ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

PATIENT INFORMATION

Last Name: _____ First:_____ MI:_____

Date of Birth: _____ Social Security #: _____-_____-_____

Address: _____

City _____ State _____ Zip_____

Home#: (_____) _____-_____ Cell#: (_____) _____-_____

Employer: _____ Employer#: (_____) _____-_____

Occupation: _____

☐ Retired ☐ Unemployed ☐ Student ☐ Self-Employed

Primary Care Physician: _____ Phone#:(_____) _____-_____

Cardiologist: _____ Phone#:(_____) _____-_____

Pharmacy Name: _____ Phone#:(_____) _____-_____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home#: (_____) _____-_____ Cell#: (_____) _____-_____

IF THIS IS RELATED TO A WORKMAN'S COMPENSATION CLAIM OR AN AUTOMOBILE ACCIDENT, PLEASE FILL OUT **PERSONAL INJURY PROTECTION BENEFITS FORM** AT THE END OF THIS PACKET

INSURANCE INFORMATION

Policy Holder's Name: _____ Relationship _____

Date of Birth: _____ Social Security #: _____-_____-_____

Primary Insurance: _____ Insurance ID#_____

Secondary Insurance: _____ Insurance ID#_____

School Insurance: _____ Policy #_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elite Orthopedics & Sports Medicine or insurance company to release any information required to process my claims. Also, please be advised Elite Orthopedics is an out of network provider.

_____ _____

Signature of Patient/Parent of Minor/Family Member Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

PATIENT MEDICAL HISTORY

Patient Name: _____ Birth date: _____ Sex: □ M □ F

Today's Date: _____ Date of Injury: _____ Are you? □ Right-handed □Left-handed

Were you sent to our office by a physician? □ Yes □ No If Yes, please provide:

Physician's Name: _____ Phone #: _____

HISTORY OF PRESENT ILLNESS/DETAIL OF INJURY:
Height: _____'_____" Weight: _____lbs. Age: _____

Problem with:	Right □ Extrem.	Left □ Extrem.

Is this Work related?	□Yes*	□No	Was it reported?	□Yes	□No
Is this Auto related?	□Yes*	□No	Was it reported?	□Yes	□No
Is this School related?	□Yes*	□No	Was it reported?	□Yes	□No
Is this a slip and fall?	□Yes*	□No	Was it reported?	□Yes	□No

***Attorney's Information**:
_____
_____
_____

Please Initial _____ The information above is true to your knowledge

Why are you here today? _____

What caused this problem? _____

Location: _____ Quality: _____
Where is the pain/problem? Does it travel to other areas? Is the pain dull, throbbing or sharp? If lump, is it warm, tender, red?

Severity: _____ Duration: _____
How severe is the pain on a scale of 1-5 with 5 being the most severe? How long have you had this pain/problem? When did it start?

Timing: _____ Context: _____
Does the pain/problem occur at a specific time? Is it rare, intermittent or constant? What were you doing at the onset of this pain/problem?

Associated signs/symptoms: _____
What other associated problems are you having? (Numbness, bladder/bowel complaints, abnormal sounds- cracking, popping, grinding, clicking, swelling, stiffness, instability, night pain)

Modifying factors: _____
What makes the pain/problem worse or better? (Activities)

Have you seen any other physicians regarding **this** condition prior to coming to our office? □ Yes □ No

Doctor	When	Tests	Results	Treatment

_____

_____

PAST HISTORY OF PRESENT ILLNESS:
Have you ever experienced any injury or symptoms regarding this body part? □ Yes □ No

If so, please provide details _____

_____

****I,_____, certify this information is true to my knowledge.****

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

PATIENT MEDICAL HISTORY (CONTINUED)

Please list any sports you enjoy: _____

Which of the above activities are you unable to perform due to your pain? _____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please check all pertinent boxes:*

□Aids or □HIV+	□Bronchitis	□Hepatitis	□Mumps	□Thyroid Disease
□Anemia	□Chicken Pox	□High Blood Pressure	□Pneumonia	□Tuberculosis
□Arthritis	□Diabetes	□Infectious Mono	□Polio	□Ulcer
□Asthma	□Diphtheria	□Kidney Disease	□Rheumatic Fever	□Venereal Disease
□Back Trouble	□Epilepsy/Seizures	□Low Blood Pressure	□Scarlet Fever	□Whooping Cough
□Bladder Infections	□Glaucoma	□Measles	□Sleep Apnea	□Cancer _____
□Bleeding Tendency	□Heart Disease	□Migraine Headaches	□Smallpox	□Other (please list)
□Blood Transfusions	□Hemorrhoids	□Mitral Valve Prolapse	□Stroke	_____

Medications: Include non-prescription & Herbal Supplements

Drug Name	Dosage	Frequency
_____		
_____		
_____		

Allergies:

Medication	Reaction
_____	
_____	

Tape Allergy: □ Yes □ No Latex Allergy: □ Yes □ No

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

Patient Social History:

Marital Status	**Use of Alcohol**	**Use of Tobacco**	**Living Situation**
□Single	□Never	□Never	□With Family
□Married	□Rarely	□Previously, but quit	□With Friends
□Divorced	□Moderate	□Currently	□Alone
□Widowed	□Daily		□Other (specify)
□Separated		____ Packs per day	_____

Family Medical History: *(Cardiovascular, Cancer, Stroke, High Blood Pressure, Asthma/Breathing/Lungs, Diabetes)*

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

PATIENT MEDICAL HISTORY (CONTINUED)

Review of Systems: **Please indicate any personal history below: (Circle all that apply)**

Constitutional Symptoms		
Bad general health lately	No	Yes
Recent weight gain	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Musculoskeletal		
Joint pain	No	Yes
Joint stiffness	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulties walking	No	Yes

Ears/Nose/Mouth/Throat		
Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems	No	Yes
Nose bleeds	No	Yes
Bleeding gums	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

Eyes		
Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Palpitation	No	Yes

Allergic/Immunologic

List food/environmental allergies

_____

_____

Respiratory		
Chronic or frequent cough	No	Yes
Spitting up food	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Cardiovascular		
Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath while walking	No	Yes
Swelling of feet, ankles or hands	No	Yes
Pacemaker	No	Yes

Gastrointestinal		
Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent Diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding, blood in stool	No	Yes
Abdominal pain	No	Yes

Dermatology (skin, breast)		
Rash or itching	No	Yes
Changes in skin color	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast Lump	No	Yes

Neurological		
Light headed or dizzy	No	Yes
Numbness or tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

Urology		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Female # of pregnancies	_____	
Female # of deliveries	_____	

Endocrine		
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes

Hematologic/Lymphatic		
Slow to heal after cuts	No	Yes
Bleeding / bruising tendency	No	Yes
Anemia	No	Yes
Enlarged glands	No	Yes

Psychiatric		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____

Signature of Patient/Parent of Minor/Family Member Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

NOTICE OF PATIENT HEALTH INFORMATION RELEASE

TO BE SIGNED BY **ALL** PATIENTS

Last Name:_____ First:_____ MI:_____

IF THERE IS A NEED FOR IT, AND IF YOU WISH ELITE ORTHOPEDICS TO DISCUSS YOUR CONDITION WITH ANY RELATIVES AND / OR FRIENDS, PLEASE CONSIDER THE FOLLOWING STATEMENT AND COMPLETE ACCORDINGLY.

I HEREBY AUTHORIZE MY DOCTOR TO RELEASE ANY INFORMATION CONCERNING MY ILLNESS AND/OR TREATMENT BY TELEPHONE, FAX, ETC. TO THE FOLLOWING PERSON(S):

_____	_____
NAME	RELATIONSHIP
_____	_____
NAME	RELATIONSHIP
_____	_____
NAME	RELATIONSHIP
_____	_____
NAME	RELATIONSHIP
_____	_____
NAME	RELATIONSHIP

_____ _____

Signature of Patient/Parent of Minor/Family Member Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

NOTICE OF TESTIMONY/COURT APPEARANCE

TO BE SIGNED BY **ALL** PATIENTS

Last Name:_____ First:_____ MI:_____

IN ORDER TO BE FAIR TO ALL MY PATIENTS, I CANNOT AGREE TO ACT AS AN EXPERT WITNESS FOR MY PATIENT'S LITIGATION MATTERS. WHILE I WILL AGREE TO RENDER ASSISTANCE SUCH AS PROVIDING PATIENT RECORDS PERTINENT TO YOUR CASE, I CANNOT AGREE TO TESTIFY IN COURT ON YOUR BEHALF AS AN EXPERT WITNESS. THE IMPOSITION ON MY MEDICAL PRACTICE IS UNFAIR TO MY OTHER PATIENTS AND TO MY STAFF.

I WILL CONSIDER AN APPEARANCE ON A VIDEOTAPED DEPOSITION TO BE PERFORMED IN MY OFFICE ON A SATURDAY SO THAT MY TESTIMONY CAN BE PRESENTED TO THE COURT ON MY BEHALF, BUT THIS IS THE ONLY BASIS UPON WHICH I WILL AGREE TO TESTIFY. ALSO, I CAN PREPARE NARRATIVE REPORTS UPON REQUEST IN A TIMELY MANNER.

I WILL NOT WAIT FOR PAYMENT FOR SERVICES RENDERED UNTIL THE CASE IS SETTLED.

I EXPECT PAYMENT AS THE TREATMENT PROGRESSES FROM THE PATIENT OR THE INSURANCE COMPANY. AGAIN, I WILL NOT WAIT FOR PAYMENT FOR THE SERVICES RENDERED UNTIL THE END OF THE LITIGATION.

PLEASE ACKNOWLEDGE THAT YOU HAVE REVIEWED THESE STATEMENTS BY SIGNING AND DATING THIS DOCUMENT. A COPY WILL BE FORWARDED TO YOUR ATTORNEY IF THE NEED ARISES.

_____ _____

Signature of Patient/Parent of Minor/Family Member Date

ASSIGNMENT OF INSURANCE BENEFITS

(To Be Signed By All Patients)

I, _____, (Patient / Guarantor), hereby AUTHORIZE and ORDER my insurance carrier, _____ to DIRECTLY pay *Elite Orthopedics & Sports Medicine, P.A.*, any and all insurance payments, benefits, reimbursements or monies that I may receive from my insurance carrier in connection with the medical services rendered. I voluntarily and knowingly assign my insurance payments to *Elite Orthopedics & Sports Medicine, P.A.*, in consideration for their medical services rendered. I understand and acknowledge that if my insurance carrier sends the payment directly to me, I shall turn over the insurance payment(s) to *Elite Orthopedics & Sports Medicine, P.A.*, within FIVE BUSINESS DAYS or I WILL BE LEGALLY RESPONSIBLE FOR THE FULL AMOUNT OF THE MEDICAL BILL. IF CHECK/PAYMENTS ARE NOT TURNED OVER IN A TIMELY FASHION, YOUR ACCOUNT WILL GO TO COLLECTION AND YOU WILL BE RESPONSIBLE FOR ATTORNEY FEES AS WELL.

I understand that it is my responsibility to resolve any issues (provide missing information, fill out questionnaire, clarify how/when/where injury occurred, etc.) with my insurance carrier, so my insurance carrier can issue a payment to *Elite Orthopedics & Sports Medicine* for services rendered to me by Dr. Fahimi, Dr. Schneidkraut, Dr. Ambrose, Dr. Sotsky or Dr. Rajaram.

I also understand that if I fail to resolve any issues with my insurance carrier in a timely fashion (customary time that insurance carriers give to resolve issues is 45 days), and as a result a payment is not issued to *Elite Orthopedics & Sports Medicine*, I will be legally responsible for the full amount of my medical bill.

By signing this form, I understand and acknowledge that I am assigning my medical insurance benefits to *Elite Orthopedics & Sports Medicine, P.A.*, in consideration for their medical services rendered.

_____ _____

Full Name of Patient | Full Name of Guarantor (if any)

_____ _____

Social Security No. of Patient/Guarantor | Date of Birth of Patient or Guarantor

_____ _____

Signature of Patient/Parent of Minor/Family Member | Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

NOTICE OF PATIENT'S RESPONSIBILITY

TO BE SIGNED BY ALL PATIENTS

Last Name:_____ First:_____ MI:_____

I FULLY UNDERSTAND THAT I AND/OR MY LEGAL GUARDIAN ARE FULLY RESPONSIBLE FOR PAYMENT IN FULL TO
ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA
IF THERE IS A QUESTION THAT MY HEALTH INSURANCE CARRIER MIGHT NOT PAY FOR THE SERVICES RENDERED DUE TO THE FACT THAT THIS CONDITION MAY BE RELATED TO A MOTOR VEHICLE ACCIDENT OR WORK INJURY.

***

PLEASE BE ADVISED THAT ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA
IS AN OUT OF NETWORK PROVIDERS OFFICE.
YOUR MEDICAL INSURANCE WILL BE SENDING YOU A CHECK THAT BELONGS TO THE DOCTOR(S). WHEN YOU RECEIVE A CHECK FROM YOUR INSURANCE IN YOUR NAME, YOU MUST ENDORSE IT AND MAIL IT TO OUR OFFICE.

***

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT THIS STATEMENT IS TRUE.

_____ _____
Signature of Patient/Parent of Minor/Family Member Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

LIEN FOR PROFESSIONAL SERVICES

LIEN APPLIES TO *ALL* MEDICAL INSURANCE

PATIENT'S NAME:_____ DATE OF ACCIDENT:_____
INSURANCE COMPANY:_____CLAIM #:_____
ID NUMBER:_____DOB:_____

THIS NOTICE IS A PROTECTION OF PAYMENT

FOR CONSIDERATION RECEIVED, I, _____, ASSIGN TO ELITE ORTHOPEDICS AND SPORTS MEDICINE, MY RIGHTS AND INTEREST IN THE PERSONAL INJURY PROTECTION ENDORSEMENT OF THE AUTOMOBILE LIABLITY INSURANCY POLICY **OR OTHER INSURANCE POLICY LISTED ABOVE**. THIS ASSIGNMENT IS GIVEN WITH RESPECT TO ALL TREATMENT, CARE, AND DIAGNOSTIC TREATMENT GIVEN BY THE OFFICE OF ELITE ORTHOPEDICS OR THEIR EMPLOYEES. BY ASSIGNING THESE BENEFITS, I HAVE EXPRESSLY AGREED THAT THE FOLLOWING RIGHTS ARE ASSIGNED TO ELITE ORTHOPEDICS OR ITS MEDICAL STAFF:

1. THE RIGHT TO COLLECT FROM THE INSURER OF THE POLICY WITH RESPECT TO THE PIP BENEFIT OR OTHER INSURANCE MENTIONED ABOVE.
2. THE RIGHT TO FILE A LAWSUIT OR PIP ARBITRATION DIRECTLY AGAINST THE INSURANCE COMPANY IN THE NAME OF ELITE ORTHOPEDICS. ASSIGNEE, AND TO DESIGNATE AN ATTORNEY OF THE CHOOSING OF THEM FOR THE PURPOSE OF FILING SAID LAWSUIT.

I HEREBY AUTHORIZE AND DIRECT YOU, MY ATTORNEY, TO PAY DIRECTLY TO ELITE ORTHOPEDICS, SUCH SUMS AS MAY BE DUE AND OWING FOR MEDICAL SERVICES RENDERED TO ME BOTH BY REASON OF THIS ACCIDENT AND BY REASON OF ANY OTHER BILLS THAT ARE DUE THEIR OFFICE, AND TO WITHHOLD SUCH SUMS FROM ANY SETTLEMENT JUDGEMENT OR VERDICT WHICH MAY BE PAID TO YOU, MY ATTORNEY, OR MYSELF AS THE RESULT FOR WHICH I HAVE BEEN TREATED OR INJURIES IN CONNECTION THEREWITH.

I FULLY UNDERSTAND THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO ELITE ORTHOPEDICS, FOR ALL MEDICAL BILLS SUBMITTED BY THEM FOR THE SERVICES RENDERED AND THAT THIS AGREEMENT IS MADE SOLELY FOR ELITE ORTHOPEDICS, ADDITIONAL PROTECTION AND IN CONSIDERATION OF THEIR AWAITING PAYMENT. FURTHER, I UNDERSTAND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGEMENT OR VERDICT BY WHICH I MAY EVENTUALLY RECOVER SAID FEE AND THAT PAYMENT ON THE ACCOUNT IS DUE AND PAYABLE UPON DEMAND.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

OUR PRACTICE IS COMMITTED TO PROVIDING THE HIGHEST QUALITY OF TREATMENT TO OUR PATIENTS. THIS NOTICE IS A PROTECTION OF PAYMENT. SINCE ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA IS AN OUT OF NETWORK PROVIDER, YOUR MEDICAL INSURANCE WILL BE SENDING YOU A CHECK THAT BELONGS TO THE DOCTOR AND YOU ARE AGREEING THAT YOU WILL FORWARD THE PAYMENT TO ELITE ORTHOPEDICS AND SPORTS MEDICINE. IF YOU DO NOT UNDERSTAND THIS LIEN, PLEASE ASK US FOR AN EXPLANATION SO WE MAY BE ABLE TO HELP YOU.

_____ _____
Signature of Patient/Parent of Minor/Family Member Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

MEDICAL RECORDS RELEASE

PATIENT NAME: _____ DOB: _____

I AUTHORIZE ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA TO RELEASE/RECEIVE MY COMPLETE MEDICAL RECORDS.

MAIL RECORDS TO: _____

_____

_____

_____

REASON: _____

_____ _____

Signature of Patient/Parent of Minor/Family Member Date

STAFF INITIALS _____

DATE MAILED: _____

APPEAL AUTHORIZATION

AUTHORIZATION TO ACT ON PATIENT'S BEHALF TO SUBMIT AN APPEAL FOR DENIAL OF PAYMENT FOR MEDICAL SERVICES PROVIDED TO PATIENT/GUARANTOR

Date: _____

Patient's Full Name: _____

Patient's Date of Birth: _____ /_____ /_____

I, _____,by signing below, agree to representation by the following authorized representative, **Elite Orthopedics and Sports Medicine, PA**, to act on my behalf in an appeal of an adverse benefits determination involving medical judgment as allowed by the Patient Protection and Affordable Care Act (PPACA) Public Law 111-148, and Section 2719 of the Public Health Services Act (PHS Act) which PPACA has incorporated into the Employment Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code), making those provisions applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. I also agree to the release of my personal health information to my appointed authorized representative name herein, to (insurance name)-_____ and its independently contracted Independent Review Organization (IRO) that will review my appeal. My consent to this appointment of this authorized representative and my authorization of release of my personal health information expires in 24 months, but I make revoke both sooner.

_____ _____

Signature of Patient/Parent of Minor/Family Member Date

Insurance ID #: _____

Relationship to Patient: [ ] I am the patient [ ] I am a personal representative

Note to patient: This form is for future use only. It will only be used if our office should need to submit an appeal to your insurance company in order for a payment to be processed correctly. It is necessary for you to be directly involved in this process and we appreciate your anticipated cooperation.

NOTICE OF PRIVACY PRACTICES

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

We Have a Legal Duty to Safeguard Your Protected Health Information (PHI)

This includes information that can be used to identify you that we have created or received about your past, present or future health condition, the provision of health care to you, or the payment for this health care. We must provide you with this notice regarding our privacy practices that explains how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use and disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice at any time. Any changes will apply to the PHI we already have collected. We will promptly post the revised policy in our office waiting room. You may also request a copy of this notice from the individual named above at any time.

How We May Use and Disclose Your Protected Health Information

We use and disclose health information for many reasons. Below we describe the different uses and disclosures.

Uses and disclosures which do <u>not</u> require your authorization:

- ***Treatment*** **-** We will use your health information for treatment. We may provide your information to hospitals, anesthesiologists, and other physicians involved in your care, nurses and technicians.
- ***Payment*** **-** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. A bill may be sent to you, a third party payer, or collection agency. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis and procedures.
- ***Health Care Operations*** **-** We may disclose your PHI in order to operate this practice. We may use your information in order to evaluate the quality of health care services our office provides. We may also provide your PHI to our accountants and attorneys, consultants, and others in order to make certain we are complying with laws that apply to our practice.
- ***Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement*** **-** We may disclose your information when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, domestic violence, or when ordered in a judicial or administrative proceeding.
- ***Business Associates*** **-** There are some services provided in our practice through contacts with business associates. Examples include radiology, anesthesiology, laboratory diagnostics, hospital and surgical facilities, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer when necessary. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.
- ***Health Oversight Activities*** **-** We will provide information to assist the government when it conducts an audit or investigation of a physician or medical practice.
- ***Tissue/Organ Donation*** **-** We may contact tissue procurement organizations to assist them in donations and transplants.

NOTICE OF PRIVACY PRACTICES (continued)

- ***Research*** **-** We may disclose information to researchers when 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 health information. We will ask for your specific written permission if the researcher will have access to any information that reveals who you are, such as your name, address or other patient identifying information.
- ***To Avoid Harm*** **-** In order to avoid a serious threat to the health and safety or a person or the public, we may provide your information to law enforcement personnel or persons able to prevent or lessen such harm.
- ***Specific Government Functions*** **-** We may disclose information on military personnel or veterans in certain situations. We may disclose information for national security purposes or conducting intelligence operations.
- ***Worker's Compensation*** **-** We may provide information to comply with applicable workers' compensation laws.
- ***Appointment Reminders and Health Related Benefits or Services*** **-** We may use information to advise you of future appointments, treatment alternatives, or other health care services or benefits we offer.
- ***Incidental Uses and Disclosures*** **-** An incidental use and disclosure is a secondary use that cannot reasonably to be prevented, is limited nature, and that occurs as a by-product of an otherwise permitted use or disclosure. Such uses are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your information than is necessary to accomplish the permitted disclosure.

Uses and disclosures where you have the opportunity to object:

- ***Disclosures to Family, Friends, and Others*** **-** Health professionals, suing their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care payment related to your care. You may object in whole or in part to these disclosures.

Other uses and disclosures of medical information not covered by this policy or applicable laws will only be made with your prior written approval. You may revoke that permission, in writing, at any time. Revoking your permission does not require us to take back any disclosures we have previously made with your permission.

Your Rights Regarding Your Protected Health Information

Although your health record is the physical property of the healthcare practitioner, the information belongs to you. You have the right to:

- Obtain a copy of the Notice of Privacy Practices upon request
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. This request must be made in writing to the attention of the Privacy Officer and must include what information that patient wants to limit and to whom the limits apply. We will consider your request, but are not legally required to accept it.
- Inspect and copy your health record as provided for in 45 CFR 164.524. This request must be made in writing to the attention of the Privacy Officer. We will respond to you within 30 days of receiving your written notice. We may charge a fee for the costs of copying, mailing, faxing, reproducing photographs, or other expenses associated with a patient's request.

NOTICE OF PRIVACY PRACTICES (continued)

- Choose how we send health information to you. You may request that we send information to you at an alternative address or by alternate means.
- Request an amendment of your health record if you feel the information we have is incomplete or incorrect as provided in 45 CFR 164.528. Requests must be made in writing to the attention of the Privacy Officer and must include a valid reason to support the request. We will respond within 60 days of receiving your written request.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528. This list will not include disclosures you have already consented to such as those made for treatment, payment, or health care operations, or disclosures made prior to the effective date of this policy. This request must be made in writing and must state a period of no longer than six years. We will respond within 60 days of receiving your written request.

For More Information or to Report a Problem

If you have any questions or would like additional information, you may contact Patricia at (973) 956-8100. If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint. All complaints must be made in writing.

Revisions of Privacy Policy

We reserve the right to changer our Privacy Practices at any time and to make the new provisions effective for all protected health information we maintain. You may request a copy of any revisions made to our Notice of Privacy Practices either by mail, telephone, or in person.

Policy Effective Date: January 1, 2016

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Patient's Name (print)

_____ _____

Patient's Signature Date

ELITE ORTHOPEDICS AND SPORTS MEDICINE, PA

PERSONAL INJURY PROTECTION BENEFITS

CONDITIONAL ASSIGNMENT OF BENEFITS
(FOR ACCIDENTS OCCURRING ON AND AFTER 11/1/2011)

Policy Number: _____ Claim Number: _____

Patient's Name: _____

I authorize and request _____ to pay directly to the above-named medical provider, the amount
(Motor Vehicle Insurance Company)
due to me under the terms of the above-referenced policy as a result of medical care rendered by that medical provider and all medical staff associated with the provider's office.

_____ Date: _____
Patient's Signature or Parent/Legal Guardian

I have read the information contained in the _____ information letter concerning the Decision
(Motor Vehicle Insurance Company)
Point Review Plan, including Medical Services Review, Decision Point Review and precertification requirements (collectively the

"Plan") and, as a condition precedent to _____'s acceptance of this assignment, I agree for
(Motor Vehicle Insurance Company)
myself, and on behalf of all medical staff associated with my office, to the following:

1) I (We) will comply with all the procedures of the Plan.
2) I (We) will initiate all Pre-certification and Decision Point Review requests as required by the Plan.
3) In the event that I (we) fail to comply with the conditions of the Plan, and such failure results in the imposition of a co-payment penalty, I (we) will hold the patient harmless for such co-payment penalty insofar as I (we) will not seek payment from the patient for any unpaid portion of the medical services arising from such co-payment penalty.
4) I (We) will submit disputes as defined in the Plan to the Internal Dispute Resolution Process set forth therein. After final determination, submission of disputes not resolved by the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
5) I (We) will submit all disputes not subject to the Internal Dispute Resolution process to the Personal Injury Protection Dispute Resolution process set forth in N.J.A.C. 11:3-5.
6) I (We) will submit medical records with clinically supported findings to support the diagnosis, casual relationship to the accident and care plan.
7) I (We) will comply with a request to (i.) submit to an examination under oath, and (ii.) provide the Company with any other pertinent information/documentation that it requests.
8) I (We) agree not to pursue payment directly from the patient, with the exception of deductibles and co-payments. I (We) may revoke the assignment, and I (we) shall be entitled to pursue payment from the patient, when benefits are not payable due to lack of coverage and/or violation of a policy condition by the patient.

I (we) agree that _____'s Assignment of Benefits is the only valid assignment of benefits.
(Motor Vehicle Insurance Company)

I (we) agree that _____ has the right to reject, terminate or revoke this assignment of benefits.
(Motor Vehicle Insurance Company)

I (we) agree that this assignment of benefits may require _____'s written consent.
(Motor Vehicle Insurance Company)

_____ Date: _____
Provider's Signature

_____ TIN Number: 261639755
Provider's Name (Please Print)