Patient Information Sheet

***Please present ALL Insurance cards and Drivers License at time of visit.**
COMPLETE ALL FIELDS as best as possible.

Name: (First) _____ (MI) _____ (Last) _____

Date of Birth: _____ Social Security #_____Age: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____Email address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

Pharmacy Name: _____ Town: _____ Phone: _____

Primary Care Physician: _____ Town: _____ Phone: _____

Referring Physician: _____ Town: _____ Phone: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Primary Insurance Plan: _____ ID#: _____

Address: _____

Primary Insurance Plan Holder's Name: _____ DOB: _____

Relationship to patient: _____

Mailing Address of Plan Holder (if different from patient): _____

Home Phone of Plan Holder: _____ Cell phone of Plan Holder: _____

Secondary Insurance Plan: _____ ID#: _____

Address: _____

Secondary Insurance Plan Holder's Name: _____ DOB: _____

Relationship to patient: _____

Patient Release: MUST BE SIGNED BY PATIENT: I understand that **LEVEL ONE NEUROSURGERY, LLC** will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **LEVEL ONE NEUROSURGERY, LLC** will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize **LEVEL ONE NEUROSURGERY, LLC** staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ **Date:** _____

Women/Mujeres: Are you pregnant? /Esta Embarazada? Yes/Si □ No□ Possiblle/Posiblemente □

What types of treatment have you had/Que tratamiento anterior a tratado?
Medical □ Acupuncture/Acupuntura□ Chiropractic/ Quiropráctic□ Physical Therapy/Fisioterapia □
Massage/Masajes□ Injections/Inyecciones□ Epidural Injections/Anestesias epidurales□ Imaging□ NCV/EMG□
Other/Otro: _____

CHECK OFF THE AREA(S) OF PAIN **SELECCIONE EL O LAS AREAS EN DONDE PRESENTA DOLOR**	**CIRCLE INTENSITY** **CIRCULE INTENSIDAD**
□**Headaches** (Dolores de Cabeza _____	**1 2 3 4 5 6 7 8 9 10**
□**Lightheadedness** (Mareos Ligeros)	**1 2 3 4 5 6 7 8 9 10**
□**Episodes of Dizziness** (Mareos Ligeros)	**1 2 3 4 5 6 7 8 9 10**
□**Loss of Balance** (Perdida de Balance)	**1 2 3 4 5 6 7 8 9 10**
□**Difficulty Sleeping/Insomnia** (Dificultad para Dormir o Linsomnio)	**1 2 3 4 5 6 7 8 9 10**
□**Nervousness** (Nerviosismo)	**1 2 3 4 5 6 7 8 9 10**
□**Anxiety/Tension** (Anciedad/Tension)	**1 2 3 4 5 6 7 8 9 10**
□**Jaw Pain/Clicking** (Dolor de Mandibula)	**1 2 3 4 5 6 7 8 9 10**
□**Neck Pain** (Dolor de Cuello)	**1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Right Arm** (Irradiación de Dolor en el Brazo Derecho)	**1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Left Arm** (Irradiación de Dolor en el Brazo Izquierdo)	**1 2 3 4 5 6 7 8 9 10**
□**Painful Right/Left Shoulder** (Dolor del Hombro Derecho/Izquierdo)	**1 2 3 4 5 6 7 8 9 10**
□**Elbow Pain** (Dolor de Codos)	**1 2 3 4 5 6 7 8 9 10**
□**Wrist Pain** (Dolor de Muñecas)	**1 2 3 4 5 6 7 8 9 10**
□**Dorsal Pain, between shoulder blades** (Dolor de la Espina Dorsal)	**1 2 3 4 5 6 7 8 9 10**
□**Weakness in Arms** (Debilidad de los Brazos)	**1 2 3 4 5 6 7 8 9 10**
□**Chest Pain** (Dolor de Pecho)	**1 2 3 4 5 6 7 8 9 10**
□**Difficulty Breathing** (Dificultad Para Respirar)	**1 2 3 4 5 6 7 8 9 10**
□**Abdominal Pain** (Dolor Abdominal)	**1 2 3 4 5 6 7 8 9 10**
□**Low Back Pain** (Dolor de la Espalda Baja o Cintura)	**1 2 3 4 5 6 7 8 9 10**
□**Pelvic Pain** (Dolor de la pelvis)	**1 2 3 4 5 6 7 8 9 10**
□**Difficulty Bending** (Dificultad Para Dolarse)	**1 2 3 4 5 6 7 8 9 10**
□**Difficulty Standing** (Dificultad Para Ponerse de Pie)	**1 2 3 4 5 6 7 8 9 10**
□**Difficulty Sitting** (Dificultar Para Sentarse)	**1 2 3 4 5 6 7 8 9 10**
□**Difficulty Walking** (Dificulta Para Caminar)_____	**1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Right Leg** (Irradiación de Dolor en la Piena Derecha)_____	**1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Left Leg** (Irradiación en la Piena Izquierda)_____	**1 2 3 4 5 6 7 8 9 10**
□**Weakness in Lower Extremity** (Debilidad en la Parte Inferior Del Cuerpo)_____	**1 2 3 4 5 6 7 8 9 10**
□**Knee Pain, Right** (Dolor en la Rodilla Derecha) □**Knee Pain,Left**(Dolor en la Rodilla Izquierda)	
□**Ankle Pain, Right** (Dolor en el Tobillo Derecho) □**Ankle Pain Left** (Dolor en la Rodilla Izquierda)	
□**Radiation of Pain to Thighs** (Irradiación de Dolor en los Muslos)_____	**1 2 3 4 5 6 7 8 9 10**
□**Radiation of Pain to Gluteus** (Irradiación de Dolor en los Glúteos)_____	**1 2 3 4 5 6 7 8 9 10**

Signature (Firma): **X**_____ **Date** (Fecha):**X** _____

Chief Complaint

Please describe the reason(s) for your visit today: _____

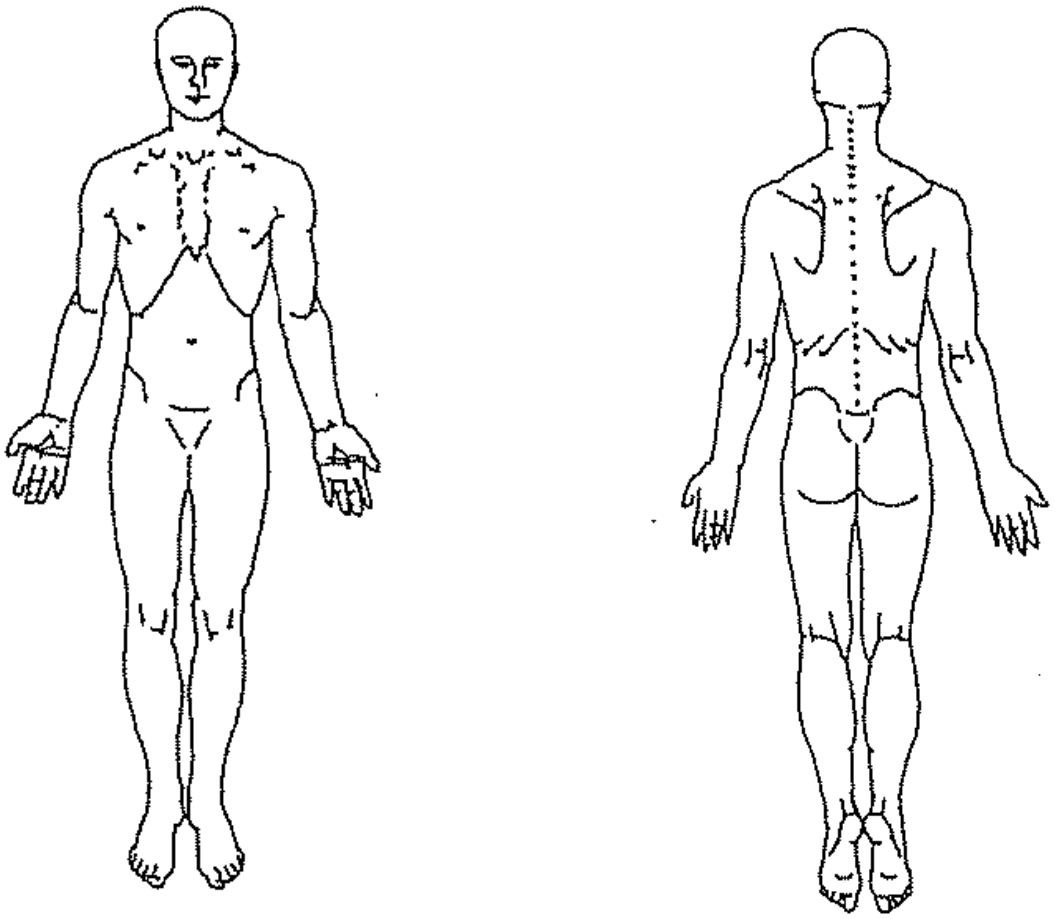
_____

_____

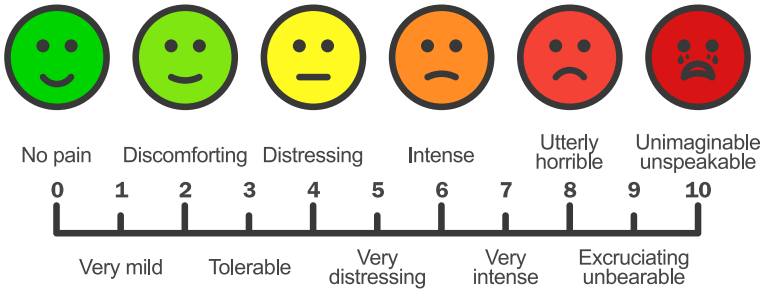
_____

Where are you experiencing pain?

- Please indicate **P** for pain, **N** for numbness, and **T** for tingling in each area. Shade area as needed to show full area of pain.
- If multiple locations please indicate where pain is most severe.



Please Indicate Pain Level



Past Medical History

PATIENT NAME: _____

Please mark your past medical history (Illnesses, Injuries, Hospitalizations, etc.)

☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Osteoporosis
☐ Asthma/Lung Disease	☐ Gastritis or Ulcers	☐ High Blood Pressure	☐ Seizures
☐ Blood Clots	☐ Headaches	☐ High Cholesterol	☐ Stroke
☐ Cancer	☐ Head Injury/Concussion	☐ Kidney or Liver Disease	☐ Thyroid Problems

☐ Other _____

Height: _____ **Weight:** _____

Past Surgical History

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Allergies to medication or foods (Please list all) _____

_____

_____

Please list your history of motor vehicle accidents, back injuries, etc. (Date, Did symptoms resolve?, Duration of symptoms) _____

_____

_____

Medications (Please list all medications, over the counter drugs, vitamins and any herbal remedies)

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Medication: _____ Dosage: _____ Frequency: _____ Date: _____

***Female patients: I do hereby state that, to the best of my knowledge, I am not pregnant nor is pregnancy suspected at this particular time.**

☐ **YES** ____ ☐ **NO** ____

Patient Signature: _____ **Date:** _____

Conservative Treatment Prior to Office Visit Today

	Successful (Yes/No)	Did you experience temporary relief?	Comments (Last Visit)
Bed Rest			
Cervical Collar			
Analgesics			
Physical Therapy			
Chiropractic Therapy Name of Chiropractor: _____			
Pain Management Name of Dr. _____			
Epidural Steroid Injection			

Review of Systems

Please circle all that apply to your current state of health.

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nails changes
Head/Neck	Head Injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks/Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardiovascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of consciousness		
Gastrointestinal	Abdominal pain	Nausea/Vomiting	Diarrhea/ Constipation	Bright red blood per rectum	Dark, black tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet, productive)	Sputum (color and amount) _____	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness / Tingling	Bowel / Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip pain	Knee pain	Shoulder pain	Back pain	Joint pain	

Social History

	Never*	Occasionally	Frequently	Daily
Alcohol Use				
Tobacco Specify: _____				
Cigars				
Illicit Drugs Specify: _____				
Vape				

*If you have quit indicate when.

Is your visit today related to a Auto Accident/Workers' Comp injury? _____

*** If yes, please fill out the Auto Accident/Workers' Comp form as well.**

Patient Signature: _____ **Date:** _____

AUTHORIZATION AND CONSENT

1. I request care from Level One Neurosurgery, LLC or one of their affiliates for treatment of my medical condition. This care may include medical tests, exams, or other treatments that are needed for my condition. I agree to this care.

Insurance and Payment Information:

Level One Neurosurgery, LLC receives payment for patient care from insurance companies and/or other third party programs.

. I agree to have my insurance company or other third party payment program make payments directly to Level One Neurosurgery, LLC , or its Affiliates
. I agree to let my doctor(s) and/or the Level One Neurosurgery, LLC submit claims and required treatment information to my insurance company or other third party payment program for my care, and receive payments directly.
3. I understand that I must pay all charges, co-payments, and deductibles that are not covered by my insurance company or third party payment program.

Permission to Communicate with Your Primary Care Physician and/or Other Community Care Providers: In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician, other community care providers and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care. Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician and/or Health Insurance Company.

Signature of the patient _____ **Date** _____

Print name: _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Auto Accident / Workers' Comp

If you are being seen as the result of an Auto Accident or Worker's Compensation case, COMPLETE ALL FIELDS as best as possible.

Name: (First) _____ (MI) _____ (Last) _____

Were you in an accident: ☐ Motor Vehicle ☐ Workers' Comp ☐ Fall ☐ Lifting ☐ Other: _____

Date of Accident/Injury: _____ State of Accident/Injury: _____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other: _____ Body Part(s) Injured: _____

ATTORNEY INFORMATION

Attorney's Name: _____ Attorney's Phone #: _____

Attorney's Firm: _____ Attorney's Fax#: _____

Attorney's Address: _____ Paralegal Name/email: _____

INSURANCE INFORMATION

Insurance Company: _____

Claim #: _____ Policy #: _____

Insurance Co. Billing Address: _____

Insurance Co. City: _____ State: _____ Zip: _____

Claims Rep. Name: _____ Email: _____

Claims Rep. Phone #: _____ Fax #: _____

Case Manager/Pre-Cert Company: _____ Case Manager/Company Phone #: _____

Case Manager/Company Phone #: _____

Does Office visit/treatment require auth? _____

Patient Release: MUST BE SIGNED BY PATIENT: I understand that **LEVEL ONE NEUROSURGERY, LLC** will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **LEVEL ONE NEUROSURGERY, LLC** will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize **LEVEL ONE NEUROSURGERY, LLC** staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ **Date:** _____

Assignment of Benefits

. I, the undersigned, hereafter referred to as "the patient," do hereby assign all of my benefits, rights and interests, including the right to direct payment from any insurance carrier or other payor, to L L ON N O , LL hereafter referred to as "the medical provider" as well as the right to pursue and obtain payment from the above-mentioned insurance carrier or other payor. This assignment shall include but is not limited to, all benefits, rights and interests available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey, and any other State Statutes, Federal Statutes, including ERISA, and/or the common law.

. I assign, to the medical provider, all my benefits, rights and interests, including the right to direct payment, under the insurance contract for payment for services rendered to me.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier or other payor, payment of my medical bills may be denied and I will be held responsible for same.

. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.

. I, the patient, do hereby direct my health insurance carrier or other payor and/or other insurance carrier or other payor to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier or other payor fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.

. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance provider.

. To prevent the insurance carrier or other payor and/or the vendor designated by the insurance carrier or other payor from refusing to accept my Assignment or submitting a challenge to my Assignment as being invalid, I execute this Special Power of Attorney and appoint and authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier or other payor in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retainer agreement between me and the attorney chosen by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if an arbitration and/or lawsuit is filed in my name individually, failure to include an outstanding medical provider's bills whom I have not executed an Assignment of Benefits with could make me liable for payment to that provider. In consideration, this medical provider has agreed to accept as payment in full, the amount awarded and/or settled and will not seek additional payment from other insurance carrier or other payors.

Signature of the patient _____ **Date** _____

Print name: _____

Major Medical Out of Network Liability Acknowledgement

I, _____ have been informed by Level One Neurosurgery, LLC that they are not participating with my health insurance carrier and therefore are out of network.

I understand that since Level One Neurosurgery, LLC is a non-participating provider that all treatment rendered will apply to my out of network benefits and that I may have additional out of pocket costs such as non-covered services, deductibles, and or/co-insurance responsibility.

I also understand that any payments from my insurance made out in my or subscriber's name and/or sent to my address shall be immediately given to Level One Neurosurgery, LLC with the appropriate endorsements and a copy of the explanation of benefits (EOB).

I furthermore understand that any payments from the insurance company deposited by me into my personal bank account with no corresponding prompt payment made by me to Level One Neurosurgery, LLC can be considered theft of services, which could result in my account being referred to collections and possibly being held personally liable in a competent New Jersey court of law.

Lastly, I shall provide Level One Neurosurgery, LLC with any secondary insurance coverage to cover some if not all the balance due. If no secondary insurance is provided, I understand that I will be 100% liable for outstanding balances and agree to pay and/or negotiate the balance due.

_____ _____

(Patient/Parent/Guardian signature) (Date)

_____ _____

(Witness) (Date)

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by [ ] and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to _____ and _____ (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to _____ and _____ for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date: _____

Patient Signature: _____