JERSEY REHAB, P.A.

This is a No-Fault update. Please take a minute to allow us to update your file.

Date: _____

Patient Name: _____

Patient Tel #: ( ) _____ - _____

Primary Care Physician: _____

Referral Source (How did you hear about us): _____

Insurance Company Name: _____

Date of Accident/Injury: _____

Dec Sheet: [ ] On File [ ] Not On File (☑ one)

Have you submitted a police report to us? [ ] Yes [ ] No

Attorney Name: _____
Address: _____
Address: _____
Tel #: (_____) _____

Recent MRI: [ ] Cervical / Location _____
[ ] Lumbar / Location _____
[ ] Other / Location _____

IME: Date performed: _____
Doctor who performed it: _____

INJECTION(S): Cervical/Location _____
Where you had it done: _____
Lumbar/Location _____
Where you had it done: _____
Knee/Location: _____
Where you had it done: _____

Where are you receiving chiropractic/physical therapy?

_____

PATIENT INTAKE & REGISTRATION

DATE: _____ TAKEN BY: _____ OFFICE: _____
APPT DATE _____ APPT TIME _____ APPT LOCATION: _____
APPT TYPE: (Please circle one) DR IE / PT IE / IME / EMG UPPER/LOWER / PM IE

REFERRING PHYSICIAN:	TEL #:	HOW DID YOU HEAR ABOUT US?
REFERRING MD NPI #:		
NAME: LAST FIRST	DATE OF BIRTH / AGE	EMAIL ADDRESS:
ADDRESS:	CITY, STATE, ZIP	
HOME TEL#:	WORK/CELL#:	
SS #:	SEX: ( ) M ( ) F	MARITAL STATUS: S M D W
EMERGENCY CONTACT:	TEL #:	REL. TO PATIENT:
CHIEF COMPLAINTS: 1.		
2.		
RECENT TESTING DONE: X-RAYS _____ MRI _____ CT SCAN _____ EMG _____ LAB WORK _____		
WHEN & WHERE TEST PERFORMED? ____/____/____ WHERE?		

*** INSURANCE ***

PRIMARY INSURANCE:	EFFECTIVE DT: ____/____/____	
TEL#: ( ) _____ - _____	GROUP #:	
POLICY/CLAIM/ID#:	SUBSCRIBER DOB:	
SUBSCRIBER:	REL TO PATIENT:	SUBSCRIBER SS#
SECONDARY INSURANCE:	EFFECTIVE DT: ____/____/____	
TEL#: ( ) _____ - _____	GROUP #:	
POLICY/CLAIM/ID#:	SUBSCRIBER DOB:	
SUBSCRIBER:	REL TO PATIENT:	SUBSCRIBER SS#

EMPLOYER INFORMATION MUST BE COMPLETED ON ALL PATIENTS

EMPLOYER:	TEL #:	OCCUPATION:
ADDRESS:	CITY, STATE, ZIP	

MOTOR VEHICLE ACCIDENT / SLIP AND FALL / WORK INJURY / OTHER(IF OTHER, SPECIFY: _____

D/A: _____ MVA CLAIM # _____ POLICE REPORT: YES / NO
DID YOU ADVISE THE PATIENT THEY MUST BRING THEIR POLICE REPORT TO THEIR APPOINTMENT? YES / NO

INSURANCE CO: _____ TEL# _____
ADDRESS: _____
ADJUSTOR: _____ TEL# _____
DO YOU HAVE AN ATTORNEY? YES / NO IF YES, PLEASE PROVIDE THE FOLLOWING:
ATTY NAME: _____ TEL# _____
ADDRESS: _____

*** INTERNAL ***

SELF PAY: YES / NO OR INSURANCE TYPE: HMO / PPO / POS / TRADITIONAL / MEDICARE / MEDICAID	
IS REFERRAL NEEDED? YES / NO	DOES THE PATIENT HAVE REFERRAL? YES / NO
DID YOU ASK PATIENT TO BRING REFERRAL? YES / NO	DOES THE PATIENT HAVE A RX? YES / NO
DID YOU ASK THE PATIENT TO READ RX? YES / NO	WHAT DOES RX READ?
DID PATIENT TREAT WITH A PAIN PHYSICIAN PREVIOUSLY? YES / NO	PAIN DR. NAME? TEL#:

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.
□ Notified the patient that they may be seeing a doctor other than the doctor requested

_____
PATIENT SIGNATURE DATE

JERSEY REHAB MEDICAL HEALTH /SCREENING FORM

DATE: _____

Patient: _____ Age: _____ DOB: _____

Date of last physical exam: _____ Reason for your visit today? _____

SYMPTOMS: PLEASE CIRCLE (YES *OR* NO) INDICATING THAT YOU HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL

Shortness of breath	yes / no
Chills	yes / no
Depression	yes / no
Dizziness	yes / no
Fainting	yes / no
Fever	yes / no
Forgetfulness	yes / no
Headache	yes / no
Loss of sleep	yes / no
Loss of weight	yes / no
Nervousness	yes / no
Numbness	yes / no
Sweats	yes / no
Do you smoke?	yes / no
Social drinking?	yes / no

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

Arms	yes / no	Hips	yes / no
Back	yes / no	Legs	yes / no
Feet	yes / no	Neck	yes / no
Hands	yes / no	Shoulders	yes / no

Fracture yes / no

Date: _____ Area: _____

Date: _____ Area: _____

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

Appetite poor	yes / no
Bloating	yes / no
Bowel changes	yes / no
Constipation	yes / no
Diarrhea	yes / no
Excessive hunger	yes / no
Excessive thirst	yes / no
Gas	yes / no
Hemorrhoids	yes / no
Indigestion	yes / no
Nausea	yes / no
Rectal bleeding	yes / no
Stomach pain	yes / no
Vomiting	yes / no
Vomiting blood	yes / no

CARDIOVASCULAR

Chest pain	yes / no
High blood pressure	yes / no
Irregular heart beat	yes / no
Low blood pressure	yes / no
Poor circulation	yes / no
Rapid heart beat	yes / no
Swelling of ankles	yes / no
Varicose veins	yes / no

EYES, EARS, NOSE, THROAT

Bleeding gums	yes / no
Blurred vision	yes / no
Crossed eyes	yes / no
Difficulty swallowing	yes / no
Double vision	yes / no
Ear ache	yes / no
Ear discharge	yes / no
Hay fever	yes / no
Hoarseness	yes / no
Loss of hearing	yes / no
Nosebleeds	yes / no
Persistent cough	yes / no
Ringing in ears	yes / no
Sinus problems	yes / no
Vision – Flashes	yes / no
Vision – Halos	yes / no

SKIN

Bruise easily	yes / no
Hives	yes / no
Itching	yes / no
Change in moles	yes / no
Rash	yes / no
Scars	yes / no
Sore that won't heal	yes / no

WOMEN

Are you pregnant?	yes / no
Gynecological disorders?	yes / no

CONDITIONS Please circle (Y *OR* N) indicating all conditions you have or have had in the past.

AIDS	Y / N	Chemical Dependency	Y / N	High Cholesterol	Y / N	Prostate Problem	Y / N
Alcoholism	Y / N	Chicken pox	Y / N	HIV Positive	Y / N	Psychiatric Care	Y / N
Anemia	Y / N	Diabetes	Y / N	Kidney disease	Y / N	Rheumatic Fever	Y / N
Anorexia	Y / N	Emphysema	Y / N	Liver disease	Y / N	Scarlet Fever	Y / N
Appendicitis	Y / N	Epilepsy	Y / N	Measles	Y / N	Stroke	Y / N
Arthritis	Y / N	Glaucoma	Y / N	Migraine Headaches	Y / N	Suicide Attempt	Y / N
Asthma	Y / N	Goiter	Y / N	Miscarriage	Y / N	Thyroid Problems	Y / N
Bleeding Disorders	Y / N	Gonorrhea	Y / N	Mononucleosis	Y / N	Tonsillitis	Y / N
Breast Lump	Y / N	Gout	Y / N	Multiple Sclerosis	Y / N	Tuberculosis	Y / N
Bronchitis	Y / N	Heart Disease	Y / N	Mumps	Y / N	Typhoid Fever	Y / N
Bulimia	Y / N	Hepatitis	Y / N	Pacemaker	Y / N	Ulcers	Y / N
Cancer	Y / N	Hernia	Y / N	Pneumonia	Y / N	Vaginal Infections	Y / N
Cataracts	Y / N	Herpes	Y / N	Polio	Y / N	Venereal Disease	Y / N

ANY FAMILY HISTORY OF THE FOLLOWING?		MOTHER, FATHER, SISTER, BROTHER	DECEASED?	AGE OF DEATH?
ARTHRITIS / GOUT	YES / NO	MOTHER, FATHER, SISTER, BROTHER	YES / NO	
CANCER	YES / NO	MOTHER, FATHER, SISTER, BROTHER	YES / NO	
DIABETES	YES / NO	MOTHER, FATHER, SISTER, BROTHER	YES / NO	
HEART DISEASE	YES / NO	MOTHER, FATHER, SISTER, BROTHER	YES / NO	
HIGH BLOOD PRESSURE	YES / NO	MOTHER, FATHER, SISTER, BROTHER	YES / NO	
KIDNEY DISEASE	YES / NO	MOTHER, FATHER, SISTER, BROTHER	YES / NO	

Occupational concerns: **Heavy lifting: Y / N Hazardous substance: Y / N**

Surgeries or other Hospitalizations: (include date and reason)

MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

Patient signature: _____ Date: _____ 9/30/04

Signature of interpreter, if used: _____ Date: _____

JERSEY REHAB, P.A.

Physical Medicine & Rehabilitation – Electrodiagnostic Medicine
Subspecialty, Pain Management

Edwin M. Gangemi, M.D. Robert A. Marini, M.D.
Shailendra Hajela, M.D. Felix A. Almentero, M.D.

Belleville – 15 Newark Avenue, Belleville, NJ 07109 Tel: (973) 844-9220 Fax (973) 844-1217

CHRONIC OPIOID THERAPY AGREEMENT
PAIN MANAGEMENT

PURPOSE

- To clarify the use of opioid therapy and the controversial issue of opioid use on chronic pain or nonmalignant pain.
- To clarify the common side effects and special concerns while taking opioid based medications.
- To clarify the Rules of Conduct of opioid use and Prescription Refill by Jersey Rehab, PA physician.
- To clarify the grounds of expulsion from Pain Management treatment by Jersey Rehab, PA physician.

CONTENT

OPIOID USE FOR CHRONIC PAIN AND NONMALIGNANT PAIN

The use of opioid therapy other than cancer pain is a controversial issue. Your Jersey Rehab, PA physician, decided you are an appropriate candidate for opioid therapy. You are aware that before the opioid therapy is initiated, we have to determine your candidacy based on the physical examinations, diagnostic tests, and previous interventions for your pain. You have to be aware that this therapy has its own limitations and is not a definitive therapy for your pain.

COMMON SIDE EFFECTS AND SPECIAL CONCERNS

- Common ***Side Effects:*** allergic reaction to opioid or other components, drowsiness, itching, difficulty of urination, nausea, vomiting, and constipation.
- ***Special Concerns:*** Tolerance, Physical Dependence, and Addiction.
    - ***Tolerance:*** Over time, you will develop tolerance to your opioid therapy. Every individual is different, so the amount of tolerance is not known. You must discuss any changes with the doctor and they will determine the cause of your tolerance. You might be required to keep a pain notebook or diary to assist you in managing your pain. Any changes or your dose or final dosage will be decided between you and your provider.
    - ***Physical Dependence:*** Opioid therapy has the potential of physical dependence while you are in chronic pain therapy. ***DO NOT CHANGE YOUR DOSE OR USE OF YOUR OPIOID MEDICATION WITHOUT NOTIFYING THE DOCTOR.*** You cannot stop your opioid therapy abruptly, otherwise you will experience signs and symptoms of withdrawal like: nausea, vomiting, sweating, restlessness, abdominal pains, diarrhea, and general malaise. If you decide to stop opioid therapy, then we will work together to slowly decrease your dose without withdrawal effects.
    - ***Addiction:*** This issue must be addressed when identified. Most experts in Pain Management believed that the risk of addiction to opioids is very low. Experts believe that opioid therapy could be effective to treat your chronic pain if you are properly supervised and maintain office visits with the doctor. Assessment and reassessment of your pain will be conducted every office visit.

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RULES OF CONDUCT FOR OPIOID USE AND PRESCRIPTION REFILL

- A Jersey Rehab physician will prescribe opioid-based therapy if you follow the Rules of Conduct.
  1. I will communicate with the doctor the character and intensity of my pain, the effect of the pain on my activities of daily living, and pain relief with current opioid therapy.
  2. I will not use any illegal controlled substances like, cocaine, marijuana, valium, etc.
  3. I will not share, sell, or trade my medication with anyone.
  4. I will not attempt to solicit any controlled substances from other doctors/providers. If the medication(s) are legally prescribed for other medical or psychiatric issue, the other doctor must furnish a letter for patient record. All pain related medications must be prescribed by my Jersey Rehab, PA Physician unless otherwise in certain unforeseen circumstances.
  5. I will be physically present for scheduled monthly follow-up visits.
  6. I will agree for psychological testing as requested by the provider. The result of the evaluation may indicate that you are not a good candidate for chronic opioid therapy.
  7. I will safeguard my pain medication at all times from loss or theft. Lost or stolen pain medications will not be replaced unless a police report has been obtained.
  8. I understand that the refill of my pain medication will be done only during office visits or otherwise instructed by the Jersey Rehab, PA physician. No refills will be available during the time office hours are not in session, or on weekends.
  9. I understand that I must seek emergency admission for unrelieved pain while taking my opioid medications.
  10. I agree that I will submit to urine or blood test if requested by my provider to determine my compliance with my program of pain control medicine.
  11. I agree to use my pain medication as prescribed.
  12. I agree to notify my provider of any changes with the use of my pain medications and a scheduled visit will be arranged. ***If you finished your medication early without being instructed,*** a Jersey Rehab, PA physician ***will not replenish*** your pain medications until the scheduled office appointment.
  13. I agree to bring my pain medication container with proper pharmacy label in every office visit.

GROUNDS FOR EXPULSION FROM THE OFFICE

- ***Noncompliance*** with the Rules of Conduct for Opioid Use and Prescription Refill. Any violations will be brought to your attention and documented in your record. ***Severe violations like: #2, #3, #4, repeated offenses of #7, and refusal of #10 are grounds for immediate expulsion from the Pain Management program.***

STATEMENT

THEREFORE, I agree to follow the Rules of Conduct for Opioid Use and Prescription Refill that have been fully explained to me. In case of noncompliance of the patient to the opioid therapy agreement, the Jersey Rehab, PA Physicians are under no obligation to continue the therapy. All of my questions and concerns regarding treatment have been adequately answered. A copy of this documentation has been given to me.

Date: _____

Patient's Printed Name: _____ Patient's Signature: _____

Doctor's Signature: _____

Notice of Privacy Practices
Jersey Rehab, P.A.

I. **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.**

II. **WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**

Pursuant to the Privacy Rules established by the Health Insurance Portability and Accountability Act of 1996, we are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we've 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 are required to provide you with this notice about our privacy practices. It 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 or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the main reception area. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of this notice on our Web site at http://www.jerseyrehab.com/.

III. **HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.**

We use and disclose health information for many different reasons. For some of these uses and disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. **Uses and Disclosures Which Do Not Require Your Authorization.**

We may use and disclose your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally-funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

3. **For health care operations.** We may disclose your PHI, as necessary, to operate this organization. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. **For health oversight activities.** For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners, funeral directors, and for organ donation.** We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us

contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. **Uses and Disclosures Where You to Have the Opportunity to Object:**

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written Authorization.** Other than as stated herein, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. **Authorization for Marketing Communications**. We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, we are permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, as long as we are not paid to do so, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

E. **Sale of PHI.** We will disclose your PHI in a manner that constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI for: public health purposes; research; treatment and payment purposes; sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; the individual; disclosures required by law; any other purpose permitted by and in accordance with HIPAA.

F. **Fundraising Activities.** We may use certain information (name, address, telephone number, dates of service, age and gender) to contact you for the purpose of various fundraising activities. If you do not want to receive future fundraising requests, please write to the Privacy Officer at the below address.

G. **Incidental Uses and Disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

H. **Business Associates.** We may engage certain persons to perform certain of our functions on our behalf and we may disclose certain health information to these persons. For example, we may share certain PHI with our billing company or computer consultant to facilitate our health care operations or payment for services provided in connection with your care. We will require our business associates to enter into an agreement to keep your PHI confidential and to abide by certain terms and conditions.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. Notwithstanding the foregoing, you have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. For our New Jersey offices, we will respond to you within 30 days after receiving your written request, and for our New York office, within 10 days. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we will charge reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request, in accordance with applicable law. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. Note also that, you have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the e-record directly to a third party. We may charge for the labor costs to transfer the information; and charge for the costs of electronic media if you request that we provide you with such media.

**Please note, if you are the parent or legal guardian of a minor, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent himself/herself (without your consent) may be restricted unless the minor patient provides an authorization for such disclosure. **

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.

To the extent that we maintain your PHI in electronic format, we will account all disclosures including those made for treatment, payment and health care operations. Should you request such an accounting of your electronic PHI, the list will include the disclosures made in the last three years.

E. **The Right to Receive Notice of a Breach of Unsecured PHI.** You have the right to receive notification of a "breach" of your unsecured PHI.

F. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, please contact our HIPAA Privacy Officer at 973-699-2215. Written correspondence to the Privacy Officer should be sent to Jersey Rehab, P.A., 15 Newark Avenue, Belleville, New Jersey 07109, Attention: HIPAA Privacy Officer.

VII. EFFECTIVE DATE OF THIS NOTICE

REVISED NOTICE – EFFECTIVE MAY 1, 2015

JERSEY REHAB, P.A.

I _____ [patient name] acknowledge receipt of the above organization's Notice of Privacy Practices:

Signature: _____ Date: _____

Printed Name: _____

OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained.

Reason: _____

Signature of Covered Entity Representative: _____

Printed Name: _____ Date: _____

JERSEY REHAB, P.A.

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Belleville – 15 Newark Avenue, Belleville, NJ 07109 Tel: (973) 844-9220 Fax (973) 844-1217

ASSIGNMENT OF BENEFITS

PATIENT NAME: _____

I irrevocably assign to Jersey Rehab, P.A. all my rights and benefits under any insurance contracts for payment of services rendered to me by Jersey Rehab, P.A. I irrevocably authorize Jersey Rehab, P.A. to file insurance claims on my behalf for services rendered to me.

Jersey Rehab, P.A. has made me aware that all claims will be submitted to my insurance carrier if provided. Any co-pay, co-insurance and deductible will be my responsibility. All payments are to be directed to Jersey Rehab, P.A. There will be three attempts by Jersey Rehab, P.A. to collect any debt. If Jersey Rehab, P.A. is unsuccessful in collecting your debt, it will be handed over to a representative for suit. I understand that it is my responsibility to inform Jersey Rehab, P.A. of any insurance change to my current policy or change in insurance company and if I do not do so, I will be fully responsible for all bills incurred within that period.

This Assignment of Benefits has been explained to my full satisfaction and I understand its nature and effect. I hereby authorize photocopies of this form to be valid as the original.

Patient's signature: _____ Date: _____

JERSEY REHAB, P.A.

Physical Medicine & Rehabilitation – Electrodiagnostic Medicine
Subspecialty, Pain Management

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Shailendra Hajela, M.D. **Felix A. Almentero, M.D.**

Belleville – 15 Newark Avenue, Belleville, NJ 07109 Tel: (973) 844-9220 Fax (973) 844-1217

WAIVER

I, _____ understand that my insurance company may not cover
(Print patient's name)

certain procedures and supplies that are necessary for my treatment. I understand that I am responsible for charges that I incur during my treatment(s) which are not covered by my insurance company.

I will make payments if necessary as discussed and agreed upon with Jersey Rehab, P.A.

Date: _____

Name: _____ (print)

_____ (Signature) _____ (Initial)

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AUTHORIZATION AND REQUEST FOR MEDICAL RECORDS

DATE: _____

PATIENT NAME: _____

SS NUMBER: _____-_____-_____

RELEASE RECORDS TO:

_____

_____

_____

You are hereby requested and authorized to disclose, make available and furnish my records to the above named person at the above address. All information you may have regarding my condition while under your observation including the history obtained, records, x-rays, reports or copies thereof relating to my examination, inspect and make copy or abstracts thereof.

_____ _____

Patient Signature **Date**

3/8/12

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RECORDS / FILMS RELEASE FORM

To: Jersey Rehab, P.A.

I, _____ hereby request that records/films be released to myself.

I will take responsibility for the records/films that I received from Jersey Rehab, P.A.

_____ _____
(Date of Request) (Patient's signature)

_____ _____
(Witness) (Address)

_____ _____
(Date) (City, State, Zip Code)

JERSEY REHAB & PAIN MANAGEMENT, P.A.

Edwin M. Gangemi, M.D.
Robert A. Marini, M.D.
Shailendra Hajela, M.D.
15 Newark Avenue
Belleville, NJ 07109
Tel: (973) 844-9220 Fax (973) 844-922

No Show Policy

Patients who schedule appointments but fail to show up are documented as "no shows".

A 24 hour notice for cancellation is required by this office.

Failure to do so will result in a $ 25.00 charge and this charge is not covered by insurance.

Please be courteous to your provider and fellow patients, and cancel your appointment as soon as possible.

Patient/Guardian Signature:_____ Date:_____

Witnessed by:_____

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ACCIDENT INSURANCE INFORMATION

TYPE OF ACCIDENT: MOTOR VEHICLE _____ WORKMEN'S COMPENSATION _____ LIABILITY _____
DATE OF ACCIDENT: _____ DO YOU HAVE AUTO INSURANCE? YES / NO
NAME OF INSURANCE COMPANY: _____
INSURANCE COMPANY ADDRESS: _____
POLICY #: _____ CLAIM #: _____
CLAIM REPRESENTATIVE: _____
WERE YOU THE DRIVER? _____ PASSENGER? _____ PEDESTRIAN? _____ OTHER _____
BRIEF DESCRIPTION OF ACCIDENT _____
_____

HAS THIS ACCIDENT BEEN REPORTED TO YOUR INSURANCE COMPANY? YES / NO
IF NOT, YOU MUST REPORT THE ACCIDENT TO YOUR INSURANCE COMPANY TO PROTECT YOUR BENEFITS, EVEN IF YOU WERE NOT AT FAULT.

IF YOU WERE THE PASSENGER IN A VEHICLE NOT OWNED BY YOURSELF WE WILL NEED THE FOLLOWING INFORMATION:
VEHICLE OWNER: _____ INSURANCE COMPANY: _____
POLICY #: _____ CLAIM #: _____
DOES ANYONE ELSE IN YOUR HOUSEHOLD HAVE AUTO INSURANCE OF THEIR OWN? YES / NO
NAME: _____ RELATIONSHIP: _____
INSURANCE CO: _____ POLICY #: _____

****

WORKMEN'S COMPENSATION INFORMATION: DATE OF ACCIDENT: _____
AUTHORIZED FOR TREATMENT: _____ UNAUTHORIZED FOR TREATMENT: _____
EMPLOYER'S NAME: _____
WORKMEN'S COMPENSATION CARRIER: _____
WORKMEN'S COMPENSATION CARRIER ADDRESS: _____
CITY _____ STATE _____ ZIP CODE _____ TEL # ( ) _____
CLAIM REPRESENTATIVE _____ OR CONTACT PERSON _____

****

ARE YOU REPRESENTED BY AN ATTORNEY FOR THIS INJURY? ( ) YES ( ) NO
ATTORNEY NAME: _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
TELEPHONE # ( ) _____ PARALEGAL OR SECRETARY NAME _____

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

IMPORTANT:
1. TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE PERSONAL INJURY PROTECTION LAW, YOU MUST COMPLETE AND SIGN THIS FORM.
2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

YOUR NAME	PHONE NO. HOME / BUSINESS
YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)	DATE OF BIRTH / / — SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / A.M. P.M.	PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)
BRIEF DESCRIPTION OF ACCIDENT	

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A PEDESTRIAN? YES ☐ NO ☐
WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐ WERE YOU A MEMBER OF THE AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

DO YOU OR ANY MEMBER OF YOUR HOUSEHOLD OWN AN AUTOMOBILE? YES ☐ NO ☐

DESCRIBE ALL AUTOMOBILES OWNED BY YOU OR ANY MEMBER OF YOUR FAMILY THAT RESIDED IN YOUR HOUSEHOLD AS OF THE DATE OF THE LOSS.

AUTOMOBILE	OWNER	INSURANCE CO.	POLICY NUMBER

DID YOU HAVE HEALTH INSURANCE ON THE DATE OF LOSS? YES ☐ NO ☐

IF YES, PROVIDE THE INFORMATION REQUESTED BELOW REGARDING YOUR HEALTH INSURER(S):

1. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP #/CERTIFICATE #: _____

2. NAME: _____
ADDRESS: _____
PHONE: _____
FAX#: _____
E-MAIL: _____
POLICY/GROUP#/CERTIFICATE #: _____

WERE YOU INJURED AS A RESULT OF THIS ACCIDENT? YES ☐ NO ☐ IF YOUR ANSWER IS YES, COMPLETE THE REST OF THIS FORM. IF NO, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: _____ DATE: _____

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐	DOCTOR'S NAME AND ADDRESS
IF YOU WERE TREATED IN A HOSPITAL WERE YOU AN IN-PATIENT? ☐ OUT-PATIENT? ☐	HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE: $	WILL YOU HAVE MORE MEDICAL EXPENSE? YES ☐ NO ☐	AT TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐	IF YES, AMOUNT LOST TO DATE $	WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN — DATE YOU RETURNED TO WORK

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR BENEFITS UNDER	YES	NO	IF YES, AMOUNT $ _____
(1) ANY WORKMEN'S COMPENSATION LAW?	☐	☐	
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐	☐ PER WEEK ☐ PER MONTH
(3) MEDICARE?	☐	☐	

LIST NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? YES ☐ NO ☐ IF YES, EXPLAIN ON REVERSE SIDE.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

SIGNATURE: _____ DATE: _____

APPLICATION FOR BENEFITS—PERSONAL INJURY PROTECTION

IMPORTANT:
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2. YOU MUST ALSO SIGN THE ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH ANY MEDICAL BILLS YOU HAVE RECEIVED TO DATE.

DATE	OUR POLICYHOLDER	DATE OF ACCIDENT	FILE NUMBER

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES OR SALARY WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW.

SIGNATURE: _____ DATE:

AUTHORIZATION TO EXTEND TIME TO SCHEDULE A PHYSICAL EXAMINATION FOR DECISION POINT REVIEW

(OPTIONAL)

TO ASSURE MY ABILITY TO ATTEND THE REQUIRED PHYSICAL EXAMINATION, I HEREBY AUTHORIZE CURE TO TAKE UP TO 14 DAYS AFTER RECEIPT OF NOTICE FROM MY HEALTH CARE PROVIDER (RATHER THAN THE 7 DAYS NORMALLY REQUIRED) FOR SCHEDULING A PHYSICAL EXAMINATION IF ONE IS NEEDED IN ORDER TO MAKE A DETERMINATION REGARDING THE MEDICAL NECESSITY OF TESTS OR TREATMENTS UNDER THE CURE DECISION POINT REVIEW PLAN.

SIGNATURE: _____ DATE:

SUBCHAPTER 25. PRIVATE PASSENGER AUTOMOBILE INSURANCE:
NOTIFICATION BYTREATING HEALTH CARE PROVIDERS

APPENDIX A

Notification of Commencement of Medical Treatment
(to be filed with insurer)

Name, address and phone number of Treating Health Care Provider:

_____

_____

Fax Number (optional) _____

Name and address of patient:

_____

_____

Name and address of insured: (if different)

_____

_____

Insurer Name: _____

Insurer Address: _____

Policy No.: _____

Date of accident/injury: _____

Date of first treatment: _____

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ATTORNEY RELEASE FORM

ATTORNEY NAME: _____

ATTORNEY ADDRESS: _____

_____

_____

RE: _____

D/A: _____

I authorize Jersey Rehab, P.A. to release my medical records and any other necessary information to the above-mentioned attorney.

Date: _____ **Patient signature:** _____