PATIENT REGISTRATION

DEMOGRAPHICS

First Name: ______________________ **Last Name:** ________________________ **Middle Initial:** ______

Address: ____

Home Phone: __________________ **Cell Phone:** ___________________ **Work Phone:** __________________

Date of Birth: ___________________________ **Social Security Number:** ____________________________

Email Address: ____________________________________ **Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other (please indicate): __________________________

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hawaiian ☐ Pacific Islander ☐ Other

ADDITIONAL INFORMATION

Primary Care Physician: ________________________ **Referring Physician:** _________________________

Pharmacy Name: ___________________________________ **Pharmacy Type:** ☐ **Retail** ☐ **Mail Order**

Pharmacy Phone Number: ______________________ **Pharmacy Fax Number:** ________________________

Pharmacy Address: ____

Employment: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed **Student:** ☐ Full-Time ☐ Part-Time

Employer/School Name: ____

Employer/School Address: ____

Central Jersey Sports & Spine
www.cjsportsandspine.com

NAIMISH BAXI MD
Interventional Pain Management
Musculoskeletal Medicine and Ultrasound
Neuromuscular Electrodiagnostics

Emergency Contact

Name: ______________________ **Home Phone:** ______________________

Cell Phone: ______________________ **Relationship to Patient:** ______________________

Insurance Information

Primary Insurance Carrier: ______________________ **ID #:** ____________ **Group #:** ________

Secondary Insurance Carrier: ______________________ **ID #:** ____________ **Group #:** ________

Responsible Party: ☐ **Patient** ☐ **Other** *(if other, please complete fields below)*

First Name: ________________ **Last Name:** ________________ **Middle Initial:** ______

Address: ____

Home Phone: ____________**Cell Phone:** ____________ **Relationship to Patient:** ____________

Patient Consent for Use and Disclosure Of Protected Health Information: Medication History

I hereby give my consent for **Central Jersey Sports & Spine** to obtain my medication history to carry out treatment and provide me with healthcare services.

With this consent, **Central Jersey Sports & Spine** may call my home or other alternative locations like the pharmacy or other physician's office or electronically from my health plan information regarding my medication history.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Patient / Legal Guardian Name: ______________________ **Date:** ________________

Patient / Legal Guardian Signature: ______________________ **Date:** ________________

NAIMISH BAXI MD
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FINANCIAL POLICY

Thank you for choosing us as your health care providers. The health care industry is rapidly evolving and with the constant changes in insurance policies and the growing costs of maintaining quality health care services, we have implemented the following financial policy which we ask that you read, accept and acknowledge.

REGARDING INSURANCES:

- ***We must have a copy of your current insurance card***. Therefore it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying if your insurance has changed since your last visit.
- ***If you have an HMO plan with whom we have a contract***, a proper referral from your Primary Care Physician is necessary for you to be seen. This referral must contain the diagnosis, number of visits allowed and have an expiration date. It is the patient's responsibility to keep track of the number of remaining referrals. You may call our office at any time to verify this information prior to your visit. **If you are seen without a valid referral, you will be responsible for the bill.**
- ***If you have a co-pay on your card***, you will be responsible for the payment of that co-pay on the day of your appointment. All co-pays are collected at the reception window upon arrival.
- ***If you have a PPO plan with which we have a contract,*** you will be responsible for the co-pay if listed on your card. If you have not met your deductible, or if you have a co-insurance that remains after the insurance company has paid their portion, you will be responsible for this balance and payment will be expected.
- ***if your insurance requires a co-pay for each test,*** you are responsible for payment of both the co-pays.
- ***If your insurance has lapsed in coverage***, or is not in effect at the time of service, You will be responsible for payment of services

REGARDING MEDICARE PATIENTS:

- ***Patients are responsible for meeting their annual deductible each year***.
- ***Once the deductible has been met,*** patients without secondary insurance will be required to pay their 20% portion at the time of their visit.
- ***If you have secondary/supplementary insurance*** it is the responsibility of the patient to provide the Receptionist with a copy of that card.
- ***We will file with secondary/supplementary carriers***; however, in the event that the secondary insurance does not pay, patients will be billed for the balance.

NON PARTICIPATING INSURANCES AND SELF-PAY PATIENTS:

- ***If you have presented us with a health insurance card with which we do not participate***, you will be expected to pay 100% of our billed amount at the time the services are rendered.
- ***Once payment is made by you***, the claim will be submitted to your health insurance carrier on your behalf. Any reimbursement due you for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

PARTIAL PAYMENTS/PAYMENT PLANS:

- ***Partial payments will only be accepted if prior arrangements have been made***.
- ***If you wish to proceed with any necessary testing*** and would like to set up a payment plan, just ask to see someone in Billing and this will be arranged for you.
- ***Once a payment plan is arranged***, payments must be made consistently or the balance will be considered delinquent. You may be subject to finance charges or eventually turned over to our collection agency.

DELINQUENT ACCOUNTS:

- ***Delinquent accounts will be subject to monthly billing charges until the account is settled in full***.

OUR CANCELLATION POLICY:

- ***We require 24 hour notice for all cancelled appointments*** or your account will be charged $25.00. Please be aware that this charge is your responsibility and is not covered by your insurance.
- ***In addition there will be a $25.00 charge for all no-shows***.

DIAGNOSTIC TESTING: (FOR ALL PATIENTS)

Please be aware that following your office visit the doctor may order blood work or other diagnostic testing that may not be deemed “medically necessary” by either Medicare or your insurance carrier. It is possible that your insurance carrier has made its own determination as to what tests they deem to be “medically necessary”. Therefore there may be charges not covered by your carrier. In such an event, these charges will become the responsibility of the patient

MANAGED CARE PLANS: (PATIENTS WITH MANAGED CARE PLANS)

In order for your visit and / or testing to be covered by your insurance, you may be required to provide this office with a valid referral issued by your primary care physician. If the referral we have for you on file has expired, or you do not bring a referral with you as needed, you will have two options: to reschedule your appointment, or pay upfront for all services provided to you at the point of care.

INSURANCE AUTHORIZATION AND ASSIGNMENT: (FOR ALL PATIENTS)

I request payment of Medicare and / or participating managed care products be made payable to Central Jersey Sports & Spine on my behalf for any services provided to me by this Practice. I authorize the release of any information about me to Medicare and / or other participating managed care products and its agents that may be needed to determine these benefits.

FINANCIAL RESPONSIBILITY FOR PAYMENT

I am aware that due to any of the reasons listed below; it may be possible that my insurance carrier will deny payment for services rendered to me today. In that event, I understand that I will be financially responsible for those charges.

- I do not have my insurance card with me
- I do not have a valid referral for this visit
- This office does not participate with my insurance carrier
- I do not have health insurance and will pay for my visit today

Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns and you will be referred to the appropriate individual.

I have read the above Financial Policy and understand and agree with its terms.

______________________________	______________________________	____________________
Signature	Print Name	Date

OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS

Our office is fully committed to compliance with HIPPA guidelines by:

1. Providing appropriate security for our patient records
2. Protecting the privacy of our patient's medical information
3. Providing our patient with proper access to their medical records
4. Appropriately maintaining our patient information and billing processes in compliance with national standards

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for clarification.

I have read and understood the terms of the HIPAA.

____________________ ____________________ _______________

Signature Print Name Date

Patient Protected Health Information Disclosure Authorization

Listed below are the names of the individuals with whom the physicians and staff at the Central Jersey Sports & Spine have my permission to disclose and discuss my protected health information with. Any information that relates to my past, present or future physical/mental health or condition and other related healthcare services may be discussed. I understand that his authorization will remain in effect until I make a written request to change it.

1) Name: ____________________ Relationship: ____________________

2) Name: ____________________ Relationship: ____________________

3) Name: ____________________ Relationship: ____________________

4) Name: ____________________ Relationship: ____________________

Patient Name: ____________________ Patient Signature: ____________________

Patient Date of Birth: ____________________ Date: ____________________

HIPAA Omnibus Notice of Privacy Practices

Effective Date: 1/1/2007 Revised on: 5/1/2014

Heart & Vascular Center of New Brunswick, DBA Central Jersey Sports & Spine

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. It describes how we, our Business Associates, and their subcontractors may use and disclose your Protected Health Information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information that identifies you individually, including demographic information that relates your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your Protected Health Information in the following situations:

- **Treatment:** We may use or disclose your Protected Health Information to provide medical treatment and/or services in order to manage and coordinate your medical care. For example, we may share your medical information with other physicians and health care providers, DME vendors, surgery centers, hospitals, rehabilitation therapists, home health providers, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

- **Payment:** Your Protected Health Information will be used to obtain payment for your health care services. For example, we will provide your health care plan with the information it requires prior to paying us for the services we have provided to you. This use and disclosure may also include certain activities that your health plan requires prior to approving a service, such as determining benefits eligibility and prior authorization, etc.

- **Health Care Operations:** We may use and disclose your Protected Health Information to manage, operate, and support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, licensing, fundraising, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration 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. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Minors:** Protected Health Information of minors will be disclosed to their parents or legal guardians, unless prohibited by law.

- **Required by Law:** We will use or disclose your Protected Health Information when required to do so by local, state, federal, and international law.

- **Abuse, Neglect, and Domestic Violence:** Your Protected Health Information will be disclosed to the appropriate government agency if there is belief that a patient has been or is currently the victim of abuse, neglect, or domestic violence and the patient agrees or it is required by law to do so. In addition, your information may also be disclosed when necessary to prevent a serious threat to your health or safety or the health and safety of others to someone who may be able to help prevent the threat.

- **Judicial and Administrative Proceedings:** As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.

- **Law Enforcement:** We will disclose your Protected Health Information for law enforcement purposes when all applicable legal requirements have been met. This includes, but is not limited to, law enforcement due to identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or warrant, and grand jury subpoena.

- **Coroners and Medical Examiners:** We disclose Protected Health Information to coroners and medical examiners to assist in the fulfillment of their work responsibilities and investigations.

- **Public Health:** Your Protected Health Information may be disclosed and may be required by law to be disclosed for public health risks. This includes: reports to the Food and Drug Administration (FDA) for the purpose of quality and safety of an FDA-regulated product or activity; to prevent or control disease; report births and deaths; report child abuse and/or neglect; reporting of reactions to medications or problems with health products; notification of recalls of products; reporting a person who may have been exposed to a disease or may be at risk of contracting and/or spreading a disease or condition.

- **Health Oversight Activities:** We may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections, licensures, and other activities as authorized by law.

- **Inmates:** If you are or become an inmate of a correctional facility or under the custody of the law, we may disclose Protected Health Information to the correctional facility if the disclosure is necessary for your institutional health care, to protect your health and safety, or to protect the health and safety of others within the correctional facility.

- **Military, National Security, and other Specialized Government Functions:** If you are in the military or involved in national security or intelligence, we may disclose your Protected Health Information to authorized officials.

- **Worker's Compensation:** We will disclose only the Protected Health Information necessary for Worker's Compensation in compliance with Worker's Compensation laws. This information may be reported to your employer and/or your employer's representative regarding an occupational injury or illness.

- **Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.

- **Breach Notification Purposes:** If for any reason there is an unsecured breach of your Protected Health Information, we will utilize the contact information you have provided us with to notify you of the breach, as required by law. In addition, your Protected Health Information may be disclosed as a part of the breach notification and reporting process.

- **Research:** Your Protected Health Information may be disclosed to researchers for the purpose of conducting research when the research has been approved by an Institutional Review or Privacy Board and in compliance with law governing research.

- **Business Associates:** We may disclose your Protected Health Information to our business associates who provide us with services necessary to operate and function as a medical practice. We will only provide the minimum information necessary for the associate(s) to perform their functions as it relates to our business operations. For example, we may use a separate company to process our billing or transcription services that require access to a limited amount of your health information. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated. Additionally, all of our business associates are under contract with us and committed to protect the privacy and security of your Protected Health Information.

USES AND DISCLOSURES IN WHICH YOU HAVE THE RIGHT TO OBJECT AND OPT OUT

- **Communication with family and/or individuals involved in your care or payment of your care:** Unless you object, disclosure of your Protected Health Information may be made to a family member, friend, or other individual involved in your care or payment of your care in which you have identified.

- **Disaster:** In the event of a disaster, your Protected Health Information may be disclosed to disaster relief organizations to coordinate your care and/or to notify family members or friends of your location and condition. Whenever possible, we will provide you with an opportunity to agree or object.

- **Fundraising:** As necessary, we may disclose your Protected Health Information to contact you regarding fundraising events and efforts. You have the right to object or opt out of these types of communications. Please let our office know if you would NOT like to receive such communications.

PROTECTED HEALTH INFORMATION AND YOUR RIGHTS

The following are statements of your rights, subject to certain limitations, with respect to your Protected Health Information:

- **You have the right to inspect and copy your Protected Health Information (reasonable fees may apply):** Pursuant to your written request, you have the right to inspect and copy your Protected Health Information in paper or electronic format. Under federal law, you may not inspect or copy the following types of records: psychotherapy notes, information compiled as it relates to civil, criminal, or administrative action or proceeding; information restricted by law; information related to medical research in which you have agreed to participate; information obtained under a promise of confidentiality; and information whose disclosure may result in harm or injury to yourself or others. We have up to 30 days to provide the Protected Health Information and may charge a fee for the associated costs.

- **You have a right to a summary or explanation of your Protected Health Information:** You have the right to request only a summary of your Protected Health Information if you do not desire to obtain a copy of your entire record. You also have the option to request an explanation of the information when you request your entire record.

- **You have the right to obtain an electronic copy of medical records:** You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost-based fee for the work required in transmitting the electronic medical records.

- **You have the right to receive a notice of breach:** In the event of a breach of your unsecured Protected Health Information, you have the right to be notified of such breach.

- **You have the right to request Amendments:** At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.

- **You have a right to receive an accounting of certain disclosures:** You have the right to receive an accounting of disclosures of your Protected Health Information. An "accounting" being a list of the disclosures that we have made of your information. The request can be made for paper and/or electronic disclosures and will not include disclosures made for the purposes of: treatment; payment; health care operations; notification and communication with family and/or friends; and those required by law.

- **You have the right to request restrictions of your Protected Health Information:** You have a right to restrict and/or limit the information we disclose to others, such as family members, friends, and individuals involved in your care or payment for your care. You also have the right to limit or restrict the information we use or disclose for treatment, payment, and/or health care operations. Your request must be submitted in writing and include the specific restriction requested, whom you want the restriction to apply, and why you would like to impose the restriction. Please note that our practice/your physician is not required to agree to your request for restriction with the exception of a restriction requested to not disclose information to your health plan for care and services in which you have paid in full out-of-pocket.

- **You have a right to request to receive confidential communications:** You have a right to request confidential communications from us by alternative means or at an alternative location. For example, you may designate we send mail only to an address specified by you which may or may not be your home address. You may indicate we should only call you on your work phone or specify which telephone numbers we are allowed or not allowed to leave messages on. You do not have to disclose the reason for your request; however, you must submit a request with specific instructions in writing.

- **You have a right to receive a paper copy of this notice:** Even if you have agreed to receive an electronic copy of this Privacy Notice, you have the right to request we provide it in paper form. You may make such a request at any time.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice and will notify you of such changes. We will also make copies available of our new notice if you wish to obtain one. **We will not retaliate against you for filing a complaint.**

COMPLAINTS

If at any time you believe your privacy rights have been violated and you would like to register a complaint, you may do so with us or with the Secretary of the United States Department of Health and Human Services. If you wish to file a complaint with us, please submit it in writing to our Privacy/Compliance Officer to the address listed on the first page of this Notice.

We are required by law to provide individuals with this notice of our legal responsibilities and privacy practices with respect to Protected Health Information. We are also required to maintain the privacy of, and abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the number listed below.

Smriti Baxi	732-846-7000 x 115	office@cminj.com
HIPAA COMPLIANCE OFFICER	**PHONE**	**EMAIL**

NAIMISH BAXI MD
Interventional Pain Management
Musculoskeletal Medicine and Ultrasound
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Patient Evaluation and Details

Please complete the following questions in order to assist us in your care.

Name: ______________________ **Age:** ________ **Appointment Date:** ____________________

Occupation: ______________________ **Referral Source:** ______________________

1. Using the symbols provided in the Key, please mark the figure with the location of your symptoms:

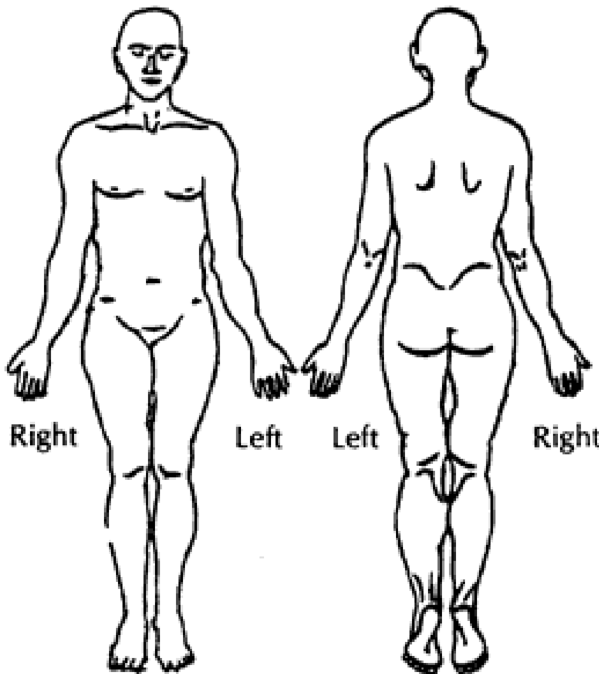

Figure 1: Human Body Diagram

Key

Pain = X
Numbness = ►
Tingling = #

2. Have you had surgery on your back or neck? ☐ YES ☐ NO

   If yes, please provide details on the surgery:

   Surgery Date: ______________________ **Name of Facility:** ______________________

   Rendering Provider Name: ______________________ **Phone Number:** ______________________

   Was the outcome successful in relieving your symptoms? ______________________

   ____

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3. What makes your pain **worse** (please select all that apply)?

☐ Any Activity	☐ Reaching
☐ Bending Forward	☐ Rotation
☐ Bending Backward	☐ Sitting
☐ Changing Positions	☐ Sneezing
☐ Coughing	☐ Standing
☐ Lying on Back	☐ Walking
☐ Lying on Stomach	☐ Weightbearing

4. Indicate when your pain is worse: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Late Night** ☐ **N/A**

5. Does the pain wake you up? ☐ **YES** ☐ **NO**

6. Have you lost control of your bowel or bladder function? ☐ **YES** ☐ **NO**

7. What makes your pain **better** (please select all that apply)?

☐ Any Activity	☐ Reaching
☐ Bending Forward	☐ Rotation
☐ Bending Backward	☐ Sitting
☐ Changing Positions	☐ Sneezing
☐ Coughing	☐ Standing
☐ Lying on Back	☐ Walking
☐ Lying on Stomach	☐ Weightbearing

8. What types of medications are you taking for the pain?

☐ **Muscle Relaxer** ☐ **Anti-Inflammatory** ☐ **Steroid** ☐ **Pain Medication**

9. Have you tried any of the following treatments? If YES, please indicate how long you felt pain relief, if at all:

   ☐ **Acupuncture:** ______________________________

   ☐ **Chiropractic Care:** ______________________________

   ☐ **Hot or Cold Packs:** ______________________________

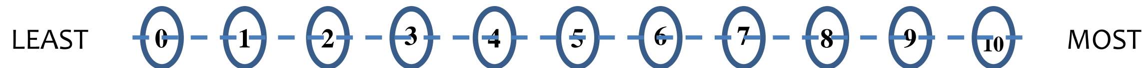
   ☐ **Physical Therapy:** ______________________________

   ☐ **Spinal Procedures:** ______________________________

10. Do you have any of the following symptoms (select all that apply)?

   ☐ **Chills** ☐ **Fever** ☐ **Night Sweats** ☐ **Unexplained Weight Loss**

11. Mark the following scale to reflect your pain when it's at it's **LEAST** :

LEAST  MOST

12. Mark the following scale to reflect your pain when it's at it's **WORST** :

LEAST MOST

13. Please indicate the situation that best describes your employment status:

   ☐ Disabled Permanently

   ☐ Disabled Temporarily

   ☐ Housewife

   ☐ Retired

   ☐ Unemployed

   ☐ Working Full Time

   ☐ Working Part Time

14. Have you missed any work as a result of this injury? ☐ **YES** ☐ **NO**

15. If you are currently NOT WORKING, how long have you been off work due to your back/neck pain?

____

16. What is your occupation?

____

17. Please indicate which studies have been completed for your injury, at what facility and when:

Type of Study	Facility	Date
X-Ray		
MRI		
CT Scan		
Nerve Test (EMG)		
Discogram		
Myelogram		

....

Thank you for taking the time to provide the necessary information to us regarding your symptoms and previous medical care.

The staff at Central Jersey Sports & Spine are dedicate to providing the most technically advanced care while preserving high quality customer service. It is our goal to exceed your expectations!