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Vincent K. McInerney,MD
Anthony Festa, MD
Anthony J. Scillia, MD
John J. Callaghan, MD
Craig Wright, MD
Robert Palacios, MD
Casey Pierce, MD
Colleen Joseph, PA-C

Name_____ **DOB**___/___/___ **Age** ____ **Marital Status S M W D**

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? _____

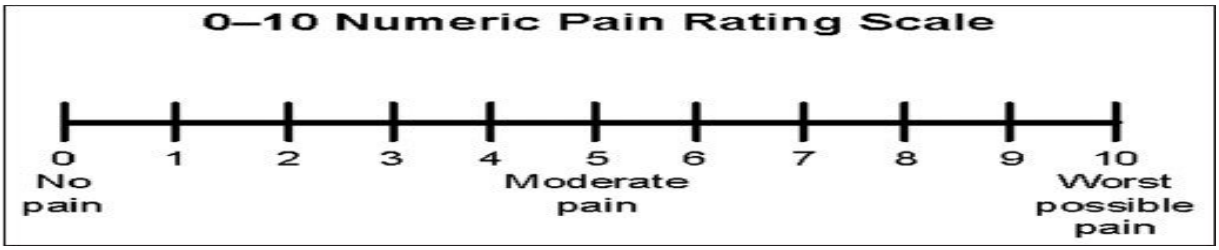
What treatment have you had so far? (injections, physical therapy, surgery, etc) _____

Have you had an X-RAY Y( ) N( ), MRI Y( ) N( ) If yes, where? _____

Are you having any pain today? Y( ) N( )If so, describe the type of pain (aching,shooting,etc)_____

Does anything make the pain better? (ice, rest, etc) _____

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



Who referred you to our practice? Internet/Social Media, Friend, Athletic Trainer, Physician, Other
Primary Physician_____Referring Physician/Trainer/Therapist_____

Current Medications_____
Allergies (list all)_____
Previous Surgeries & Dates_____ **Complications Y( ) N( )** _____
List any conditions which run in your family_____

Pharmacy Address/Phone Number_____

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 · Livingston · West Milford

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Medical History: Do you have or have you had any of the following?

___High Blood Pressure	___Heart Attack	___Arrhythmia(abnormal heart beat)
___Angina	___CHF(congestive heart failure)	___Breathing Difficulties
___Bronchitis (chronic)	___HIV	___Pneumonia
___Stomach Problems	___Kidney or Liver Problems	___Seizures
___Strokes	___Thyroid Problems	___Arthritis
___Blood Clot	___Gout	___Lyme Disease
___Cancer/Lupus	___Diabetes	___Poor Wound Healing

Review of Systems: Do you currently have any of the following?

___Chills	___Fevers	___Night Sweats
___Presistent Infection	___Bruising	___Rash
___Head Injury	___Decreased Memory	___Headache
___Numbness	___Dizziness	___Loss of Consciousness
___Parasthesia	___Vision Changes	___Nick Pain
___Neck Stiffness	___Claudication	___Edema
___Leg Cramps	___Leg Pain/Swelling	___Abdominial Pain
___Nausea/Vomiting	___Back Pain	___Decreased Range of Motion
___Joint Pain	___Joint Stiffness	___Joint Swelling
___Myalgia	___Blood clots	___Bruises Easil

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_____

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Patient/Guardian Signature_____**Date**____/____/____
Patient Name: _____
Guardian Name (if applicable): _____

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.

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Guardian Name (if applicable): _____

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.

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Patient/Guardian Signature_____**Date**____/____/____
Patient Name: _____
Guardian Name (if applicable): _____

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.

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Guardian Name (if applicable) _____

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

NOTICE OF PRIVACY PRACTICES
NEW JERSEY ORTHOPAEDIC INSTITUTE, LLC

Effective __/__/__

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability & Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This Notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our Practice except when the release is required or authorized by law or regulation.

ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE You will be asked to provide a signed acknowledgment of receipt of this Notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information in accordance with law.

OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION "Protected health information" is individually identifiable health information and includes demographic information (for example, age, address, etc.), and relates to your past, present or future physical or mental health or condition and related health care services. Our Practice is required by law to do the following: (1) keep your protected health information private; (2) present to you this Notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the Notice currently in effect; (4) post and make available to you any revised Notice; and (5) notify affected individuals following a breach of unsecured protected health information. We reserve the right to revise this Notice and to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice's effective date is at the top of the first page and at the bottom of the last page.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION - Following are examples of permitted uses and disclosures of your protected health information. These examples are not exhaustive.

Required Uses and Disclosures By law, we must disclose your health information to you unless it has been determined by a health care professional that it would be harmful to you. Even in such cases, we may disclose a summary of your health information to certain of your authorized representatives specified by you or by law. We must also disclose health information to the Secretary of the U.S. Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws on the protection of your health information.

Treatment We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we may disclose your protected health information from time-to-time to another physician or health care provider (for example, a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care. In emergencies, we will use and disclose your protected health information to provide the treatment you require.

Payment Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities we may need to undertake before your health care insurer approves or pays for the health care services recommended for you, such as determining eligibility or coverage for benefits. For example, obtaining approval for a surgical procedure might require that your relevant protected health information be disclosed to obtain approval to perform the procedure at a particular facility. We will continue to request your authorization to share your protected health information with your health insurer or third-party payer.

Health Care Operations We may use or disclose, as needed, your protected health information to support our daily activities related to providing health care. These activities include billing, collection, quality assessment, licensing, and staff performance reviews. For example, we may disclose your protected health information to a billing agency in order to prepare claims for reimbursement for the services we provide to you. We may call you by name in the waiting room when your physician is ready to see you. We will share your protected health information with other persons or entities who perform various activities (for example, a transcription service) for our Practice. These business associates of our Practice are also required by law to protect your health information. We may use or disclose your protected health information as necessary to contact you in order to raise funds for our Practice. Any such communication will tell you how you may opt out of receiving future fundraising communications from us.

Required by Law We may use or disclose your protected health information if law or regulations requires the use or disclosure.

Public Health We may disclose your protected health information to a public health authority who is permitted by law to collect or receive the information. For example, the

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disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products. We may provide proof of immunization without authorization, to your school if (i) the school is required by State or other law to have proof of immunization prior to admission and (ii) we obtain and document your permission or, for a minor, the permission of the parent, guardian or other person acting *in loco parentis* for the individual.

Communicable Diseases We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.

Food and Drug Administration We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing review.

Legal Proceedings We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement We may disclose protected health information for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaver organ, eye or tissue donations.

Research We may disclose protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Threat to Health or Safety Under applicable Federal and State laws, we may disclose your protected health information to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation We may disclose your protected health information to comply with workers' compensation laws and similar government programs.

Inmates We may use or disclose your protected health information, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access State laws concerning minors permit or require certain disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION - In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

Individuals Involved in Your Health Care Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. If you should become deceased, we may disclose your protected health information to a family member or other individual who was previously involved in your care, or in payment for your care, if the disclosure is relevant to that person's prior involvement, unless doing so is inconsistent with your prior expressed preference. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION - You may exercise the following rights by submitting a written request to our Privacy Officer. Our Privacy Officer can guide you in pursuing these options. Please be aware that our Practice may deny your request; however, in most cases you may seek a review of the denial.

Right to Inspect and Copy You may inspect and/or obtain a copy of your protected health information that is contained in a "designated record set" for as long as we maintain the protected health information. A designated record set contains medical and billing records and any other records that our Practice uses for making decisions about you. This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. You will be charged a fee for a copy of your record and we will advise you of the exact fee at the time you make your request. We may offer to provide a summary of your information and, if you agree to receive a summary, we will advise you of the fee at the time of your request.

Right to Request Restrictions You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care operations. Your

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request must be made in writing to our Privacy Officer. In your request, you must tell us: (1) what information you want restricted; (2) whether you want to restrict our use or disclosure, or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. If we believe that the restriction is not in the best interests of either party, or that we cannot reasonably accommodate the request, we are not required to agree to your request. If the restriction is mutually agreed upon, we will not use or disclose your protected health information in violation of that restriction, unless it is needed to provide emergency treatment. You may ask us not to disclose certain information to your health plan. We must agree with that request only if the disclosure is not for the purpose of carrying out treatment (only for carrying out payment or health care operations) and is not otherwise prohibited by law and pertains solely to a health care item or service for which we have been paid out of pocket in full by you or by another person on your behalf other than your health plan. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Alternative Confidential Communications You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

Right to Request Amendment If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment.

Right to an Accounting of Disclosure You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures made for purposes other than treatment, payment or health care operations as described in this Notice and excludes disclosures made directly to you, to others pursuant to an authorization from you, to family members or friends involved in your care, or for notification purposes. The accounting will only include disclosures made no more than 6 years prior to the date of your request. The right to receive this information is subject to additional exceptions, restrictions, and limitations as described earlier in this Notice.

Rights Related to an Electronic Health Record – If we maintain an electronic health record containing your protected health information, you have the right to obtain a copy of that information in an electronic format and you may choose to have us transmit such copy directly to a person or entity you designate, provided that your choice is clear, conspicuous, and specific. You may request that we provide you with an accounting of the disclosures we have made of your protected health information (including disclosures related to treatment, payment and health care operations) contained in an electronic health record for no more than 3 years prior to the date of your request (and depending on when we acquired an electronic health record).

Right to Obtain a Copy of this Notice You may obtain a paper copy of this Notice from us, view or download it electronically at our Practice's website at www.njorthoinstitute.com, or, if you agree, by email.

Special Protections This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded and have been taken into consideration in developing our policies and this Notice. Psychotherapy notes, release of protected health information for marketing purposes or sale of protected health information, are all specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

Complaints If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

CONTACT INFORMATION - Our Privacy Officer is Kinga Dybas and can be contacted at this office or by calling our telephone number 973-694-2690. You may contact our Privacy Officer for further information about our complaint process or for further explanation of this Notice of Privacy Practices.

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

Patient Name: _____

Guardian Name (if applicable): _____