injury occurred:

_____

_____

_____

Were you taken to the ER? □ Yes □ No **Did you go to the ER via**: □ Ambulance □ Car

Is this your first car accident? □ Yes □ No **Have you injured this body part before?** □ Yes □ No

Where did the accident occur: □ New Jersey □ New York □ Pennsylvania □ Other _____

What previous treatments have you had?

□ NSAIDs (Ibuprofen/Motrin/Aspirin/Aleve) □ Narcotic Medication (Percocet, Hydro, Oxy)

□ Physical Therapy: How Long? _____ weeks _____months. Where? _____

□ Chiropractic: How Long? _____ weeks _____months. Where? _____

□ Injections. What body parts? _____ How many injections? _____

□ Other treatments: _____How Long? _____

□X-rays □ MRIs Where were they done? _____ Date: _____

Medical History:

☐High Blood Pressure	☐Anemia	☐DVT or PE
☐Diabetes	☐Heart Murmur	☐Cirrhosis
☐Heart Attack	☐Angina	☐HIV
☐Congestive Heart Failure	☐Rheumatoid arthritis	☐Bleeding Tendency
☐Asthma	☐Chronic Bronchitis	☐Depression
☐Emphysema	☐Frequent Pneumonia	☐Anxiety
☐COPD	☐Tuberculosis	☐Hepatitis A, B, C
☐High Cholesterol	☐Osteoporosis	☐Gout
☐Stroke	☐Stomach Ulcer	☐UTI
☐Multiple Sclerosis	☐Enlarged Prostate	☐MRSA Infection
☐Hypothyroidism	☐Cancer: what type_____	☐Other: _____

Medications

Medication	Dose	Frequency	Reason for Taking	Prescribing Physician

☐Medications continued on the back of this page (if necessary)

Allergies

Medication/Allergen	Reactions

☐Allergies continued on the back of this page (if necessary)

Surgical History

Surgery	Date

☐Surgeries continued on the back of this page (if necessary)

Social History:

Marital Status	☐Married ☐Single ☐Separated ☐Divorced ☐Widowed
Who lives at home with you?	
Alcohol	☐None ____ drinks per ☐day ☐week ☐month
Tobacco Use	___ packs per day ☐Chew ☐Never ☐Quit: how long ago?_____
Illicit Drug Use	☐Yes ☐No Which one(s) _____
Work Status	☐Full time ☐Part time ☐Disabled ☐Retired ☐Student
Employer	_____ Location: ☐NJ ☐NY ☐PA ☐CT
Occupation	

Family History

Family Member	Medical Problems
Mother	
Father	
Siblings	

Review of Systems: Circle those that apply

General	*Fever fatigue unintentional weight loss night sweats sleep disturbance*
HEENT	*Dizziness blurred vision sinusitis hearing loss sore throat vertigo*
Cardiac	*Chest pain irregular heart beat shortness of breath fainting heart attack*
Pulmonary	*Persistent cough excessive mucus/phlegm trouble breathing COPD*
Gastrointestinal	*Heartburn constipation nausea vomiting diarrhea GERD ulcers*
Musculoskeletal	*Joint swelling joint pain arthritis cramps weakness osteoporosis*
Endocrine	*Excessive thirst weight fluctuations excessive sweating appetite change*
Neurological	*Loss of balance numbness tingling weakness seizures burning pain*
Genitourinary	*Difficulty urinating blood in urine current UTI frequent UTIs amenorrhea*
Hematological	*Excessive bleeding history of blood clots easy bruising blood disorder*
Dermatological	*Open sores new moles difficult wound healing skin infections bruising*
Psychological	*Feeling of hopelessness depressed mood change in sleep patterns*

Height: _____ Weight: _____ *Circle one:* Left or Right Hand Dominant

_____ _____ _____

Patient Signature Print Name Date

Do not write below this line- for medical assistant use only

_____

BP: _____ Temp: _____ P: _____ R: _____ O2 Sat: _____

NEXGEN ORTHOPEDICS

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby request a copy of the following patient's medical records:

Name of Patient: _____DOB:_____ SSN: _____
Address: _____ City: _____ State:_____ Zip Code: _____

Information to be released:
This authorization includes release of information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol related conditions, and HIV or AIDs related conditions.

Date of service or date ranged requested: _____

___ Discharge Summary	___ History & Physical	___ Face Sheet
___ Emergency Dept Record	___ Operative Reports	___ Pathology Reports
___ Laboratory Reports	___ Immunization Records	___ Outpatient Records
___ Itemized Bills	___ Neuropsych Reports	___ Psychological Reports
___ Imaging Reports	___ Other:	___ Entire Medical Records

The above information is to be released to

Next Gen Orthopaedics
623 Lafayette Avenue, Suite 102
Hawthorne, NJ 07506
Tel: 844-724-6735
Fax: 855-723-2174

_____ _____ _____
Patient Print Name Patient Signature Date

NEXGEN ORTHOPEDICS

PATIENT RIGHTS AND RESPONSIBILITIES

Patient's Rights

Every patient has the right to be treated as an individual with his/her rights respected. The facility and medical staff have adopted the following list of patient rights:

1. To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
2. To be treated with respect, consideration and dignity in receiving care, treatment, procedures, surgery and/or services.
3. To be provided privacy and security of self and belongings during the delivery of patient care service.
4. To receive information from his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
5. To receive information about and proposed treatment or procedures as he/she may need to give informed consent prior to the start of any procedure/treatment.
6. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient, or to a legally authorized person.
7. To make decisions regarding the health care that is recommended by the physician. Accordingly, the patient may accept or refuse any recommended medical treatment. If treatment is refused, the patient has the right to be told what effect this may have on their health, and the reason shall be reported to the physician and documented in the medical record.
8. To be free from mental and physical abuses, free from exploitation, and free from use of restraints. Drugs and other medications shall not be used for the discipline of patients or for convenience of facility personnel.
9. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly.
10. Leave the facility even against the advice of his/her physician.
11. Reasonable continuity of care and to know in advance the time and location of appointment, as well as the physician providing the care.
12. Be informed by his/her physician or a delegate of his/her physician of the continuing health care requirements following his/her discharge from the facility.
13. To know the identity and professional status of individuals providing services to them, and to know the name of the physician providing the care.
14. Know which facility rules and policies apply to his/her conduct while with a patient.
15. Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. All personnel shall observe these patient rights.
16. To be informed of any research or experimental treatment or drugs and to refuse participation without compromise to the patient's usual care. The patient's written consent for participation in research shall be obtained and retained in his or her patient record.
17. Examine and receive an explanation of his/her bill regardless of source of payment.
18. To appropriate assessment and management of pain.

Rights and Respect for Property and Person

The patient has the right to:

- Exercise his or her rights without being subjected to discrimination or reprisal.
- Voice grievance regarding treatment or care that is or falls to be furnished.
- Be fully informed about a treatment or procedure and the expected outcome before it is performed.
- Confidentiality of personal medical information.

Privacy and Safety

The patient has the right to personal privacy, receive care in a safe setting, be free from all forms of abuse or harassment.

Patient Signature: _____ **Date:** _____

NEXGEN
ORTHOPEDICS

NOTICE OF PRIVACY PRACTICES

WE MAY USE YOUR HEALTH INFORMATION TO:

Recommend alternative treatments, remind you of appointments, tell you about health services and products that may benefit you, or to share information with your family or friends involved in your care or payment of your care when appropriate.

We may need to share information with third parties who assist us with treatment, payment, and health care operations. Our business associates must follow the privacy practices and disclose your health information as required by federal, state, and local law.

SHARING YOUR HEALTH INFORMATION

In some limited situations, we are permitted or required to disclose health information without your signed authorization. These situations are: for public health purposes, or for health oversight activities such as investigation, audits and inspections. Information may be shared when requested by law or a court order, or an insurance company regarding a claim.

All other uses and disclosures not described in this notice require your signed authorization. We have provided a place to write those names. You may revoke your authorization at any time with a written statement.

I, _____, acknowledge receipt of Next Gen Orthopaedics Notice of Privacy Practices.

Patient Signature: _____ Date: _____

NEXGEN ORTHOPEDICS

FINANCIAL POLICY AGREEMENT

We have been informed that some Insurance Carriers will no longer be paying doctors directly for care. Instead, they will only send insurance payments directly to patients.

By signing this, you agree to forward all payments to our office immediately upon receipt. If we receive payments within 10 days of you receiving them, endorsed, and un-cashed, with documentation we will accept those insurance payments in full and you will not be responsible for any additional amounts should they pay less than anticipated. I understand this may not include the following:

- **Co-payments, Deductibles, and Fees**: Co-payments, deductibles and fees for services not covered by your insurance are due at the time service is rendered. We accept cash, checks, and most major credit cards.
- **Insurance:** You must present a current insurance card at each visit. If your insurance plan is not one we participate with, we will assist in filing your insurance claim, but payment in full is expected at the time of service. It is your responsibility to provide timely and accurate information to our office so claims can be properly submitted.
- **Auto Insurance/Third Party Liability:** Please notify our office immediately if your injury is a result of an auto accident or third party liability. You may be responsible for payment at the time of service if your treatment is related to third party liability.
- **Missed Appointments:** Repeatedly missing, rescheduling, or cancelling appointments may be grounds for dismissal from the practice

Prompt Payment: We expect that you will make every effort to pay your bill promptly. If you do not have medical insurance, have a financial hardship, or if you are unable to pay your bill in its entirety please contact our billing office prior to your appointment to discuss payment options. Chronic non-payment will be grounds for dismissal from the practice. We reserve the right to turn any account over to a collection agency if the account is not paid within 30 days.

Remember: Send or bring all original checks to our office and do not cash them. Sign your name on the back of the check and write "Pay to the order of **Dr. Lloydine Jacobs".**

Include all paperwork sent with check by insurance company.

_____	_____	_____
Print Patient Name	Patient Signature	Date

NEXGEN ORTHOPEDICS

OUT OF NETWORK NOTICE

I have been informed that Next Gen Orthopaedics, LLC and some of its affiliates may be an "**Out of Network"** entity. I understand that there is a possibility that partial or total reimbursement for their services may be sent directly to me by my insurance company. When this correspondence from the insurance company arrives, I take responsibility to contact the office within 7 days to provide the following:

The **EXPLANATION OF BENEFITS AND ENDORSED CHECK, PERSONAL CHECK OR DEBIT/CREDIT CARD** for the amount of the reimbursement and any corresponding co-insurance, including my deductible.

While it is my understanding that Next Gen Orthopedics, LLC and its health care providers puts the needs of its patients first and intends to work with you on payments, I also understand that if I do not make an attempt to work with Next Gen Orthopaedics, LLC to resolve payment for its health care providers or affiliates for rendered medical services, I may be sent to collections and additional fees of late charges, interest payments, collection agency fees, attorney fees may apply.

_____	_____	_____
Print Name Patient	Patient Signature	Date

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

I hereby assign benefits and authorize payment directly to NextGen Orthopaedics LLC and/or its staff (hereinafter collectively "You") of any insurance benefits made as payment to me (or a minor for whom I am guardian) as reimbursement for services provided to me (or a minor for whom I am the guardian) for their services. I agree to immediately forward to this office any insurance payments which are made directly to me

I, _____, irrevocably assign to you, Dr. Lloydine Jacobs, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code. I request that the insurance carrier consent to my assignment of benefits within 10 days of receipt otherwise it is deemed consented to.

As medical provider I agree to attempt to reasonably comply with the PIP carrier's decision point review/precertification plan and to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

PLEASE SELECT INSURANCE:

□ BLUE CROSS BLUE SHIELD	□ UNITED HEALTHCARE	□ CIGNA
□ AETNA	□ GHI/EMLBEM HEALTH	□ OTHER

_____ _____ _____ _____

Print Name Patient | Patient Signature | Date | Doctor's Signature

Legal Assignment of Benefits & Designation of Authorized Representative

I_____, the undersigned, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to, **Next Gen Orthopaedics LLC** and all medical professionals, including physician assistants of this practice, including, but not limited to **Dr. Lloydine Jacobs** as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA.

I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the Designated Authorized Representative(s) any and all plan documents, including Governing Plan Documents, including, but not limited to a written explanation of how level of benefit payments are determined for out-of-network providers, Summary Plan Description, 5500 Form (Plan Annual Return), Certificate for PPACA Grandfathered Health Plan, where applicable, insurance policy and/or settlement information upon written request from the Designated Authorized Representative(s) in order to claim certain medical benefits in connection for healthcare services provided to the undersigned. This, includes, but is not limited to, receiving disbursement benefit checks for claims submitted, member's rights to appeal claim denials, as well as to claim any applicable statutory penalties on behalf of the plan participant and beneficiary. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the Designated Authorized Representative(s) to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, cause of action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor, including, but not limited to, issuance of reimbursement checks, Explanation of Benefits and any/all correspondence related to claims reimbursement; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the Designated Authorized Representative(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the Designated Authorized Representative(s) against any such liable party or employee group health plan in my name with derivative standing but at such Designated Authorized Representative(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

PLEASE SELECT INSURANCE:

□ BLUE CROSS BLUE SHIELD	□ UNITED HEALTHCARE	□ CIGNA
□ AETNA	□ GHI/EMLBEM HEALTH	□ OTHER

I have read and fully understand this agreement.

_____	_____	_____	_____
Print Name Patient	Patient Signature	Date	Doctor's Signature