PMP
Pain Medicine Physicians
Life Without Pain

NEW PATIENT INTAKE FORM

Name: _____ **DOB:** ____/____/____

Age: _____ **Sex:** M F **Marital Status:** S M W D **Height:** _____ **Weight:** _____

Address: _____ **City/State:** _____ **Zip:** _____

Phone #: (___) ___-_____ **Cell #:** (___) ___-_____

Email: _____

Occupation: _____

Please circle for the following questions:

Race: White / Black / Hispanic / American Indian / Alaska Native / Asian / African American / Native Hawaiian /Other

Ethnicity: Hispanic / Latino / Not Hispanic / Not Latino / Other

Language: English / Spanish / Italian / French / German / Chinese / Arabic / Other

Emergency Contact: _____ **Relation:** _____ **Phone:** (___) _____

PCP: _____ **Phone:** (___) ___-_____ **Address:** _____

Referring MD: _____ **Phone:** (___) ___-_____ **Address:** _____

How did you hear about our office? Doctor / Attorney /Friend / Internet

Is your pain related to: Work Injury / Motor Vehicle Accident / Other: _____

INSURANCE INFORMATION

*If your pain was caused by an accident, please use that information as your **primary insurance***

	Primary Insurance	**Secondary Insurance**
Company:	_____	_____
Card Holder: Name:	_____	**Name:** _____
Card Holder: DOB:	__/__/____	**DOB:** __/__/____
Policy #	_____	_____
Group #	_____	_____
Employer:	_____	

Date of Accident: ____/____/____ **Claim #** _____

Attorney: _____ **Phone #** (___) ___-_____ **Fax #** (___) ___-_____

Adjuster: _____ **Phone #** (___) ___-_____ **Fax #** (___) ___-_____

MEDICAL INTAKE FORM

NAME:_____ **DOB:**_____

MEDICATION ALLERGIES:

Check Here If None ☐

MEDICATION LIST:

Please include vitamins, fish oil and aspirin

Please List Name	Reaction	Name and Dosage	Doses per day

Medical History:

Past Surgeries:

Please List Diagnoses		Please List	Date

Pharmacy Info:_____

Have you ever been diagnosed with?

Cancer ☐ **Stomach Ulcers** ☐ **Kidney Disease** ☐ **Liver Disease** ☐ **Bleeding Problem** ☐ **Depression** ☐

Questions about Your Pain: *Please check below which of the treatments below you have had for your pain*

	Chiropractor		TENS		Epidural		Anti-inflammatory
	Physical Therapy		Brace		Surgery		Narcotic
	Acupuncture		MRI		Neurology Consult		Muscle relaxant
	MUA		CT scan		Orthopedic Consult		Antidepressant
	X-ray		EMG		Surgical Consult		Other procedure

Do any of your family members have medical problems?

Please list: High Blood Pressure, Diabetes, Cancer, Addiction, Other

Mother:_____ **Father:**_____ **Grandparent:** _____

Sister: _____ **Brother:**_____ **Other:** _____

SOCIAL HISTORY

Please check all of the boxes below that apply to you:

Alcohol

- ◘ I currently do not use alcohol and never have.
- ◘ I currently do not use alcohol but used to:
  Date I quit using alcohol: _____ Amount of years I drank alcohol: _____
- ◘ I currently use alcohol socially:
  Amount of drinks per day: _____
  Amount of drinks per week: _____
  Amount of drinks per year: _____

Type of alcohol I drink:

☐ Beer ☐ Wine ☐ Vodka ☐ Scotch ☐ Whiskey ☐ Gin
☐ Bourbon ☐ Rye ☐ Liquors ☐ Champagne ☐ Other _____

Tobacco

- ◘ I currently do not smoke and have never smoked.
- ◘ I used to smoke but do not currently smoke.
  Amount of years I smoked: _____ Year I quit: _____
- I currently smoke.

What I smoke: _____ Amount per day I smoke: _____ Years smoked: _____

Addiction

- I have a family history of addiction to alcohol
  - Family member(s) involved: _____
  - Was there a fatal overdose involved? _____
  -
- ◘ I have a history of an addiction to alcohol
- ◘ I am currently addicted to alcohol

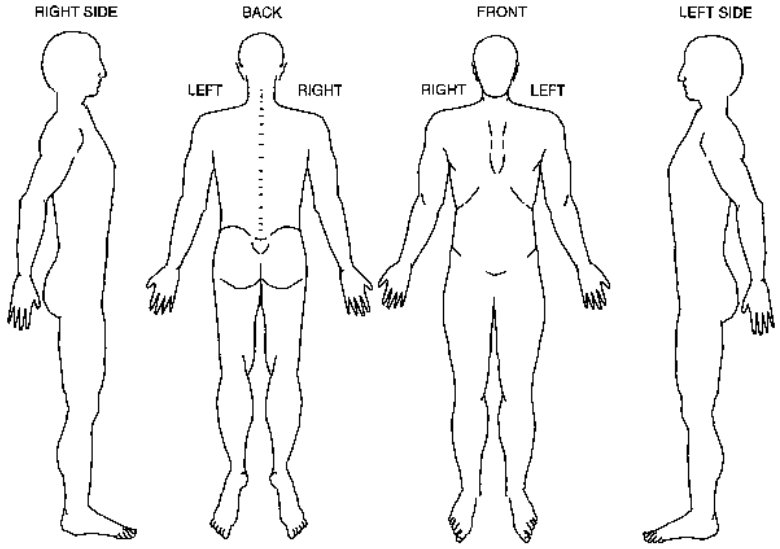
- I have a family history of addiction to drugs
- Family member involved: _____
- Which drug(s)? _____
- Was there a fatal overdose involved? _____

- I have history of an addiction to alcohol
- I am currently addicted to drugs
- Prescription medications _____
- Street drugs _____
- How I obtain the drugs _____
- I have seen a ☐ psychiatrist ☐ psychologist ☐ therapist ☐ sponsor
  ☐ Addiction specialist ☐ none of the above ☐ other _____

.

NAME: _____ **DOB:** _____

INSTRUCTIONS: Please mark the areas on your body where you feel your **PAIN**. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



WORST _____ **BEST** _____ **NOW** _____

187 Millburn Ave Suite 103 Millburn NJ 07041 **2701 Highway 70 Manasquan, NJ 08736**

519 River Rd Edgewater, NJ 07020
www.pmppain.com
Phone: 973-467-1466 Fax: 973-467-1422

REVIEW OF SYSTEMS

Please write in the number next to any of the symptoms below: **1 PRESENTLY HAVE 2 PREVIOUSLY HAD**

	Fever		Arthritis		Heart Problems
	Headaches		Bursitis		High Blood pressure
	Sleep Loss		Foot Trouble		Heart Murmurs
	Weight Loss		'Poor Posture		Poor Circulation
	Nausea		Chronic Cough		Swelling of Ankles
	Wheezing		Spinal Curvature		Chest Pain
	Hearing Loss		Frequent Colds		Depression/Nervousn ess
	Bowel/Bladder Problems		Tingling/Numbness		Hemorrhoids
	Earache		Constipation		Diarrhea
	Weakness		Frequent Urination		Difficult Breathing
	Fatigue		Inability to Control Bladder		Kidney Infection or Stones
	Bloody Stool		Fainting		Vomiting
	Sinus/Hay Fever		Painful Menstruation		Loss of Interest or Energy
	Heat/Cold Intolerance		Joint Pain/Swelling/Stiffness		Loss of Appetite
	Dizziness		Excessive Hunger/Thirst		Loss of Consciousness
	Vision Problems		Muscle Pain/Cramps		Thyroid Problem
	Glasses/Contact Lens		Irritable		Asthma
	Sexual Dysfunction		Memory Problems		Back or Neck Pain
	Speech Problems/Hoarseness		Clumsiness		Stress (Emotional)
	Excessive Sweating		Diabetes		Seizures or Convulsions
	Swallowing Difficulties		Palpitations		Easy Bruising or Bleeding

Giovanni Ramundo, M.D.
Henry Wroblewski, M.D.
Lori D'Andrea, PA-C
Avni Sawhney, DPT

Authorization Of Record Release

NAME: _____ DOB: _____

I_____, authorize the release of all medical records to Pain Medicine Physicians at the address below.

I understand that "all" medical information includes all of my medical information, including reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B and C testing/treatment and/or sensitive information.

If at any time you wish to revoke this authorization, please request so in writing.

Thank you.

Patient Signature: **Date:**

_____ _____

PAIN MEDICINE PHYSICIANS

Patient Bill of Rights

As a patient at Pain Medicine Physicians, a New Jersey healthcare facility, you have the following rights under state law and regulations.

1. **To be informed** of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical *record,* that the patient was offered a written copy of these rights. Also given a written and verbal explanation of these rights, in terms the patient could understand. Pain Medicine Physicians shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. **To be informed** of services available in the facility, of the names and Professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. **To be informed** if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment;
4. **To receive** from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health; or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. **To be given** informed written consent prior to the start of specified, non-emergency medical procedures or treatments. Your physician should explain to you-in words you understand-specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives;
6. **To refuse** medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life threatening or the procedure is required by law. Such refusal shall be documented in the patient's medical record.
7. **To expect** and receive appropriate assessment, management and treatment of pain and reasonable continuity of care.
8. **To be included** in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, role and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
9. **To obtain a copy of your medical record, at a** reasonable fee, within 30 days after a written request to Pain Medicine Physicians.
14. **To be advised in writing of** Pain Medicine Physicians' rules regarding the conduct of patients, family members and visitors.
15. **To be free from mental** and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to, protect the patient or others. Drugs and other medication shall not be used for discipline of patients or for convenience of facility personnel;
16. **To confidential treatment of** information about the patient Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health facility to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
17. **To be treated** with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient. Also to have physical privacy during medical treatment and personal hygiene functions, unless you need assistance;
18. **To not be required** to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, state, and federal laws and rules;
19. **To exercise civil** and religious liberties, including the right to independent personal decisions. No religious beliefs, or practices or any attendance at religious services, shall be imposed upon any patient;
20. **To not be discriminated** against because of race, age, religion, sex, national origin, sexual preferences, handicap, diagnosis, ability to pay, source of payment or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility:
21. **To present questions or grievances** to Dr. Giovanni Ramundo (973) 467-1466 and receive a response in a reasonable time. Pain Medicine Physicians must provide you or your guardian with the names, addresses, and telephone numbers of the government agencies to which you can make a complaint and ask questions. Such as the New Jersey Department of Health & Senior Services. You may call the complaint hotline at (800) 792-9770.

Below is the patient and family responsibility as a patient at Pain Medicine Physicians:

1. To provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations and other issues related to his/her health.
2. To make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
3. To follow the treatment plan established by the provider, including the instructions of health professionals as they carry out the physician's order.
4. To keep appointments and/or notify the clinic when he/she is unable to do so.
5. To assure that the financial obligations of his/her medical care are fulfilled as promptly as possible.
6. To follow Pain Medicine Physicians policies and procedures.
7. To be considerate of the rights of other patients and personnel.

This Patient Bill of Rights is an abbreviated summary of the current New Jersey law and regulations governing the rights of Pain Medicine Physicians patients. For more complete information, consult the NJ Department of Health regulations at v.vm.state.ni.us/health regarding NJAC 8:43 G-4, or Public Law 1989 Chapter 170.

Advance Directives

You have the right to enter into an advance directive. An advance directive means a written statement of your instructions and directions for health care in the event of your future decision making incapacity. An advance directive may include a proxy directive or an instruction directive, or both (N.J.A.C. 8:43 A-I-3). Pain Medicine Physicians does not honor advance directives. However, you may provide Pain Medicine Physicians a copy of your advance directive in the event that you require additional treatment at another health care facility. Pain Medicine Physicians will ensure your advance directive is forwarded to that facility.

Physician Ownership

I have been informed that Giovanni Ramundo, M.D. does have a financial interest in Pain Medicine Physicians and Short Hills Surgery Center.

We sign this with the knowledge and understanding that the rights of the patient can only benefit the patient's interest and individually and, further, that these rights have been explained to me/us verbally. By signing you or your legal representative, acknowledge that: (1) you have been informed that part or all of your procedure will be considered "out-of-network", if applicable; (2) you have the right to enter into an advance directive; (3) Physician Ownership.

**Out of Network Disclosure

Please take notice that *Dr. Giovanni Ramundo* is **non-participating or contracted** with any insurance provider EXCEPT Medicare, and Cigna. Please take notice that *Dr. Henry Wroblewski is* **non-participating or contracted** with any insurance provider EXCEPT Medicare. Such part or all of your upcoming procedure may be considered "out-of-network". You may be personally responsible for the co-payment, co-insurance, deductible, or other charges associated with such "out-of-network" services that are not covered by your insurance carrier.

Patient Signature:_____**Date**_____

(Parent or Legal Guardian)

PAIN MEDICINE PHYSICIANS

NOTICE OF PRIVACY/PATIENT RIGHTS/OWNERSHIP ACKNOWLEDGEMENT

Please complete the following and check all that apply:

HIPAA DISCLOSURE AND AUTHORIZATION

I hereby acknowledge that I have been given opportunity to request materials of the Health Information Portability and Accountability Act (HIPAA)/Notice of Privacy Practice. I have received a copy of Pain Medicine Physicians' Notice of Privacy Practices. I give my permission to release information to the following individuals during my visit.

I wish to have the following restrictions to the use or disclosure of my health information:

_____ _____

_____ _____

Note: Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or clinical staff to disclose the following protected health information to:

☐ **Myself Only** ☐ **My spouse, partner, or parent** ***(specify name)***_____ ☐ **Other Specify:**_____

☐ **Lab Test Results** ☐ **Prescriptions** ☐ **Referrals** ☐ **Diagnosis**

Check the phone number to be contacted:

☐ **Home phone # ( ) -** _____ ☐ **Cell # ( ) -** _____ ☐ **Work phone # ( ) -** _____

Check your choice:

☐ **Yes,** I give permission for medical information to be left on my answering system.

☐ **No,** I do not want medical information left in my answering system.

This authorization shall be effective for three years from today. I understand that I have the right to revoke this authorization in writing to Dr. Giovanni Ramundo or Dr. Henry Wroblewski at 187 Millburn Ave., Millburn, NJ 07041, Suite 103. I understand that disclosed information pursuant to this authorization may no longer be protected by the federal HIPAA Privacy Rule of state law.

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, Patient Rights and Physician Ownership, but was not able to because:

☐ Individual refused to sign

An emergency situation prevented us

☐ Communication barriers prohibited obtaining the acknowledgement

Other (Please specify)

Please Print Name

Patient Signature

(Parent or Legal Guardian)

STATEMENT OF FINANCIAL RESPONSIBILITY

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Pain Medicine Physicians ("PMP") of any insurance benefits otherwise payable to me or on my behalf for the services performed by PMP staff, its affiliates and subsidiaries. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize PMP, it affiliates and subsidiaries to release medical information related to the procedure(s) as may be requested by third party payers in order to process payment of my claims.

CHARGES

I understand that the fees for anesthesia services are separate from the Surgery Center's facility fees and my surgeon's fees. I understand that PMP is only a network provider with Medicare, and Dr. Giovanni Ramundo is in network with Cigna. The payment by your insurance company may be based on your out-of-network benefits and the status of your deductible.

APPEAL, DOBI AND ARBITRATION

I consent to and authorize PMP to file any appeal for payment, mediation by DOBI and arbitration by an attorney on my behalf.

CREDIT POLICY

After your procedure, a claim will be filed with your insurance carrier. You will be notified when an action by your insurance company has been taken. At all times, you are fully responsible for any and all deductible, co-pays and coinsurance. Your insurance contract is between you and the insurance company. It is your responsibility to question your insurance company about delays in payment, amount of payment and/or denial of coverage, as well as any requirements to have a second surgical opinion and pre-certifications if any funds are owed, payment will be expected within 10 days of the receipt of the notice.

If your insurance company issues payment to you, you are responsible to send PMP the full payment along with a copy of the Explanation of Benefits that came with your insurance company check. In the event that you do not forward your insurance payment in timely manner and we are forced to utilize the services of a collection agency and/or an attorney, you will be responsible for all of the costs of collection *in* addition to the amount originally owed by you.

I HAVE READ AND UNDERSTAND THE TERMS OF THIS FINANCIAL RESPONSIBILITY STATEMENT

Patient's Signature:_____ **Date:**_____

(Parent or Guardian if minor/dependent)

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, **Pain Medicine Physicians** (the "provider(s)"), **and their affiliated law firms** 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 provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(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 provider(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 provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(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. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

_____

Print Name of Insured/Guardian

DISCLOSURE FORM

Dear Patient,

You have been scheduled to have your upcoming procedure at Short Hills Surgery Center the "Facility".

Physician Ownership

Public Law of the State of New Jersey mandates that a physician, podiatrist and all other licensees of the **Board of Medical Examiners** must inform patients of any significant financial interest in a health care service.

The Facility is a physician, owned ambulatory surgery center. Accordingly, please take notice that the physician who will be performing your procedure is an owner in the Facility as a result of his/her commitment to quality healthcare and to provide better services to his/her patients.

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

I, Giovanni B. Ramundo am an owner at Short Hills Surgical Center in Millburn, NJ.

Out of Network Disclosure

Please take notice that the Facility is non-participating or contracted with any insurance **provider EXCEPT Horizon Blue** Cross Blue Shield of **New** Jersey, United HealthCare/Oxford, CIGNA HealthCare of New Jersey, Traditional and Railroad Medicare, QualCare, CHN, FOCUS and First MCO. As such, part or all of your upcoming procedure may be considered "out-of-network". You will be personally responsible for the co-payment, co-insurance, deductible, or other charges associated with such "out-of-network" services.

PATIENT'S NAME: _____

You have the right to make informed decisions regarding your care including the right to make decisions concerning the right to accept, refuse, or choose from alternatives of medical and/or surgical treatment.

By signing this disclosure you or your legal representative, acknowledge that: (1) you are receiving this notice prior to the date of the procedure; (2) you have been informed of the financial interests of the practitioners in this office; (3) you voluntarily desire to have your procedure performed at the Facility; (4) you have been informed that part or all of your procedure may be considered "out-of-network", if applicable; (5) you have the right to enter into an advance directive; and (6) you have the right to make informed decisions regarding your care.

Understood and Agreed:

Patient / Responsible Party Signature: _____

Printed Name: _____

Witness: _____

Printed Name: _____

Date: _____ **, 20** _____

Complaints may be lodged with the following:

N.J. Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, NJ 08625-0367
Complaint Hotline: 1-800-792-9770
http://www.state.nj.us/health/healthfacilities

and/or

Office of the Medicare Beneficiary Ombudsman
http://www.medicare.gov/Ombudsman/activities.asp

PAIN MEDICINE PHYSICIANS

ASSIGNMENT OF BENEFITS

PATIENT'S NAME: _____

I IRREVOCABLY ASSIGN TO **PAIN MEDICINE PHYSICIANS** ALL OF MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY **PAIN MEDICINE PHYSICIANS.** I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIM BY **PAIN MEDICINE PHYSICIANS** TO BE RELEASED TO **PAIN MEDICINE PHYSICIANS**. I IRREVOCABLY AUTHORIZE **PAIN MEDICINE PHYSICIANS** TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO **PAIN MEDICINE PHYSICIANS**. I IRREVOCABLY AUTHORIZE **PAIN MEDICINE PHYSICIANS** TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

I IRREVOCABLY AUTHORIZE **PAIN MEDICINE PHYSICIANS** TO OBTAIN COUNSEL AND ENTER LEGAL OR OTHER ACTION ON MY BEHALF AND/OR IN MY NAME, INCLUDING THE ARBITRATION/DISPUTE RESOLUTION PROCESS, TO COLLECT SUCH SUMS DUE IT SHOULD SUMS NOT BE PAID WITHIN THE LEGALLY PRESCRIBED TIME FRAME. IN THE EVENT THAT **PAIN MEDICINE PHYSICIANS** ELECT TO BRING A LAWSUIT OR PETITION FOR ARBITRATION/DISPUTE RESOLUTION AGAINST THE INSURANCE CARRIER, I IRREVOCABLY ASSIGN MY RIGHTS TITLE, AND INTEREST UNDER THE MEDICAL EXPENSE BENEFITS AND/OR PIP SECTION OF ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS. THIS ASSIGNMENT SHALL ALLOW AN ATTORNEY OF **PAIN MEDICINE PHYSICIANS'S** CHOOSING TO BRING SUIT OR SUBMIT TO ARBITRATION/DISPUTE RESOLUTION THEIR CLAIM FOR ANY UNPAID BILLS FOR SERVICES RENDERED FOR INJURIES THAT I SUSTAINED IN THIS OR ANY ACCIDENT.

IN THE EVENT THAT THIS ASSIGNMENT IS HELD INVALID FOR ANY REASON, I HEREBY AUTHORIZE **PAIN MEDICINE PHYSICIANS** TO APPOINT ANY ATTORNEY OF ITS CHOICE TO REPRESENT ME DIRECTLY AGAINST AN INSURER FROM WHICH I MAY COLLECT PIP BENEFITS AND TO BRING A CLAIM IN A FORUM OF IT'S CHOICE. THIS APPOINTMENT IS INTENDED ON ENABLING THE ATTORNEY TO COLLECT THE BILLS OF **PAIN MEDICINE PHYSICIANS.** THE UNDERSIGNED PATIENT DOES HEREBY AGREE AND ACKNOWLEDGE THAT HE/SHE MAY RECEIVE BENEFIT CHECKS DIRECTLY FROM THE INSURANCE CARRIER FOR SERVICES RENDERED BY THE PROVIDER. THE UNDERSIGNED PATIENT HEREBY AGREES TO IMMEDIATELY FORWARD SAID CHECKS TO **PAIN MEDICINE PHYSICIANS** UPON RECEIPT OF THE SAME.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE VALID AS THE ORIGINAL. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT.

PATIENT'S SIGNATURE: _____ DATE: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** *PMP PROCEDURES OR ANY SERVICES PROVIDED BY OUR OFFICE* below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** *PMP PROCEDURES OR ANY SERVICES PROVIDED BY OUR OFFICE* below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ***PMP PROCEDURES OR ANY SERVICES PROVIDED BY OUR OFFICE*** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☑ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

PAIN MEDICINE PHYSICIANS

NOTICE OF PRIVACY PRACTICE

Effective Date: 11/29/2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AM) DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

If you have any questions about this notice, please contact Dr. Giovanni Ramundo (973) 467-1466

WHO WILL FOLLOW THIS NOTICE:

This notice describes Pain Medicine Physicians practices and that of:

> Any health care professionals authorized to enter information into your medical chart.

> All departments and units of Pain Medicine Physicians.

> My member of a volunteer group we allow to help you while you are in Pain Medicine Physicians.

> All employees, staff and other Pain Medicine Physicians personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Pain Medicine Physicians. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Pain Medicine Physicians, whether made by Pain Medicine Physicians personnel or your personal doctor. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identified you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you, and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use and disclose your protected health information (PHI) to provide, coordinate, or manage your medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other Pain Medicine Physicians personnel who are involved in taking care of you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. This includes the management or coordination of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Also your protected health information may be provided to a physician ta whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

For Payment. We will use and disclose medical information about you so that the treatment and services you receive or may receive at Pain Medicine Physicians maybe billed to an insurance company, third party or you. For example, obtaining approval for a hospital stay may require that your relevant protected health information (PHI) be disclosed to the heath plan to obtain approval for the hospital admission.

For Health Care Operations. We may use and disclose, as needed, your protected health information (PHI) in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of Medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sip-in sheet at the front desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

- **Appointment Reminders.** We may use and disclose your protected health information, as necessary, to contact you to remind you of your appointment.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Research**. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research project, however are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave Pain Medicine Physicians. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care at Pain Medicine Physicians.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Organs and Tissue Donation** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transportation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose medical information about you for public health activities.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections and licensure.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, warrant, summons, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
- **Coroners, Medical Examiners and Feral Directors.** We may release medical information to a coroner, medical examiner or funeral director as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services of the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized person or foreign heads of state or conduct special investigations.
- **Inmates.** We may release information about inmates to a correctional institution or law enforcement.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Rights to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Mother licensed health care professional chosen by the Privacy Officer will review your request and the denial. The person conducting the review will not be the person who denied your request We win comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Pain Medicine Physicians.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if you ask us to amend information not created by us, unless the person that created the information in longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Rights to an Accounting of Disclosures. You have the right to request an "account of disclosures". This is a list of the disclosure we made of medical information about you.

Rights to Request Restrictions, You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment and/or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, if we do agree; we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (I) what information you want to limit. (2) Whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical *matters in a certain* way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you with to be contacted. We have the right to deny your request.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the notice at any time. Even if you have agreed to receive this notice electronically you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any front desk person.

CHANGES TO THIS NOTICE

We reserve the rights to change this notice. We reserve the right to make the revised or changed notice effect for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in Pain Medicine Physicians. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at our clinic for treatment or health care services as an outpatient, we will offer you copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Pain Medicine Physicians or with the Secretary of the Department of Health and Human Services. To file a complaint with Pain Medicine Physicians, contact the Privacy Officer at 973-467-1466 x203. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke-that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.