LANDA SPINE CENTER

NEW PATIENT REGISTRATION FORM

(Please print clearly)

Today's Date______________________________ ❑ Male ❑ Female Date of Birth _________/_______/___________

Name ____________________________________ Height: __________________ Weight: _______________________

SSN: _____________________________________ Referred By: ____

Home Address____

Street City State Zip

Mailing Address (if different)____

Street City State Zip

Email: ____

Home Phone ____________________ Work Phone _____________________ Other/Cell Phone _________________

How did you hear about our spine center? ____

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Employed: ❑ Full-Time ❑ Part-Time ❑ N/A Employer:______________________________________

Student: ❑ Full-Time ❑ Part-Time ❑ N/A School:_ ______________________________________

In case of emergency, please notify:

Name: ____ Relationship: _______________________________________

Phone: ____

FOR AUTO ACCIDENT RELATED INJURY:

Auto insurance company name: __________________________ Date of accident: ________/________/_____________

Claim #:____ Policy #_______________________________________

Adjuster name: ______________________________________ Phone: ____

Attorney Name: ______________________________________Phone: ____

FOR WORKER'S COMP:

Employer name: ______________________________________ Date of Injury__________/__________/______________

Attorney Name: ______________________________________ Phone: ____

MEDICAL INSURANCE INFORMATION:

Primary Insurance ____

Member ID number ______________________________Group # ______________

Employer ____

Name of Insured (**if different from above**): ________________ Date of Birth: ______________

Relationship to Patient: ❑ Parent ❑ Spouse ❑ Partner ❑ Other

Address (if different from patient) ____

Street *City* *State* *Zip*

MEDICAL HISTORY

Past Medical History: ❑ None

❑ Heart Attack ❑ Angina ❑ High Blood Pressure ❑ Stroke ❑ Stomach Ulcer

❑ Duodenal Problems ❑ Diabetes ❑ Kidney Stones ❑ Gout ❑ Hepatitis Cirrhosis

❑ Depression ❑ Anxiety ❑ Degenerative Arthritis ❑ Asthma ❑ Bleeding Tendency

❑ Rheumatoid Arthritis ❑ Anemia ❑ Emphysema/Bronchitis ❑ Menstrual Problems

❑ Cancer: type____

Please list all current medications: ❑ None

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

Please list all previous surgeries and dates: ❑ None

1.____
2.____
3.____
4.____
5.____
6.____

7.____

8.____

9.____

10.____

Allergies:

Are you allergic to any medications: ❑ No ❑ Yes

Please list medication allergies: ____

Are you allergic to contrast dye or media? ❑ No ❑ Yes

Are you allergic to LATEX? ❑ No ❑ Yes

Social History:

Do you smoke? ❑ No ❑ Yes _______ packs per day for ______years

Do you drink alcoholic beverages? ❑ No ❑ Yes ❑ Socially

Do you have a drug history? ❑ No ❑ Yes

(If yes please describe)____

Previous Treatments:

Chiropractic Treatment ❑ No ❑ Yes Date:_________________________

Spinal Injections ❑ No ❑ Yes Date:_________________________

Acupuncture ❑ No ❑ Yes Date:_________________________

Psychiatric Therapy ❑ No ❑ Yes Date:_________________________

Physical Therapy ❑ No ❑ Yes Date:_________________________

Previous Tests (please check all that apply):

❑ X-Ray ❑ MRI ❑ Discography ❑ CT Scan ❑ CT Myelogram

❑ Bone Scan ❑ Nerve Test (EMG/NCV)

❑ Other (please specify): ____

REVIEW OF SYSTEMS

System	Symptoms	Y	N	System	Symptoms	Y	N
General	Recent Weight Loss >10 lbs.				Organ Transplant		
	Recent Weight Gain >10 lbs.			**Endocrine**	Thyroid Problems		
	Fevers			**Bones/Joints:**	Shoulder Pain		
	Chills				Wrist/Hand Pain		
	Night sweats				Hip Pain		
Cardiac	Shortness of Breath				Knee Pain		
	Chest Pain				Lupus		
Respiratory	Wheezing				Muscle Weakness		
	Pneumonia				Fibromyalgia		
	Chronic Cough			**Genitourinary**	Abnormal Kidney Function		
Gastrointestinal	Abdominal Pain				Pain during Urination		
	Nausea				Frequent Urinary Infections		
	Vomiting			**Nervous System**	Headache		
	Diarrhea				Tremors		
Skin	Open Sores				Poor Speech		
	New Moles				Changes in Vision		
Hematologic	Easy Bruising			**Mental Health**	Sleep Disturbance		
	Blood thinning medications				Feeling of Hopelessness		
	Blood Transfusions				Depression		

AUTHORIZATION AND CONSENT

1. I request care from Landa Spine Center or one of their affiliates for treatment of my medical condition. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:

Landa Spine Center, LLC receives payment for patient care from insurance companies and/or other third party programs.

1. I agree to have my insurance company or other third party payment program make payments directly to Landa Spine Center, or its Affiliates
2. I agree to let my doctor(s) and/or the Landa Spine Center submit claims and required treatment information to my insurance company or other third party payment program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company or third party payment program.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

***Female patients: I do hereby state that, to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this particular time.**

Signature of the patient ____Date _________________________

Print name: ____

ASSIGNMENT OF BENEFITS

Patient Name____

1. I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my rights and interests to Landa Spine Center, hereafter referred to as "the medical provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.
2. I assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance provider.
7. To prevent the insurance carrier and/or the vendor designated by the insurance carrier from refusing to accept my Assignment or submitting a challenge to my Assignment as being invalid, I execute this Special Power of Attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retainer agreement between me and the attorney chosen by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if an arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical provider's bills whom I have not executed an Assignment of Benefits with could make me liable for payment to that provider. In consideration, this medical provider has agreed to accept as payment in full, the amount awarded and/or settled and will not seek additional payment from other insurance carriers.

Signature of the patient ____**Date** __________________________

Print name: ____

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you. There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage. At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OFINFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _________________________, by marking √ (or x) and signing below, agree to:

❑ representation by in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner,

❑ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _______________________________________ Ins. ID#:______________ Date: ___________

Relationship to Patient: I am the Patient I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

THIS PAGE IS FOR YOUR REFERENCE ONLY, PLEASE REMOVE AND TAKE HOME

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.
You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329

OR for courier service to:

20 West State Street OR by fax to: (609) 633-0807
You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!
REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS
I hereby revoke my consent to representation by and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has
already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.
Signature: Ins. ID#______________ Date:______________
Relationship to Patient: I am the Patient I am the Personal Representative
Contact Information of Personal Representative
Please provide the following contact information IF it is different from the patient's contact information:
PRINT NAME: ____
ADDRESS:____
____
PHONE: _______________ FAX: _______________ EMAIL: __________
New Jersey Department of Banking and Insurance
NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORD

Signature _____________________________________ Date _________________________