New Jersey
SPORTS MEDICINE
Non-Surgical Solutions to Orthopedic Injuries

Date:_____ Email address:_____

Name:_____, _____
(Last) (First)

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Birthdate:_____ SSN:_____ Gender: M or F (circle)

Marital Status: Single Married Divorced Seperated Widowed (circle)
Race: _____ Ethnicity: _____
Language: _____

Employer:_____
Employer Address:_____
Occupation:_____ Work Phone:_____

IS THIS VISIT RELATED TO MVA OR WORKERS COMP? Y or N
If yes, what is the date of injury? _____
Insurance:_____
Claim Address:_____
Claim #:_____
Adjustor:_____ Phone:_____

MEDICAL INSURANCE:_____
Address:_____
Subscriber's Name:_____ DOB:_____
ID#:_____ Group#:_____

SECONDARY INSURANCE:_____
Address:_____
Subscriber's Name:_____ DOB:_____
ID#:_____ Group#:_____

Referring Doctor:_____

Primary Doctor:_____

Emergency Contact:_____ Phone:_____

Pharmacy: _____ Phone: _____
Address: _____

Mail Order Pharmacy: _____ Phone: _____
Address: _____

CONSENT FOR EXTERNAL PRESCRIPTION HISTORY

I, the undersigned, hereby authorize New Jersey Sports Medicine to receive all external prescription history from my pharmacy. This information is required by the practice to obtain in order to appropriately prescribe any medications to the patient in the future.

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependants. I further agree to acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____
(Name of Insured) (Name of Insurance)
to pay and hereby assign directly to New Jersey Sports Medicine LLC all benefits, if any, otherwise payable to me for services provided. I understand that I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to New Jersey Sports Medicine LLC will be credited to my account, in accordance with the above said assignment.

_____ Date: _____
(Signature of Insurance Subscriber or Patient)

NEW JERSEY SPORTS MEDICINE LLC.

Notice of Privacy Practices Notice and Designation of Disclosure

I. Patient Receipt Acknowledgment

I, _____, acknowledge that I have received the Notice of Privacy Practices. I have been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my individually identifiable health information, or to request additional confidential treatment of communications between the Practice and myself or others.

_____

Signature of Patient/Parent/Guardian Date

_____

Witness Relationship

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

___Home Telephone
- ___OK to leave a message with detailed information
- ___ Leave message with call back number only

____Work Telephone
- ___OK to leave a message with detailed information
- ___Leave message with call back number only

____Written Communication
- ___OK to mail to home
- ___OK to mail to work/office
- ___OK to fax to this number _____

____Other _____

III. Designation of Certain Relatives, Close Friends, and Other Caregivers

I agree that NJSM, LLC may disclose certain health information to a family member, close personal friend, or other caregiver because such person is involved with my healthcare or payment relating to my healthcare. In that case, NJSM, LLC will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of NJSM, LLC making the limited disclosures described above. I understand that I am not required to list anyone, and that I may change this list at anytime in writing. I also understand this form is only valid for one year from the date signed.

Print Name:_____ Relation:_____

Print Name:_____ Relation:_____

Print Name:_____ Relation:_____

_____

Signature of Patient/Parent/Guardian Date

NEW JERSEY SPORTS MEDICINE LLC.

Name: _____ Sex:_____ Age:_____

Handedness: Right or Left

Referral source: Self or Physician (specify): _____

Primary Care Physician (PCP):_____

Reason for visit?: _____

Complaints/Symptoms: _____

Precipitating Event: _____

Date of Onset: _____

Pain Intensity (0-10 scale) - Average pain: (0- no pain, 10 worst)_____

What makes your pain worse: _____

What makes your pain better: _____

Other symptoms (weakness, numbness, tingling, etc.)_____

Previous Tests (X-rays, CT scans, MRI's, Bone scans, EMG). Please give approximate dates and results if known.

_____

_____

_____

_____

_____

_____

Prior Treatments:

Medications: _____

_____

Any relief?_____

Therapy (PT?OT? etc.):_____

Any improvement?_____

Bracing:_____

Procedures (injections, surgery):_____

Any improvement?_____

[Continued on next page]

Review of Systems- Do you have any of the following:

- Constitutional

Generally Good Health	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/Contact Lenses	Yes	No
Blurred Vision/Double Vision	Yes	No
Glaucoma	Yes	No

- Ears/Nose/Throat

Hearing Loss or Ringing	Yes	No
Chronic Sinus Problems/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	Yes	No
Palpitations	Yes	No
Shortness of Breath w/Walking	Yes	No
Shortness of Breath w/Lying Flat	Yes	No
Swelling of Feet/Ankles/Hands	Yes	No

- Respiratory

Chronic of 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 Movements	Yes	No
Constipation	Yes	No
Rectal Bleeding	Yes	No
Abdominal Pain or Heartburn	Yes	No
Stomach Ulcer	Yes	No

- Genitourinary

Frequent Urination	Yes	No
Burning or Painful Urination	Yes	No
Blood in Urine	Yes	No
Change in Force or Straining w/Urinating	Yes	No
Incontinence or Dribbling	Yes	No
Kidney Stones	Yes	No
Sexual Difficulty	Yes	No
Male- Testicle Pain	Yes	No
Female- Pain w/Periods	Yes	No
Female- Irregular Periods	Yes	No
Female- Vaginal Discharge	Yes	No

Female #Pregnancies___ #Miscarriages___

Female- Date of Last Pap Smear_____

- 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

Rash or Itching	Yes	No
Change 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

- Neurologic

Frequent or Recurrent Headaches	Yes	No
Lightheaded or Dizzy	Yes	No
Convulsions or Seizures	Yes	No
Numbness/Tingling Sensations	Yes	No
Tremors	Yes	No
Paralysis	Yes	No
Stroke	Yes	No
Head Injury	Yes	No

- Psychiatric

Memory Loss or Confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No

- Endocrine

Glandular or Hormone Problems	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/Glove Size	Yes	No

- Hematologic/Lymphatic

Slow to Heal after Cuts	Yes	No
Bleeding or Bruising Tendency	Yes	No
Anemia	Yes	No
Phlebitis	Yes	No
Past Blood Transfusion	Yes	No
Enlarged Glands	Yes	No

Doctor Reviewed:_____

Date

[Continued on next page]

Medical History (circle):

High Blood Pressure | Diabetes Mellitus | Cardiac Disease (Type:_____)

Peripheral Vascular Disease | Stomach Ulcers | Depression/Anxiety | Psychiatric

Thyroid Disease | Cancers Type:_____ | Stroke | Osteoporosis

Joint Disease (Rheumatoid, osteoarthritis, etc.) | Asthma | Substance Abuse Drug:_____

Other: _____

Surgical History:

_____Appendix
_____Gall Bladder
_____Neck or Back surgery (specify)_____
_____Carpal Tunnel Release
_____Joint replacements/repairs (specify)_____
_____Other/please specify:_____

Medications (Please List All the **Pills** You are Taking):

Anti-inflammatories (specify) _____
Opioid (specify) _____
Tricyclics (specify) _____
Anticonvulsants (specify):_____
Vitamins/Supplements: _____
Other: _____

Allergies/Intolerances to Medications: _____

Social History:

_Yes_No__Alcohol How much caffeine do you consume? (coffee, tea, soda, etc.)____Cups
_Yes_No__Smoke (Did you ever smoke, if so when did you quit?)_____
_Yes_No__Non-prescription Drugs (marijuanna, cocaine, vitamins, herbs, etc.)_____
Occupation:_____ or on Disability (for how long)_____
Marital status (circle): single married divorced separated
Children: _____

Family History (circle):

High Blood Pressure | Diabetes Mellitus | Cardiac Disease

Peripheral Vascular Disease | Stomach Ulcers | Stroke

Thyroid Disease (Anxiety/Depression/Etc.) | Cancers Type:_____ | Psychiatric

Joint Disease (Rheumatoid, Osteoarthritis, Connective tissue disease) Osteoporosis

Functional History (circle):

Activities of Normal Daily Life: Independent Need Assistance Dependent on Help
Difficulty walking Yes No Difficulty Sleeping Yes No
Transfers Problems Yes No
Equipment (ie cane, walker, tub bench, etc.)_____

Do you exercise routinely (circle): Yes No
Type of Exercise: _____ How Frequent?: _____

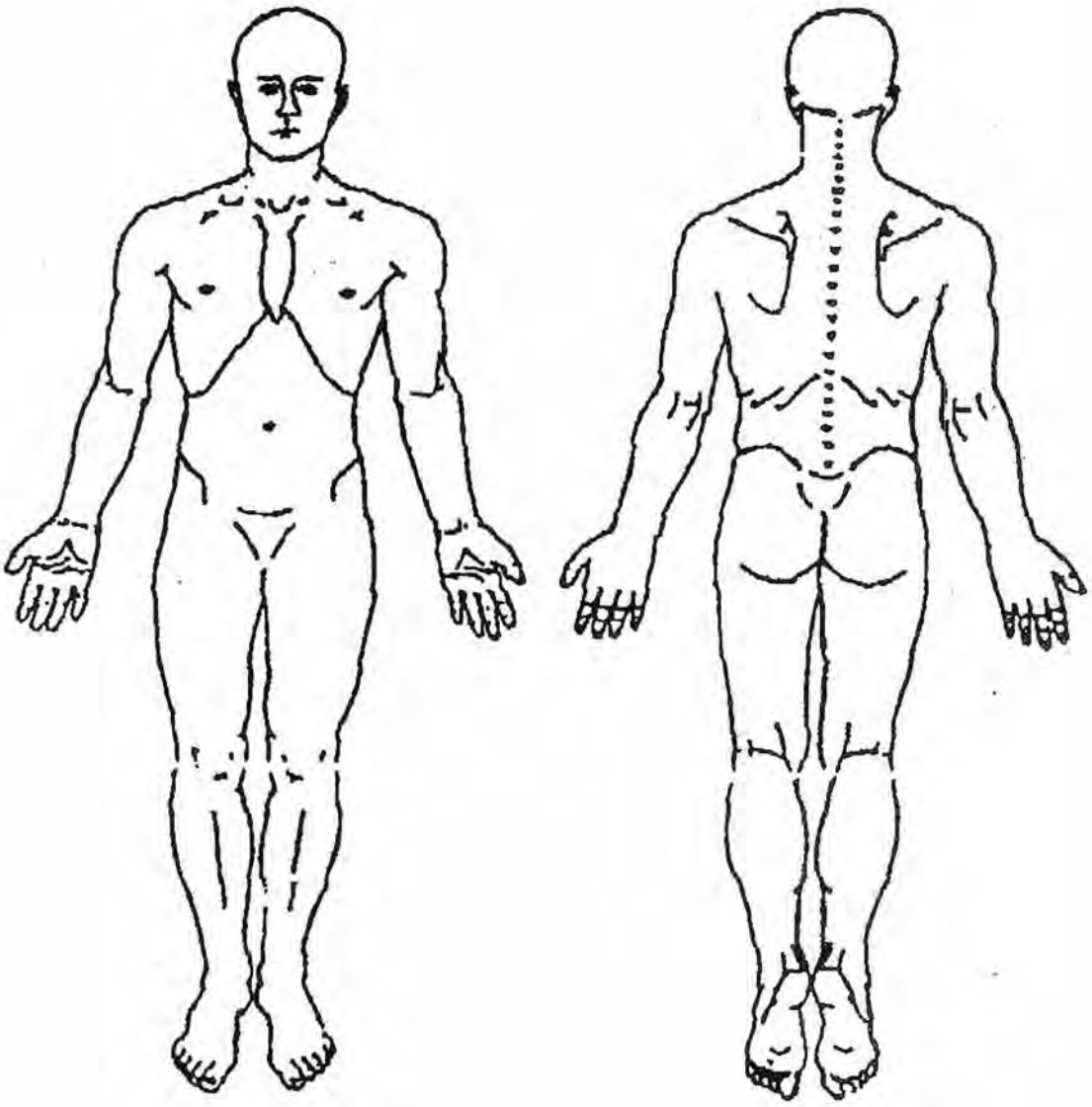
[Continued on next page]

NAME:_____ DATE:_____

PAIN DRAWING

Using the symbols given below, mark the area on you body where you feel the described sensations. Include all affected areas. Just to complete the picture, please draw in your face.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	=====	OOOOO	XXX	/////	.....



NEW JERSEY SPORTS MEDICINE, LLC
PAYMENT POLICY

Thank you for choosing our practice. It is our goal to provide you with quality and affordable health care. In order to avoid any confusion regarding our policies and your responsibility for services rendered, we have set forth below our payment policy. Please read it, ask any questions you may have and then sign in the space provided below.

Copayments and Deductibles. All copayments (deductibles) must be paid in full by you at the time services are rendered.

Patients Without Insurance. If you do not have any type of health insurance you will be required to pay in full for services rendered at the time services are rendered.

Methods of Payment. We accept payment in the form of cash, check, or credit card. We accept Visa, Mastercard, Discover and American Express. For larger out of pocket expenses, New Jersey Sports Medicine also accepts healthcare credit cards that offer convenient finance options to patients. More information on these healthcare credit cards are in the waiting room or you can ask the office manager.

Insurance; Noncovered Services. We participate in some insurance plans; however we do not participate in Medicare. Please speak to us to determine whether we participate in your insurance plan. It is your responsibility to notify us if your insurance changes. We will bill your insurance company as a courtesy to you, however, you may be required to supply additional information directly to your insurance company. Any portion of our fee that is not paid by your insurance company remains your responsibility. Your insurance benefit is a contract between you and your insurance company and we are not a party to that contract. Additionally, certain services provided by us may not be covered by your insurance or may not be considered reasonable or necessary by your insurance company. In such event, you are responsible for payment for such services.

Minors. If a patient is younger than 18 years of age, a parent or guardian must be responsible for payment of services in accordance with these policies.

Missed appointments. We reserve the right to charge $25.00 for missed appointments not canceled more than 24 hours in advance. This charge is your responsibility and will be billed directly to you. Your insurance company will not pay for this charge.

Returned Checks. Checks that are returned from the bank for any reason will be charged a $30 returned check fee in addition to the amount that you owe. If your check is returned from the bank for any reason in the future you must pay by cash or credit card.

Proof of Insurance. You must complete a patient information form before services are rendered. We are required to obtain a copy of your driver's license and current valid insurance card.

Referrals. Your insurance plan may require that you obtain a referral for our services at or prior to the time services are rendered. It is your responsibility to know if your insurance company requires a referral and you must obtain the referral prior to your appointment. Many primary care physicians' offices will not issue a referral if not given 24-72 hours. We will accept a faxed referral, but some

primary care physicians will not fax a referral as per their own office policy. If you do not bring a valid referral, you may pay for services rendered and submit a claim to your insurance company for reimbursement. However, it is possible that your insurance company will not reimburse you. In the alternative, you may reschedule your appointment.

Authorizations. Authorizations for outside diagnostic tests such as MRI, x-rays, etc. may be obtained by our office staff. However, insurance companies do not guarantee coverage or payment of these services. The patient is responsible for contacting their insurance company to dispute if coverage or a claim is denied for these services.

Medical Records; Completion of Forms. If you require copies of your medical records, you must submit a request in writing. We may charge a reasonable copying fee. If we are requested to complete any forms for you (i.e. - forms from patient's insurance carriers, employer, etc.) we charge $10 per page. This excludes DMV handicap parking certificates and forms for disability. Payment is required at the time forms are submitted to us.

Past due balances. Past due balances are due at the earlier of your next office visit or the end of the month. Our billing company, Resolutions, will send you a statement so that you are aware of the amount that you owe. You must make a payment of at least 50% of your past due balance before your next office visit or at the time of your next scheduled office visit. This does not include that day's fee-for-service which must also be paid that same day. If you do not make any effort to pay your past due balance of $50 or more and >120 days old; we may refer your account to a collection agency and you will be responsible for all collection expenses and attorney fees. We may also not be willing to provide future services except on an emergency basis for a previously treated injury or problem.

Alternative arrangements. Other payment arrangements must be discussed with our Practice Administrator. If an agreement is made, it will be put forth in writing and signed by you.

Questions. If you have a billing question or question regarding a statement received, you may call Resolutions at 1-877-632-9292.

I have read and understand the above payment policy and accept the terms.

_____ _____

Patient Signature Date

_____ _____

Witness Date