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

Name of Doctor	Specialty	Date of 1st visit	Still treating Yes or No

What test did you have done?	Location of test	What body part(s)
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):

Employer's Name	Job Description	Years Worked

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: _____

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

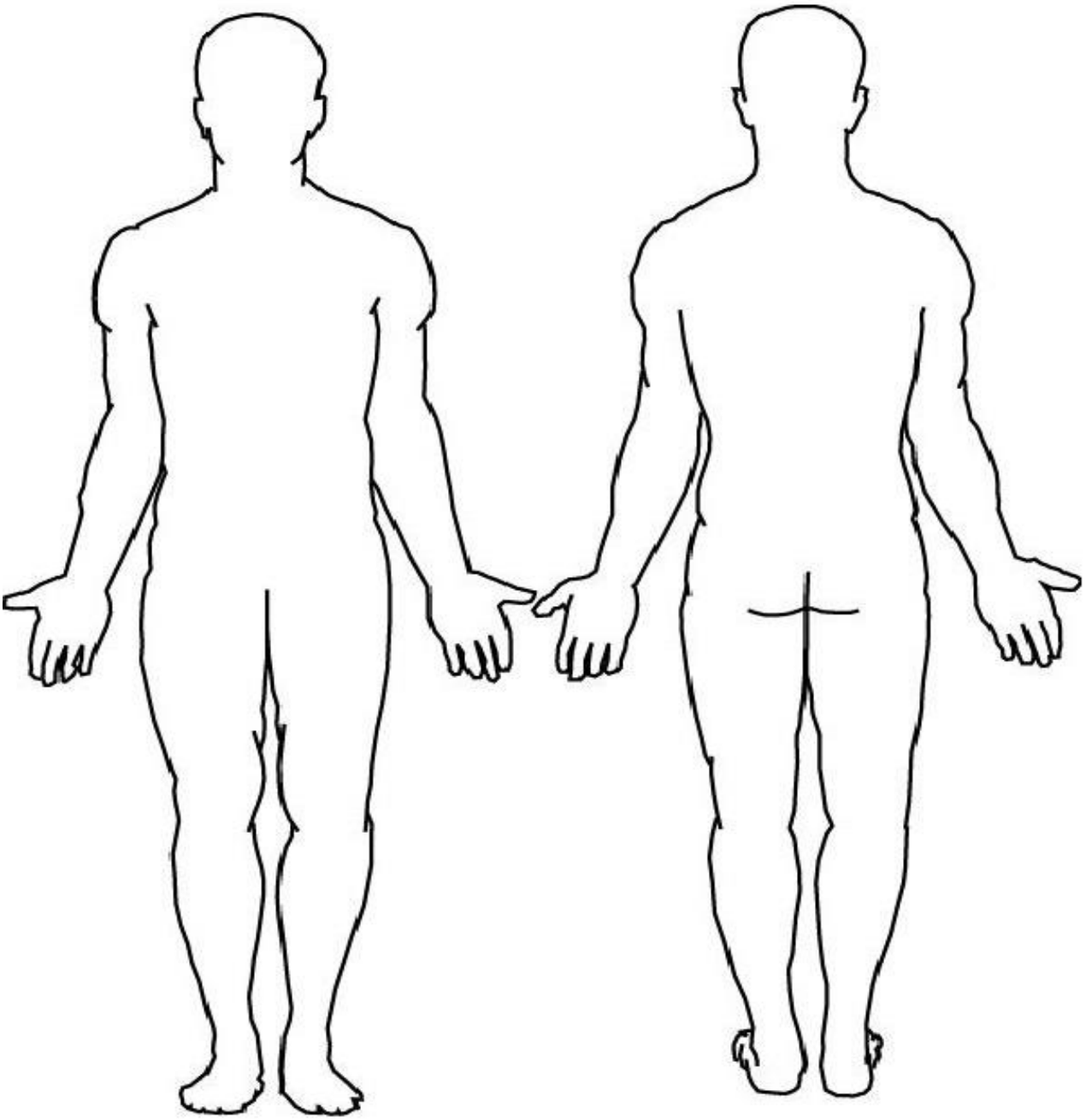
GENITOURINARY		
Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change in force/strain when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Sexual difficulty	YES	NO
Male - testicular pain	YES	NO
Female - pain with periods	YES	NO
Female - irregular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

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	Burning	Stabbing	Other
^ ^ ^	= = =	o o o	x x x	/ / /	. . .

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

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 duty 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.

_____ _____

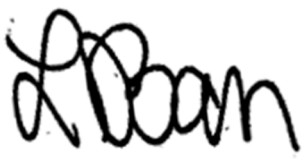
Sign Date

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.



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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 INVOLES AN ATTORNEY FOR A MOTOR VEHICLE ACCIDENT, OR A PERSONAL INJURY CASE: We will work with you and you 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

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: _____

GARDEN STATE ORTHOPAEDICS
1030 NORTH KINGS HIGHWAY
SUITE 200
CHERRY HILL NJ 08034

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)	Gender: Male □ / Female □		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code	Date of Birth	Social Security No. (if none, enter "none")	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)	Email:		

Date of Accident	Time of Accident AM PM	Place of Accident (Street, City/Town & State)

Brief Description of Accident

	Yes	No
Do you own a vehicle? Yes No Name of Insurance Company _____		
Does anyone living in your residence own a vehicle? Yes No Name of Insurance Company _____		
Do you have health insurance? Yes No Name of Insurance Company _____		
Were you the driver of the vehicle?		
Were you a passenger in the vehicle?		
Were you a pedestrian?		
Were you a member of vehicle owner's household?		

As a result of this accident were you injured? Yes **X** No If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: [redacted] Date: _____

Describe your injury: _____

Were you treated by a doctor? Yes No	Doctor's Name and Address
If you were treated in a hospital, were you an In-patient? Out-patient?	Hospital's Name and Address

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes No	At the time of your accident, were you in the course of your employment? Yes No	Did you lose wages or salary as a result of your injury? Yes No If yes, amount loss to date: $ _____._____	What is your average weekly wage or salary? $_____

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under: Yes No
(1) Any Workers' Compensation Law?
(2) Employees' Temporary Disability Benefit Statute?
(3) Medicare?

If yes, amount: $_____ Per week Per month

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes No If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization, I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Signature: _____ Date: _____