

GARDEN STATE ORTHOPAEDICS

Patient Registration Form

Account #: _____ Date: _____ Referred by: Dr. _____
Attorney _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home phone #: _____ Other phone#: _____ cell work (please specify)

Referring Physician _____ Address _____ Phone Number _____

City _____ State _____ Zip _____

Family Physician _____ Address _____ Phone Number _____

City _____ State _____ Zip _____

Attorney _____ Address _____ Phone Number _____

City _____ State _____ Zip _____

Sex: _____ Date of Birth: _____ Age: _____ SSN: _____ - _____ - _____

Marital Status: Single Married Divorced Widowed
Employment Status: Employed Retired Student Unemployed

Employer Name: _____ Phone: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____

TYPE OF ACCIDENT

Date of accident: _____

Motor Vehicle Accident – Is your health insurance primary? Yes No

Work related

Medical

Other: please specify place of accident: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Claim/policy number: _____

Address: _____ Policy Holder: _____

City: _____ State: _____ Zip: _____

Adjuster: _____ Phone #: _____ Fax #: _____

Did you file an accident report? Yes No

Secondary Insurance Carrier: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to subscriber: _____

REASON FOR VISIT:

Medical Accident related

If accident, state cause: Auto accident Auto accident work related At work At home

Fall on another's property At school Other _____

Date of accident: _____ Did you go to a hospital/ER? YES NO

If yes, where? _____ Were you taken by ambulance? YES NO

Were x-ray-rays taken? YES NO If yes, of what body part(s)? _____

ACCIDENT INFORMATION

Where did this accident/injury take place? _____

How did it happen? _____

What body parts were injured during the accident? _____

What was your position sitting in the vehicle?

Driver Front passenger Rear right Rear left Other _____

Were you wearing a seat belt? YES NO

Was your car Moving Stopped in traffic Stopped?

If moving, what was your approximately speed at the time of impact? _____ mph

Were you hit hit another vehicle?

If you were hit, where? rear ended back driver's side back passenger's side head on

front driver's side front passenger's side other _____

If you were the driver, did you have both hands on the steering wheel? YES NO

If you were the passenger, did you brace with your hands on impact? YES NO

Did any part of your body come in contact with any part of the vehicle? YES NO

If yes, describe: _____

Describe your body movement at the time of impact: _____

How many vehicles were involved in the accident? _____

Did you lose consciousness? YES NO If yes, for how long? _____

Since the accident/injury, do you have trouble with the following? (please check all that are appropriate)

physical exercise bending crawling sitting stiffness driving

walking standing lifting kneeling climbing stairs

sleeping overhead work getting up in the morning

Since the accident/injury, what are you having trouble doing (include sports, problems at work, household chores, etc.)? _____

Due to your injuries, what are your current symptoms? _____

Nausea Vomiting Dizziness Fainting Nervousness

Do you have pain in your: Head Neck Chest Abdomen Mid back

Low back R shoulder L shoulder R arm L arm R hand

L hand R wrist L wrist R leg L leg R knee L knee R foot

L foot R ankle L ankle

Are there any complaints of numbness or tingling? _____

How frequent is your pain? Constant Frequent Occasional Intermittent

What makes the pain worse? _____

What makes the pain better? _____

Did you seek treatment with a doctor after the hospital? YES NO

<u>Name of Doctor</u>	<u>Specialty</u>	<u>Date of 1st visit</u>	<u>Still treating Yes or No</u>

<u>What test did you have done?</u>	<u>Location of test</u>	<u>What body part(s)</u>
X-ray		
MRI		
CT Scan		
EMG		

Did you have any physical therapy treatment? YES NO If yes, where? _____

Did you have any chiropractic treatment? YES NO If yes, where? _____

When did you start treatment? _____ Are you currently going? YES NO

What type(s) of treatment have you received? Hot packs Electric stimulation Exercise

Ultrasound Traction Ice Manipulation

Other _____

How often do you or did you go? _____ How long did you go? _____

Has it been helpful? YES NO

Have you missed any work due to the accident? YES NO If yes, how long? _____

MEDICAL HISTORY

Height _____ Weight _____ Right-handed Left-handed Ambidextrous

Have you had any prior motor vehicle accidents or significant injuries? YES NO If yes, when? _____

What areas of the body were involved in any PRIOR accident? _____

Were these injuries resolved prior to your current injuries? YES NO

If no, what complaints remained? _____

Are you still treating for these injuries? YES NO

List any fractures/sprains: _____

List any surgeries: _____

Current medical problems: Hypertension Diabetes Asthma Epilepsy/seizure disorder

Heart attack Migraines Stroke Cardiac disease Ulcers Cancer

Anemia Thyroid disease Other _____

List current medications: _____

Are you allergic to any medications? YES NO

If yes, please list medications: _____

EMPLOYMENT HISTORY (if work-related)

When the accident/injury occurred, did you have a job? YES NO

Job title: _____

Job description: _____ Full time Part time _____ hrs/wk

Job duties: Lifting/carrying _____ lbs. Sitting _____ hrs/wk

Standing _____ hrs/wk Walking _____ hrs/wk

Did you miss time from work due to accident/injury? YES NO Date first missed work: _____

If yes, how much time? _____ days/months Date returned to work: _____

Employer for work comp claim at time of injury: _____

Hours worked weekly: _____ Years at job: _____

Are you actively working now? YES NO

If yes: same job (same duties) same job (different duties) new job side jobs

Any work restrictions? _____

List duties _____

Employment history (last five years):

<u>Employer's Name</u>	<u>Job Description</u>	<u>Years Worked</u>

SOCIAL HISTORY:

Do you use tobacco? YES NO

Do you drink alcohol? YES NO

How many packs of cigarettes per day? _____

How many drinks per day? _____

How many years have you smoked? _____

If you quit, when? _____

FAMILY HISTORY:

Have any family members had the following:

diabetes, who? _____

cancer, who? _____

heart disease, who? _____

arthritis, who? _____

other disease(s), who? _____

PATIENT'S SIGNATURE: _____

TODAY'S DATE: _____

PAIN DRAWING

Using the symbols giving below, mark the area(s) on your body where you feel the described sensations. Include all affected areas.

Aching
^^^

Numbness
===

Pins & Needles
ooo

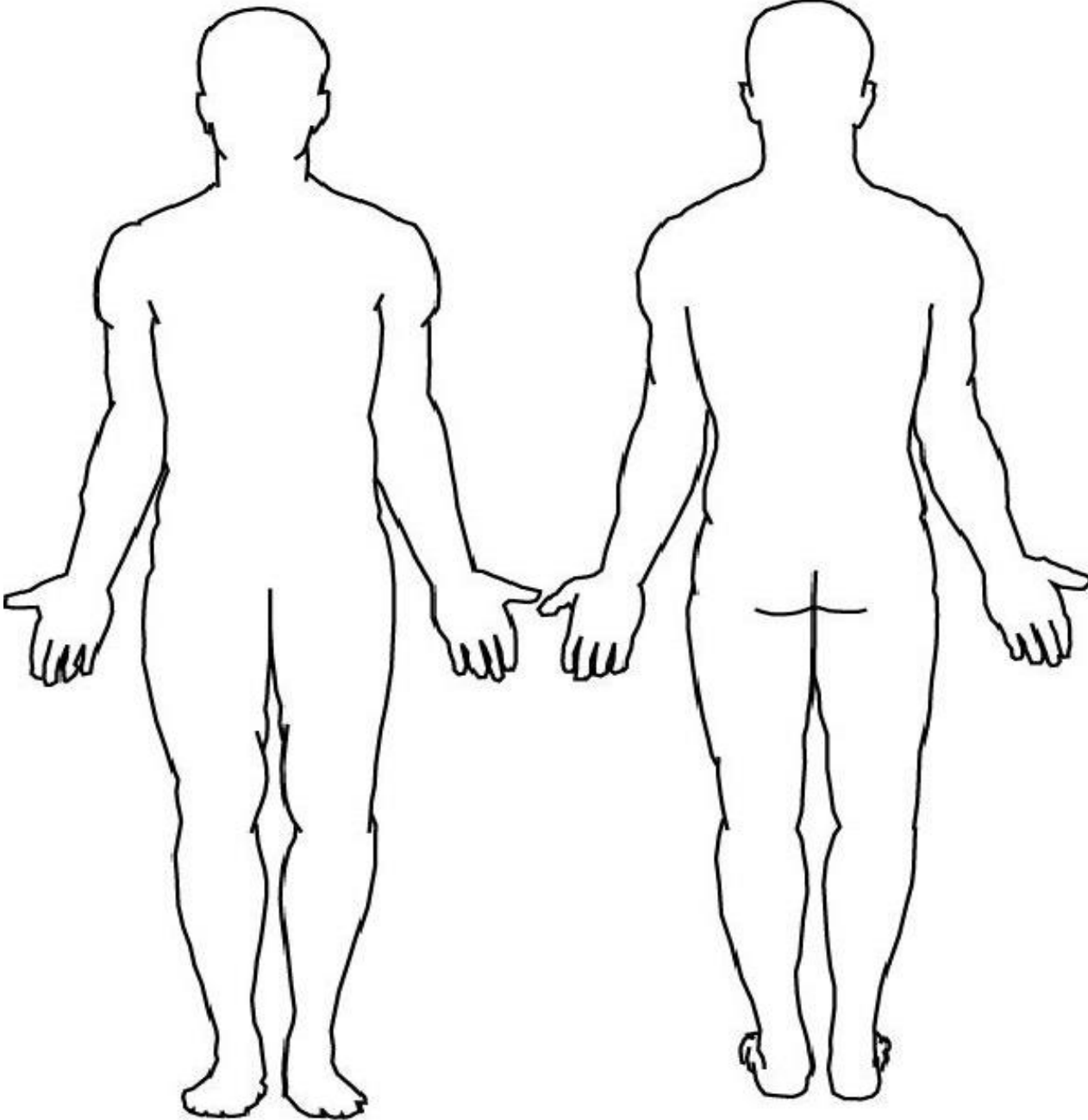
Burning
xxx

Stabbing
///

Other
...

FRONT

BACK



Pain in the arm(s) compared to the neck: worse same less
Pain in the leg(s) compared to the back: worse same less

PATIENT NAME: _____ DATE: _____

SYSTEM REVIEW

CONSTITUTIONAL SYMPTOMS

Good general health lately YES NO
 Recent weight change YES NO
 Fever YES NO
 Fatigue YES NO
 Headaches YES NO

EYES

Eye disease or injury YES NO
 Wear glasses or contacts YES NO
 Blurred or double vision YES NO
 Glaucoma YES NO

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing YES NO
 Earaches or drainage YES NO
 Chronic sinus problem or rhinitis YES NO
 Nose bleeds YES NO
 Mouth sores YES NO
 Bleeding gums YES NO
 Bad breath or bad taste YES NO
 Sore throat or voice change YES NO
 Swollen glands in neck YES NO

CARDIOVASCULAR

Heart trouble YES NO
 Chest pain or angina pectoris YES NO
 Palpitation YES NO
 Shortness of breath with walking or lying flat YES NO
 Swelling of feet, ankles or hands YES NO

RESPIRATORY

Chronic or frequent coughs YES NO
 Spitting up blood YES NO
 Shortness of breath YES NO
 Asthma or wheezing YES NO

GASTROINTESTINAL

Loss of appetite YES NO
 Change in bowel movements YES NO
 Nausea or vomiting YES NO
 Frequent diarrhea YES NO
 Painful bowel movement or constipation YES NO
 Rectal bleeding or blood in stool YES NO
 Abdominal pain or heartburn YES NO
 Peptic ulcer (stomach or duodenal) YES NO

PSYCHIATRIC

Memory loss or confusion YES NO
 Nervousness YES NO
 Depression/Insomnia YES NO

MUSCULOSKELETAL

Joint pain YES NO
 Joint stiffness or swelling YES NO
 Weakness of muscles or joints YES NO
 Muscle pain or cramps YES NO
 Back pain YES NO
 Cold extremities YES NO
 Difficulty walking YES NO

INTEGUMENTARY (Skin, Breast)

Rash or itching YES NO
 Changes in skin color YES NO
 Change in hair or nails YES NO
 Varicose veins YES NO
 Breast pain YES NO
 Breast lump YES NO
 Breast discharge YES NO

ENDOCRINE

Glandular or hormone problem YES NO
 Thyroid disease YES NO
 Diabetes YES NO
 Excessive thirst or urination YES NO
 Heat or cold intolerance YES NO
 Skin becoming dryer YES NO
 Change in hat or glove size YES NO

HEMATOLOGICAL/LYMPHATIC

Slow to heal after cuts YES NO
 Bleeding or bruising tendency YES NO
 Anemia YES NO
 Phlebitis YES NO
 Past transfusions YES NO
 Enlarged glands YES NO

GENITOURINARY

Frequent urination YES NO
 Burning or painful urination YES NO
 Blood in urine YES NO
 Change in force/strain when urinating YES NO
 Incontinence or dribbling YES NO
 Kidney stones YES NO
 Sexual difficulty YES NO
 Male - testicular pain YES NO
 Female - pain with periods YES NO
 Female - irregular periods YES NO
 Female - vaginal discharge YES NO
 Female - number of pregnancies # _____
 Female - number of miscarriages # _____
 Female - date of last pap smear _____



Dr. Lawrence I. Barr

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Consent for Treatment

The undersigned hereby consents to any medical services rendered to the patient by the physicians, employees and contracted healthcare providers of Garden State Orthopaedics.

Authorization to Release Information

The undersigned authorizes Garden State Orthopaedics (GSO) to release all or any part of the medical record of the patient named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the medical services rendered. The undersigned also authorizes other healthcare providers to release all or any part of the medical record of the patient named on this encounter form to GSO that may be required to assist GSO in patient's diagnosis and/or treatment.

Assignment of Insurance Benefits

As a convenience to our patients, Garden State Orthopaedics will bill your insurance carrier directly. I hereby assign, transfer, and set over to GSO all of the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining precertification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

HIPAA Privacy Policy

The undersigned acknowledges that he/she received a copy of GSO's notice of privacy policy as required by HIPAA.

Financial Responsibility

The undersigned agrees, whether signing as the patient or an agent, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to be responsible for all and any unpaid portion of the bill incurred. The bill may include this office's administrative fees, such as no-show fees and fees for filling out disability forms. I further understand the unpaid section of the bill may be insurance deductibles, coinsurance, co-payments, or the entire bill if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the patient or is a duly authorized representative of the patient and accepts and consents to the above terms.

Signature of patient/authorized representative

Date



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Financial Agreement

I authorize payment to be made on my behalf by my insurance company and/or attorney directly pay Garden State Orthopaedics such sums as may be due and owing this office for services rendered me both by reason of accident, or illness and by reason of any other bills that are due the office, and to withhold such sums from any disability benefits, medical payment benefits. No fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obligated to reimburse or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of benefits form to the extent of the office's services provided.

In the event my insurance company refuses to make such payments upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further authorize this office to compromise, settle or otherwise resolve said claim or cause of action they see fit.

I understand that I am financially responsible to Garden State Orthopaedics for the total amount due and/or for any amount not covered by my insurance for their services, or in the event of no recovery upon settlement. I further understand and agree that this assignment, lien, and authorization does not constitute any consideration of the office to await payment and they may demand payments from me upon rendering services at their option.

In the event your account with Garden State Orthopaedics is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court costs will be added to your total amount.

I authorize Garden State Orthopaedics to release any information pertinent to my case to any insurance company, adjuster, or attorney to facilitate collection under this assignment, lien and authorization and I understand that Garden State Orthopaedics will be using my social security number as identification. I agree that the above-mentioned office be given the power of attorney and to endorse/sign my name on all checks for payment of services rendered.

I certify that the information provided to Garden State Orthopaedics regarding the injuries I sustained in my accident is honest and truthful.

I HAVE READ AND UNDERSTAND THE MEANING AND TERMS OF THE ABOVE PARAGRAPHS. I ACCEPT ON BEHALF OF MYSELF AND/OR THIS PATIENT ALL OF THE LISTED ITEMS IN THESE PARAGRAPHS.

Signed: _____ Date: _____

(Patient or Guardian)



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Assignment of Benefits

Policy#: _____

Claim #: _____

Patient's Name: _____

Medical Provider: Dr. Lawrence Barr

I Authorize and request my insurance company to pay directly to Garden State Orthopaedics and Sports Medicine, the amount due under the terms of the above referenced policy pertaining to the medical care rendered by Garden State Orthopaedics.

Sign

Date

I have read the information sent by the insurance carrier concerning the Decision Point Review plan, including any pre-certification requirements and, as a condition precedent to the insurance carrier acceptance of this assignment, I agree for myself, and on behalf of all medical staff associated with my office to the following:

1. I (we) have complied and will comply with all the procedures identified within the plan.
2. I (we) will comply with all requests for additional information from the insurance carrier concerning the presentation of the claim including but not limited to the submission of medical records with clinically supported findings to support the diagnosis, causal relationship to the injury and care plan and if necessary, submit to Examination Under Oath.
3. I (we) will submit all disputes in accordance with the Internal Appeal Procedure set forth in the plan.
4. I (we) will not institute litigation or initiate the Personal Injury Protection Dispute Resolution process outlined in the plan until there is a final determination of the internal Appeal Procedure of the dispute.
5. If I (we) fail to comply with the requirements of the plan, and such failure results in the imposition of a co-payment penalty, we will not hold the patient responsible for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services attributable to such failure to comply with the plan.

The Insurance Carrier does not provide coverage for any insure or pay benefits to any provider who has made fraudulent statements or engaged in fraudulent conduct or made any material misrepresentation in connection with either obtaining the policy or with any accident/injury or loss for which coverage or benefits are sought.

I (we) understand that the insurance carrier has the right to reject this assignment of benefits.



————— **Dr. Lawrence I. Barr** —————

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HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

***PLEASE NOTE THAT IF YOU WOULD LIKE TO READ AND/OR NEED A COPY OF
HIPAA NOTICE OF PRIVACY PRACTICES PLEASE SEE THE FRONT DESK RECEPTIONIST***



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STANDARD OFFICE POLICIES AND PROCEDURES

- All cellular devices must be turned off in the examining rooms.
- Eating and drinking are not allowed in the examining rooms
- Disability papers must be pre-paid. \$15 per form. Forms are not filled out every day.
- Medications will only be filled during business hours
- Motorcycle cases must use health insurance.
- **IF YOUR VISIT TODAY INVOLVES AN ATTORNEY FOR A MOTOR VEHICLE ACCIDENT, OR A PERSONAL INJURY CASE:** We will work with you and your attorney in getting your medical bills paid. If you have health insurance as a secondary coverage, we will bill them for your co-pays and deductibles. However, if a referral is required, this **must be obtained before your visit**. For motor vehicle cases, once your insurance has exhausted, we will then bill your health insurance as primary. At that time, we will collect any co-pays or deductibles for which you are responsible. However, whatever patient responsibility is incurred throughout treatment is expected to be paid at the time of service. When treatment concludes, we expect there to be a zero-dollar balance regardless of the status or outcome of your case. This includes all deductibles, co-pays and any outstanding balances not covered or paid for by your insurance company or legal settlement.
 - **Radiology for Motor Vehicle Cases:** If our office refers you for an MRI, bone scan, CT scan and/or Xray, it must be authorized through your motor vehicle insurance first. Once approval is received, it will be sent to a radiological facility, and they will contact you for an appointment. Our office does not schedule patients for radiologic testing. If testing is denied, our office will contact you. The authorization process will take 7-14 business days from the date you were seen.

I have read and understand the above:

Signature _____ Date: _____



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COVID-19 Liability Waiver Form

I acknowledge:

- the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing.
- That Garden State Orthopaedics has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.
- That Garden State Orthopaedics cannot guarantee that I will not become infected with the Coronavirus/Covid-19.
- That the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others.
- That I am voluntarily seeking services provided by Garden State Orthopaedics and that I am increasing my risk to exposure to the Coronavirus/COVID-19.
- That I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

- I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.
- I have not traveled internationally within the last 14 days.
- I have not traveled to a highly impacted area within the United States of America in the last 14 days.
- I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19.
- I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities.
- I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Garden State Orthopaedics harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of Garden State Orthopaedics, or that may otherwise arise in any way in connection with any services received from Garden State Orthopaedics. I understand that this release discharges Garden State Orthopaedics from any liability or claim that I, my heirs, or any personal representatives may have against them with respect to any bodily injury, illness, medical treatment, or death or property damage that may arise from, or in connection to, any services received from Garden State Orthopaedics.

Patient signature

Date



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COVID-19 Screening Form

Please circle “yes” or “no” to the following questions.

YES	NO	Have you had a cough, shortness of breath, difficulty breathing, fever (temp 100 or greater), chills, repeated shaking with chills, muscle pain, headache, sore throat, or new onset loss of taste or smell in the last 14 days?
YES	NO	Have you had close unprotected contact with a suspected or laboratory confirmed COVID-19 individual in the last 14 days?
YES	NO	Have you had a laboratory confirmed or suspected diagnosis of COVID-19 in the past 14 days?
YES	NO	Have you or someone you know had close contact with someone who traveled to others states or out of the country?

- All patients’ assistants and visitors must wear a face mask or face covering all the time at the facility.
- All patients and assistants must maintain a social distance at the facility.
- Please wash your hands with soap and water after handing this form back to our staff.
- Please wash your hands with soap and water before leaving this office.

To the best of my knowledge my above answers are correct and accurate. By signing this form, I agree to comply with the above rules and recommendations.

Signature

Date