Vincent K. McInerney, MD
Robert M. Palacios, MD
Nicole Bettini, PA - C

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Name_____**DOB**___/___/___**Age** _____

Marital Status S M W D

****Indicates required question per government reporting guidelines**

****Height**_____ ****Weight**_____ **Sex MALE FEMALE**

What is the reason for today's visit? _____

Is today's visit due to an injury? □Y □N How did the injury occur? _____

Did this injury occur at: □Work □School □ Motor Vehicle Accident □Other Date of injury___/___/___

What is your occupation? _____

****Any treatment since onset? (check all that apply) □Physical Therapy □Injection □Surgery □Medication □None**

If yes, when/where was this treatment done? _____

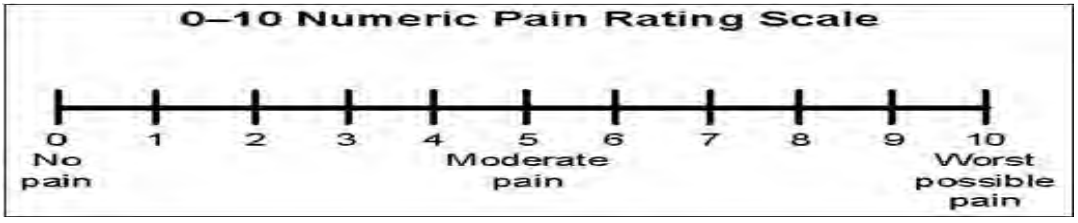
Have you had an X-RAY □Y □N, MRI □Y □N, CT □Y □N, Ultrasound □Y □N

If yes, where? _____

Describe Pain (all that apply): □Sharp □Aching □Shooting □Dull □Constant □Sometimes □Worse w/ Activity

Does anything make the pain better? □Ice □Heatpack □Rest □Medication □Therapy □Injection □Other___

****PLEASE INDICATE THE LEVEL OF PAIN YOU ARE HAVING ON THE SCALE BELOW**



****Flu Vaccine (Month/Year)** ____/____ **Pneumonia Vaccine (Month/Year)** ____/____

****Do You Smoke □Y □N #cig/day** ____ **for**____ **Do You Drink? □Y □N #drinks/wk**____ **for**____

****Allergies (list all & reactions)**_____

504 Valley Road Suite 200, Wayne, NJ 07470
Phone 973.694.2690 | Fax 973.694.2692
Main Location: Wayne
Satellite Locations: Butler · Clark · Clifton · Morristown · West Milford · West Orange

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Previous Surgeries & Dates & Complications _____

****Current Medications**_____**(Please Initial To Give Consent to Allow Access to Your Pharmacy Medication List)**

"Over The Counter" Vitamins/Medications_____

Pharmacy Address & Phone Number_____

Who referred you to our practice? ☐Internet/Social Media ☐Friend ☐Athletic Trainer ☐Physician ☐Other___

Primary Physician_____Referring Physician/Trainer/Therapist_____

Family History(check all that apply) ☐Heart Disease ☐Diabetes ☐Cancer ☐Blood Clot ☐Hypertension ☐High Cholesterol ☐Other:__

Medical History: Do you have or have you had any of the following? (check all that apply)

☐ High Blood Pressure
☐ Heart Attack
☐ CHF (congestive heart failure)
☐ Angina
☐ Arrhythmia (abnormal heart beat)
☐ Strokes
☐ Blood Clot
☐ Pulmonary Embolism
☐ Bleeding Disorder (Factor V)
☐ Cancer
☐ Asthma
☐ Sleep Apnea
☐ Pneumonia
☐ Bronchitis (chronic)
☐ Stomach Ulcer
☐ Kidney Disease
☐ Liver Disease
☐ Thyroid Problems
☐ Gout
☐ Rhumatoid
☐ Lyme Disease
☐ Lupus
☐ Poor Wound Healing
☐ Autism
☐ Seizures
☐ HIV
☐ Diabetes
☐ Other: _____

Review of Systems: Do you currently have any of the following? (check all that apply)

☐ Joint Pain
☐ Joint Stiffness
☐ Muscle Pain
☐ Swelling
☐ Bruising
☐ Bruises Easily
☐ Neck Pain
☐ Neck Stiffness
☐ Back Pain
☐ Numbness
☐ Head Injury
☐ With Loss of Consciousness
☐ Nausea/Vomiting
☐ Dizziness
☐ Headache
☐ Decreased Memory
☐ Vision Changes
☐ Chronic Infection
☐ Chills or Fever
☐ Decreased Range of Motion
☐ Abdominal Pain
☐ Leg Cramping
☐ Night Sweats
☐ Skin Rash
☐ Unable to work due to pain
☐ Stopped sports due to pain

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UCLA Activity Score: Check one box that best describes your current activity level (please check one)

☐ Wholly inactive, dependent on others, and cannot leave residence
☐ Mostly inactive or restricted to minimum activities of daily living
☐ Sometimes participates in mild activities, such as walking, limited housework, and limited shopping
☐ Regularly participates in mild activities
☐ Sometimes participates in moderate activities, such as swimming, or could do unlimited housework/shopping
☐ Regularly participates in moderate activities
☐ Regularly participates in active activities, such as bicycling
☐ Regularly participates in active activities, such as golf or bowling
☐ Regularly participates in active activities, such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, etc.
☐ Regularly participates in impact sports

What sports/activities do you participate in, and at what level? (recreational, collegiate, etc)_____

Email_____

Patient/Guardian Signature_____**Date**____/____/____

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ASSIGNMENT OF BENEFITS
&
LIMITED POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/healthcare carrier/worker's compensation carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the New Jersey Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept assignment, or my assignment is challenge or deemed invalid, I execute this limited/special power of attorney and appointment and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing arbitration demand or lawsuit. I specifically authorize the attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said Insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospital, diagnostic center, etc., and I specifically authorize such healthcare provider(s) to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

Patient/Guardian Signature_____**Date**____/____/____
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NOTICE TO PATIENT

INSURANCE PARTICIPATION AND REFERRALS

Please be advised that it is the patient's responsibility to advise the practice of any insurance coverage changes or termination of coverage. It is not the responsibility of the practice to know your personal insurance coverage, participation, and/or any out of pocket expenses you may incur. If you have questions or concerns you are advised to notify your insurance company Member Services Department, or Human Resource Department at your place of employment.

Please note that if your plan requires a referral, it is the patient's responsibility to obtain one and it must be presented at the time of service. If you do not have one then you will have to reschedule your appointment until the time that you obtain a referral. If you choose to see a doctor without the required referral, you may become responsible for payment in full, should your insurance company deny your claim.

LITIGATION MATTERS

In order to allow our physicians to devote as much time as possible to the care and treatment of our patients, it is the policy of this office that our physicians do not testify in court as expert witnesses in connection with patient litigation or prepare narrative reports in connection with a patient's litigation. If the physician, in his or her sole discretion, agrees in any litigation, the physician will furnish the testimony by means of a videotaped deposition to be performed in our office at the physician's convenience, at the patient's sole cost and expense, and we will be entitled to compensation for the physician's time. Payment for such services will be coordinated with your attorney and must be paid in advance..

New Jersey Orthopaedic Institute will not wait for payment of services rendered until the case is settled. We will not accept a lien. Payment is due at the time of service.

Please acknowledge by signing and dating below that you have received and reviewed the above policy. A copy of this document will be forwarded to your attorney if and when the need arises.

Patient/Guardian Signature_____**Date**____/____/____
Patient Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996, (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information is used to:

- Conduct, plan, and direct my treatment and follow up among multiple healthcare providers that may be involved in my treatment directly and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses of disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy of Practices*.

If you wish to have New Jersey Orthopaedic Institute discuss your condition with any family members, relatives, physicians, athletic trainers, etc. or to release any information concerning your health and/or treatment by telephone, fax, mail, email, etc. Please list them below:

Name_____ Relationship_____
Name_____ Relationship_____
Name_____ Relationship_____

I understand that I may also request, in writing, that you restrict how my private information is used and/or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions. I understand that request to forward my medical records to another treating physician other than my primary care physician must be in writing.

Patient Name_____
Patient/Guardian Signature _____**Date**____/____/____

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PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _____, hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore;

- I understand it is **important that any and all recommendations by doctors are followed completely** in order to increase the likelihood of a positive and health treatment/outcome.

- I acknowledge and understand that if any physician in this office prescribes medicine to me, that the **proper taking of any such medicine shall be my sole responsibility** (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

- I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome.

- I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that **if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.**

- I understand that is **solely my responsibility to follow any of the medical advice given by any medical person in this office** and any bad health outcome from my failure to follow the advice of my doctors should be expected.

_____

Print Name

_____

Signature//Date

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