MINE HILL SURGICAL CENTER

PATIENT DEMOGRAPHIC INFORMATION

Patient Last Name: ______________________ First Name: ____________________ MI _____

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Other

Social Security #: ______________________ Employment Status: ☐ Employed ☐ Retired

Email address: ______________________________ ☐ Other ☐ Student

Home Address: ____

City: ______________________ State: ________ Zip: ______________

Home Phone #: ______________________ Cell Phone #: ______________________

Employer: ______________________Work Phone #: ______________________

INSURANCE INFORMATION: WORK COMP YES ☐ NO☐ MOTOR VEHICLE YES ☐ NO ☐ DOI: ________

Primary Insurance: ______________________ Secondary Insurance: ______________________

ID#: ______________________ ID #: ______________________

Group #: ______________________ Group #: ______________________

Guarantor (Policy Holder): ______________________ Guarantor (Policy Holder): ______________________

Guarantor's Date or Birth: ______________________ Guarantor's Date of Birth: ______________________

Guarantor's Employer: ______________________ Guarantor's Employer: ______________________

Work Comp/Motor Vehicle Claim #: ______________________ Adjuster Name______________________

Phone Number: ______________________**Attorney Info:**______________________

PRIMARY CARE DOCTOR INFORMATION:

Primary Care Physician: ____

Address: ____

Phone #: ______________________ Fax #: ______________________

IN CASE OF EMERGENCY WE SHOULD CONTACT:

Name: ____

Relationship: ____

Phone #'s: ____

Patient Signature: ______________________________ Date: ______________

Int: ________ Date:__________ Int: ________ Date: __________ Int: ________ Date: __________

Int: ________ Date: __________ Int: ________ Date: __________ Int: ________ Date : __________

Int: ________ Date:__________ Int: ________ Date: __________ Int: ________ Date: __________

Int: ________ Date: __________ Int: ________ Date: __________ Int: ________ Date : __________

MINE HILL SURGICAL CENTER LLC
CHAMPEY PAIN GROUP LLC
MINE HILL ANESTHESIA GROUP

PATIENT NOTIFICATION

(Insurance, Ownership, Lab, Privacy, HIPPA, Rights, Valuables)

Ownership:

____ Initial — I am aware that my physician may have ownership interest in Mine Hill Surgical Center, LLC (MHSC), Champey Pain Group LLC (CPG) and Mine Hill Anesthesia Group (MHAG). If choose to go to another health care facility for this procedure, it will have no effect on my relationship with my physician.

Valuables:

____ Initial — I release all Providers from ANY responsibility for loss and/or damage to money, jewelry or other valuables brought into Provider's facility. I agree that all Providers are not responsible for any valuables that I have elected to bring.

Insurance Authorization and Assignment:

____ Initial — I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to the Providers for any services furnished me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I understand if assignment monies are paid directly to me, such payment will be forwarded to the Provider upon receipt.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

Irrevocable Assignment of Benefits/Guarantee to Cooperate:

____ Initial — In consideration of services rendered or to be rendered to the patient named below, I hereby authorize and I assign payment from any and all sources including, but not limited to all first party no-fault automobile insurance benefits, as applicable, directly to Provider to which I am otherwise entitled for services rendered by Provider. Provider in turn agrees to comply with the requirements of the no-fault insurance carrier's precertification plan/decision point review plan and Provider agree not to seek to obtain payment from the insured or persons receiving treatment or undergoing medical testing whenever charges have been reduced in accordance with the no-fault carrier's precertification plan.

I authorize, assign and direct payment of insurance benefits to Provider's office for monies due on bills which related to services rendered. I assign to Provider's office the right to prosecute the claim(s) against the insurance carrier who affords benefits and I agree to fully cooperate with Provider's office's efforts to prosecute a claim against the insurance carrier if there is not timely payment on the claim.

In the event the Provider's charges are outstanding and I fail to file an application for benefits under the State No-Fault laws, I hereby authorize the Provider to file such a claim on behalf so that the Provider may realize payment of its charges. I also authorize Provider to release any medical information necessary for the use of attorneys, doctors, insurance companies or collection services.

As part of my assignment of benefits, I specifically request that my insurance carrier forward to the Provider copies of any and all reports from Independent Examiners, Peer Review Doctors and auditing companies.

Additionally, should I recover any money by virtue of claim or legal cause of action, I hereby assign my right to payment directly to Provider named above and I direct my attorney or other legal representative to honor this irrevocable assignment as a lien on my file for any funds that may be due me. My attorney or legal representative is hereby authorized and directed to make such payment from the recovery in such claim or action up to the amount due to Provider so as to be consistent with this assignment. This assignment will also serve as a letter of protection for Provider. This letter of protection grants the provider the ability to recover outstanding balances, which are not due to fee scheduling reductions, from any and all settlements I may recover.

I understand the above assignment may not be revoked or amended without the express written consent of Provider. Additionally, by signing this agreement I fully understand the terms contained therein. My signature also represents that I fully understand this agreement if I needed assistance interpreting it. I have not been coerced in any way to give this assignment. If any portion of this form is found to be invalid, the remainder shall remain in effect. A photocopy of this shall be deemed as valid as an original.

Laboratory Testing:

____ Initial During the course of your procedure it may be necessary for your physician to obtain and send tissue samples, blood samples, or request other laboratory testing. The State of New Jersey now requires clinical laboratories to directly bill patients for their testing services. In other words, they may not present a bill for its services to any person other than the person who is the recipient of the services, or that person's legal representative. Therefore, it is necessary for the Provider to receive authorization from the patient in order for us to allow the laboratory to bill your insurance company for you.

Patients'Rights and Privacy Practices (initial each):

____ I have been offered a copy and an explanation of the NJ Patients' Bill of Rights with grievance process.

____ I have been offered a copy and an explanation of the HIPAA Notice of Privacy Practices.

____ I have been made aware of physician ownership.

____ I have been offered a copy and explanation of Provder's privacy policy.

Advanced Directives:

____ Initial Advance directives or "living wills" are recognized in the state of New Jersey as legal documents which offer evidence of an individual's medical treatment preferences. The United States Supreme Court affirmed, in its Cruzan decision, that an individual's personal wishes are then subjected to constitutional protection. I understand that I am not required to have an Advanced Directive in order to receive medical treatment in this health care facility. I further understand that it is the policy of this facility to resuscitate patients that require resuscitation in order to maintain their vital functions. In case of an emergency, I understand that I may be transferred to a local hospital for treatment.

I AM STATING THAT I HAVE READ THIS CONSENT (OR IT HAS BEEN READ TO ME, AND I FULLY UNDERSTAND IT AND THE POSSIBLE RISKS, COMPLICATIONS AND BENEFITS THAT CAN RESULT FROM THE SURGERY. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL THE ITEMS LISTED IN THESE PARAGRAPHS.

________________________________ ____________ ____________

Signature of Patient Date Time

New Jersey Department of Banking and Insurance

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 OF INFORMATION 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: X______________________ Ins. ID#:______________ Date: X__________

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

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* 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.

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.

CHAMPEY PAIN GROUP

PATIENT RECORD OF DISCLOSURES

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply).

- ❑ Home Telephone: ______________________
- ❑ Work Telephone: ______________________
- ❑ OK to leave message with detailed information
- ❑ Leave message with call back number only
- ❑ Other: ______________________
- ❑ Written Communication
- ❑ OK to mail to my home address ______________________
- ❑ OK to mail to my work address ______________________
- ❑ Other: ______________________

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of any requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below. If completed properly, it will constitute an adequate record. Note: Use and disclosures for Treatment, Payment, and/or Health Care Operations (TPO) may be permitted without prior consent in an emergency.

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

Date	Disclosure to Who Address & Fax	1	Description of Disclosure	By Whom Disclosed	2

(1) T = Treatment P = Payment O = Healthcare Operations

(2) F = Fax P = Phone E = E-mail M = Mail C = Cell Phone O = Other

EXPIRATION DATE OF AUTHORIZATION:

This authorization is effective indefinitely unless revoked or terminated by the patient or the patient's personal representation. Expiration Date of Authorization: ______________

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION:

You may revoke or terminate this authorization by submitting a written revocation to Champey Pain Group.

POTENTIAL FOR RE-DISCLOSURE:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Overall, by signing this form you are giving Champey Pain Group permission to release or receive your medical records to or from any physician office, hospital, attorney, or any person's name from above you approved us to disclose information to.

______________________ ______________ ______________

Name of Patient or Patient Representative (Please Print) Date of Birth Date

______________________ ______________________

Signature of Patient or Patient Representative Relationship to Patient

CHAMPEY PAIN GROUP
ASSIGNMENT OF BENEFITS

Patient Name: ___________________________________ DOB: __________________

For treatment provided and other good and valuable consideration, I _____________________ ____________________________ (Hereinafter Patient) hereby assign all rights and benefits that PATIENT has under any group health, HMO Plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay benefits for services and treatment that PATIENT has received or will receive.

This assignment includes, but is not limited to, all rights to collect benefits directly from PATIENT'S insurance company for services and treatment that PATIENT has received and all the rights to proceed against PATIENT'S insurance company in any action including legal suit if for any reason PATIENT'S insurance company fails to make payments of benefits to which PATIENT is due. This assignment also includes the right to recover attorney's fees and cost for such action brought by the provider as PATIENT'S assignee.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

____ ______________________

Signature of Insured Date

CHAMPEY PAIN GROUP

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

NAME OF PATIENT: ____ DATE: __________________

PAIN MANAGEMENT POLICY: I understand and agree to the following: That this pain management policy relates to my use of any and all medication(s) (i.e., opoids, also called "narcotics", "painkillers", and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided as long as I follow the rules in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any illegal behavior.

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician all medication(s) that I take at any time, prescribed by any other physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
- **I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed at the next scheduled visit. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physicians to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they WILL NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) may be allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician.
- Informed that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).

- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified practitioner such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavior therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that **my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.

- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

- I hereby give my **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

- I must take medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

____

Patient Signature

CHAMPEY PAIN GROUP
MEDICAL HISTORY

To help us understand your problem, please complete ALL QUESTIONS and ALL of the attached forms:

Name: ______________________ Age: ________ Date: ____________

Who referred you to us? ______________________ Height: ________ Weight: ____________

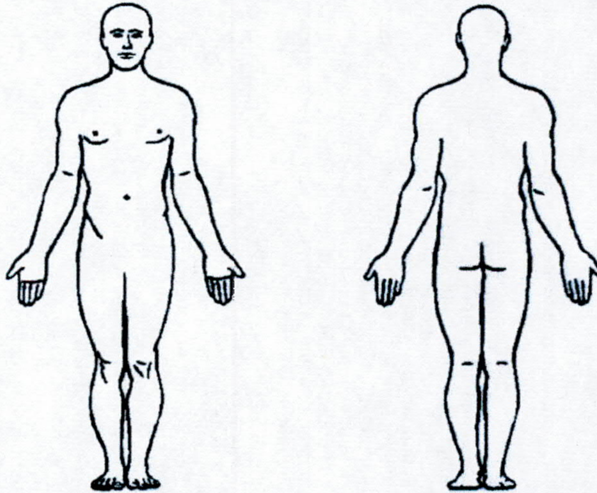
Which part of your body hurts the most? ______________________

How long have you had this pain? ______________________

On a scale from 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that described you level of pain:

No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Worst pain imaginable

Shade in or circle areas below where you have pain and check ALL the words that best describe your pain:



( ) Aching	( ) Stinging	( ) Cramping
( ) Numbness	( ) Radiating	( ) Excruciating
( ) Hotness	( ) Coldness	( ) Soreness
( ) Burning	( ) Shooting	( ) Stabbing
( ) Tightness	( ) Heaviness	( ) Dullness
( ) Sharpness	( ) Constant	( ) Brief
( ) Tingling		

Pain caused from: Accident ( ) Yes ( ) No Illness ( ) Yes ( ) No Unknown Cause ( ) Yes ( ) No

If accident or illness, please explain and give date: ______________________

____

____

____

____

Social History:

Marital Status: ( ) Married ( ) Divorced ( ) Single

Do you currently work: ( ) Yes ( ) No What is/was your occupation? ______________________________

Smoker ? ( ) Yes ( ) No If you quit, when? __________ How many cigarettes did you/do you smoke per day? _____ Number of years? _____

Alcohol use ? ( ) Yes ( ) No If yes, how much? ____________________ how often? ________________

History of street drug use? ( ) Yes ( ) No If yes, what type? ______________________________

Do you have a history of alcoholism? ( ) Yes ( ) No

Family history of drug or alcohol abuse? ( ) Yes ( ) No

Is there any possibility that you are pregnant? ( ) Yes ( ) No

Have you been tested for HIV Virus? ( ) Yes ( ) No

Have you ever been treated for depression or any other mental health issue? ( ) Yes ( ) No If yes, please explain:

____

Treating Physician's Name: ______________________________ Phone Number: ________________

Last Visit: ____________________ Frequency of Visits: ________________

Origin of Depression: ____

Cardiovascular	Respiratory	Genitourinary	Muscle/Joint Disease
( ) Palpitations	( ) Shortness of Breath	( ) Change in Bowel Control	( ) Redness in Joints
( ) Leg Swelling	( ) Chronic Cough	( ) Change in Bladder Control	( ) Arthritis/Joint Disease
( ) Chest Pain/Angina	( ) Wheezing	( ) Blood in Urine	( ) Frequent Muscle Spasm
	( ) Sputum Production		( ) Back or Neck Problems
			( ) Swelling of Joints

Neurological	Endocrine	Gastrointestinal	Hematologic
( ) Epilepsy or Seizures	( ) Frequent Urination	( ) Nausea	( ) Easy Bleeding
( ) Weakness	( ) Change in Appetite	( ) Diarrhea	( ) Poor Blood Clotting
( ) Dizziness	( ) Heat or Cold Tolerance	( ) Rectal Bleeding	( ) Bleeding Disorder
( ) Fainting	( ) Sweating	( ) Heartburn	
( ) Numbness		( ) Constipation	
( ) Headache			

Psychiatric	Constitutional
( ) Depression	( ) Recent Weight Loss
( ) Anxiety	( ) Recent Weight Gain
( ) Stress	( ) Fever/Chills
( ) Previous Psychiatric Care	( ) Visual Chance
	( ) Hearing Change

Please list past or current medical problems:

( ) Heart Disease	( ) Lung Disease	( ) Diabetes	( ) Stroke	( ) Herpes (Shingles)
( ) Hypertension	( ) Kidney Problems	( ) Liver Disease	( ) Seizures	( ) HIV/AIDS
( ) Migraines	( ) Thyroid Disease	( ) Anxiety/Depression	( ) Gerd/Ulcer	( ) Heptatitis
( ) Open Wound	( ) Infection	( ) Other		

Have you ever had cancer? ( ) Yes ( ) No If yes, which type(s)? ____________________

Are you currently receiving treatment? ( ) Yes ( ) No If yes, type(s) of treatment? ____________________

____

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12

Do you have any allergies to medication or food? ( ) Yes ( ) No

Please list your allergies and the reaction below:

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given:	YES	NO	ADVERSE REACTION?
Anticoagulants, Blood thinners, Coumadin, Plavix, Pletal	( )	( )	____________________
Cortisone or Steroids	( )	( )	____________________

Please list any surgeries:

Surgery/Date	Surgery/Date
1.	5.
2.	6.
3.	7.
4.	8.

Family History: Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

Relationship	Age	Yes	No	Medical History or Cause of Death
Father				
Mother				
Sibling				
Sibling				

Please indicate the factors or activities that increase or decrease your pain:

Factors	Increase	Decrease	No Effect	Factors	Increase	Decrease	No Effect
Weather Change				Pressure			
Heat				Sexual Activity			
Cold				Bowel Movement			
Physical Activity				Bright Light/ Noise			
Posture				Sneeze, Cough			
Walking				Lying Down			
Sitting				Other			

Please check any of the following treatments you have had for this pain problem:

Treatment	Approx. Date/Details	Yes	No
( ) Pain Clinic			
( ) Nerve Blocks, Epidurals			
( ) Tens Unit			
( ) Physical Therapy			
( ) Acupuncture			
( ) Chiropractor			
( ) Psychiatrist/Psychologist			
( ) Massage Therapy			
( ) Other			

Please indicate which diagnostic procedure (test) you have had for this pain problem:

Procedure/Test	Body Part	Approx. Date	Facility Performed
( ) MRI Scan			
( ) CY Myelogram			
( ) X-Ray			
( ) EMG/NCV			
( ) Discogram			
( ) Bone Scan			

Please list other physicians you have seen for your pain:

Name	Recommendation	Specialty	Appt. Date