Central Jersey Orthopaedic Specialists, P.A.

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1907 Park Avenue Suite 102
South Plainfield, NJ 07080
Tel: 908-561-3400

IMPORTANT

Dear Patient:

We would like to welcome you to Central Jersey Orthopaedic Specialists. We hope you enjoy your visit. In order to make your visit easy and efficient we ask you to Please complete all forms in this packet and date with the date of Service. Please use black or blue pen (no pencil) and bring them to the office the day of your first appointment.

*If you are being referred by another doctor, or have a family physician you must furnish us with their complete name, address and phone number.

- ☐ **NEW PATIENT**
- ☐ **NEW PROBLEM**
- ☐ **FOLLOW-UP**

For Your Convenience:

PATIENT MUST BRING THE ITEMS LISTED BELOW IN ORDER TO BE SEEN:

- ☐ **INSURANCE CARD(S)**
- ☐ **A PHOTO ID** (e.g. Drivers License, Passport, Or Other Government Issued Photo Id)
- ☐ **ANY XRAY OR MRI FILMS AND WRITTEN REPORTS**
- ☐ **LIST OF CURRENT MEDICATIONS**(e.g. Prescribed and Over-The-Counter Medications, Vitamins Or Supplements)
- ☐ **COMPLETED PAPER WORK**

Patients who do not bring the listed items to their appointment will be rescheduled.

SPECIAL NOTE: In order to keep appointments available for our patients, there is a **$50.00 fee for missed appointments.** This includes appointments canceled without 24 hours notice. The patient or responsible party will be held personally responsible for payment of any missed appointment fees. This fee cannot be billed to the insurance company. This fee must be paid in advance of scheduling any future appointments.

After 3 or more missed appointments you may be asked to change to another physician's office.

Central Jersey Orthopaedic Specialists
1907 Park Ave – Suite 102 - South Plainfield, NJ 07080
908-561-3400

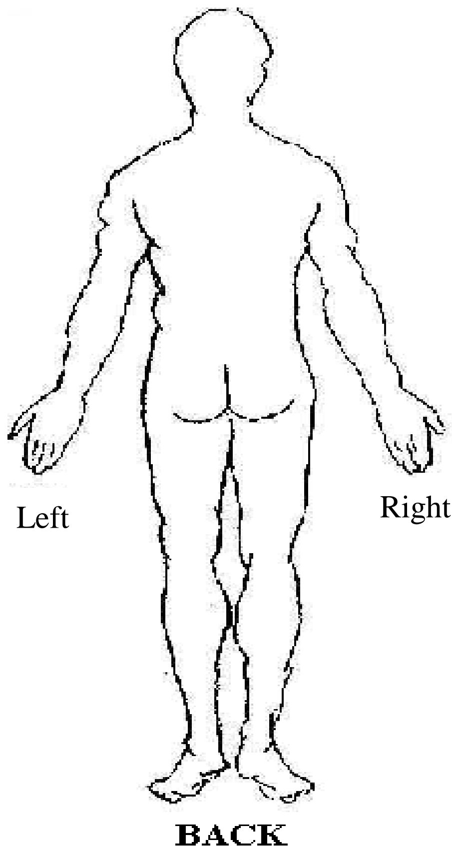
PAIN DESCRIPTION FORM

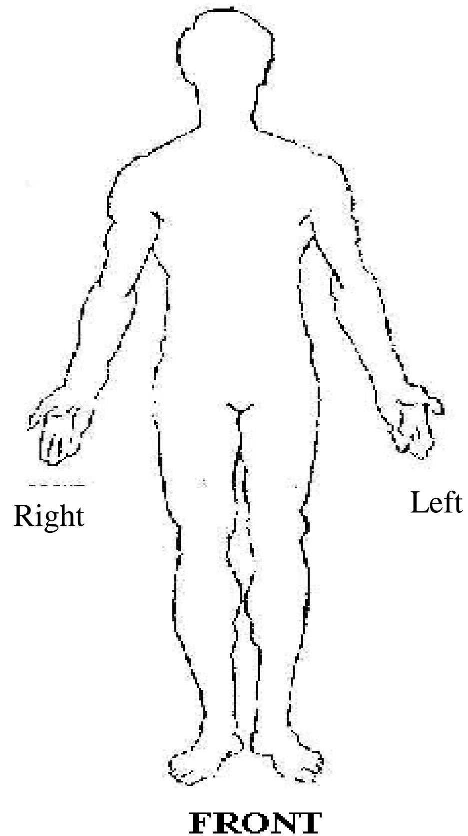
Name ____ DOB:_______________ Age:______ Date _____________

ALL PATIENTS MUST COMPLETE INFORMATION BELOW			
Describe ILLNESS or INJURY :(if injury, describe how occurred.) (please indicate i.e.: LT leg pain, RT leg pain	**Type of Accident circle one** Auto Fall Work Other(Specify)	**Where did you fall?**	**Date of Accident/onset**
Patient TREATED at or REFERRED by any of the following for current problem?	Hospital (In-Patient) Emergency Room "Walk-in" Facility Primary Care Dr. Other		
Occupation	Job description		
Circle whether: Right handed Left handed			
Name, Address & phone # of your Pharmacy:			

Using the symbols shown below, mark the areas on your body where you feel the described sensations.
Include only the affected areas you are being seen today.

Aching	Numbness	Pins and Needles	Burning	Stabbing	Other
^ ^ ^	= = =	O O O	X X X	/ / /	+ + +





Patient Initials: ______

I authorize the doctors at Central Jersey Orthopaedic Specialists, P.A. (C.J.O.S.) to examine me or the patient for whom I am legally responsible for and to do any x-rays or other tests that may be needed to make a diagnosis and to recommend and provide treatment. I consent to necessary office or other outpatient treatment after being properly informed of alternatives, benefits and risks.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize C.J.O.S. to release to any insurance company, health plan or governmental agency such medical information that may be required to process my claim for payment of the medical bill.

I also authorize C.J.O.S. to release appropriate medical information to any doctor, hospital or other health-care facility that has or will participate in my (the patient's care).

I further authorize any other doctor, hospital or health-care facility to release to C.J.O.S. any medical information concerning my (the patient's) illness or injury.

FINANCIAL AGREEMENT

I agree to pay all professional fees charged by C.J.O.S. for my (the patient's) care, irrespective of any insurance benefits to which I may be entitled, except if C.J.O.S. has agreed to accept insurance benefits as full payment for covered services in accordance with federal or state law (e.g., Medicare, Medicaid) or by contract with a prepaid health plan or managed-care plan, and provided such insurance benefits are paid within 60 days of claims submission, and provided there is no recovery from a third-party negligence lawsuit (see Injuries and Third-Party Negligence, below). I also understand that I will be responsible for all unpaid balances for services rendered, whether they are due to applicable co-payments, coinsurance, deductibles, no valid referral, non-covered services and items, unauthorized services, or any other fees denied (see delinquency below). I further understand that if a copayment is not paid at the time of service there will be a **$5.00 per month service charge, till fully collected,** unless specific arrangements have been made with the billing dept.

If a claim for payment for a work-related injury is denied by an employer or its carrier; or if a prepaid health plan, managed-care health plan, or Medicare considers certain services ineligible or uncovered services, then I shall pay for those services. I understand that claims for services remaining unpaid 90 days after claims submission shall be presumed ineligible for insurance reimbursement, and I shall pay for those services.

Injuries and Third-Party Negligence. I understand and agree that if C.J.O.S. has granted discounts from its usual fees for any reason, including its participation in prepaid or managed-care health plans, and if I (the patient) recover(s) any monies as the result of any judgment, award or settlement of any lawsuit arising from treated injuries or illness, then I shall give a lien to C.J.O.S. against such monetary recovery in the full amount of such discounts. If I give a lien against any monetary recovery from a third-party lawsuit I agree to pay 12% annual interest on any medical bill balance outstanding from the date of giving such lien.

Delinquency. If my (the patient's) account becomes delinquent I understand C.J.O.S., at its' sole discretion, may refer my account to a collection agency or an attorney as allowed by law. In the event that my account is referred to an attorney/collection agent, there will be a 35% delinquency surcharge added to my account, as well as any attorney or court fees to obtain payment of my bill.

INSURANCE ASSIGNMENT

I authorize any insurance company or third-party payor to whom a claim for payment has been submitted to pay any eligible benefits directly to C.J.O.S. I understand, however, that I am ultimately responsible to pay the medical bill if this assignment is not honored in whole or in part.

I hereby assign to C.J.O.S. full rights to represent my (the patient's) interests in any complaints of appeals of denial of benefits or reimbursement of New Jersey's Department of Banking and Insurance and to the Department of Health and Senior Services. I hereby authorize said assignee C.J.O.S. to furnish these agencies such information as may be necessary to support such complaints or appeals.

RELEASES ON FILE

I authorize a photocopy, facsimile or other electronic transmission of the above Assignments, Authorizations, and Releases to be used in place of the original until and unless I send written notice to the contrary to the offices of C.J.O.S., or until two years from the below date, whichever occurs sooner. However, I agree I cannot revoke the FINANCIAL AGREEMENT or the INSURANCE ASSIGNMENT at any time while any portion of the medical bill remains unpaid.

I have read, understood and do hereby agree to the terms of the forgoing Authorizations, Agreements, Assignments, and Releases. I also certify that the PATIENT INFORMATION I have provided on the this form is true and accurate to the best of my knowledge.

Signature of Patient, Parent or Legal Guardian	Date

Form Updated_____________ Patient Initial Change__________

LIFETIME SIGNATURE AUTHORIZATION

Dear Patient:
Central Jersey Orthopaedic Specialists, P.A. is pleased that you have selected this group to provide for your medical needs. Central Jersey Orthopaedic Specialists, P.A. is asking you to review the following Lifetime Authorization Statement. Please do not hesitate to ask a staff member for clarification on any part of this document. If you are comfortable with the document, please sign where indicated and return it to the receptionist. If you disapprove, Central Jersey Orthopaedic Specialists, P.A. certainly respects your right of refusal. However, please be aware that Central Jersey Orthopaedic Specialists, P.A., without your legal signature, cannot file with your insurance carrier for the services you are scheduled to receive. Therefore, Central Jersey Orthopaedic Specialists, P.A. will have no alternative but to require that you be responsible for the cost of services rendered in full.
Thank you in advance for your cooperation.

LIFETIME AUTHORIZATION STATEMENT

Central Jersey Orthopaedic Specialists, P.A. agrees to bill my health/auto insurance carrier and/or Medicare Part B whenever possible. I request my health/auto insurance carrier to pay Central Jersey Orthopaedic Specialists, P.A. directly all benefits due me related to my pending claim for medical and/or surgical services. I understand that Central Jersey Orthopaedic Specialists, P.A. does accept assignment for Medicare and payments will be directed to Central Jersey Orthopaedic Specialists, P.A. I also understand that I will be responsible for all unpaid balances for services rendered, whether they are due to applicable co-payments, coinsurance, deductibles, no valid referral, non-covered services and items, unauthorized services, or any fees denied. Should the account be referred for collection procedures, I will also pay a 35% delinquency surcharge and any attorney's fees and collection expenses including court costs incurred to obtain payment of my bill.

CONSENT FOR TREATMENT

I authorize Central Jersey Orthopaedic Specialists, P.A. to treat as necessary for which my minor child or I are being seen. This includes, but is not necessarily limited to, injection, fracture care, casework, rehabilitation, or any other treatment deemed proper care of my injury or illness.

RELEASE OF MEDICAL RECORDS

I hereby authorize Central Jersey Orthopaedic Specialists, P.A. to release any medical information in connection with these services to any person or corporation which is or may be liable for all or any portion of the patient's charges, including insurance companies, health care service plans, workman's compensation carriers to the extent necessary to obtain reimbursement. Also, to the patient personal physician, referring physicians, or primary care physician

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS ALL THE ABOVE, AND AS THE PATIENT, GUARANTOR, OR THE PATIENT'S RESPONSIBLE PARTY, AGREES TO AND ACCEPTS THE TERMS.

______________________________ ____________ ___________________________

Signature of Patient/Responsible Party Date Health Insurance ID#
Beneficiary Name

Central Jersey Orthopaedic Specialist, P.A.

Notice of Privacy Policies

At Central Jersey Orthopaedic Specialist, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective October 1, 2002, and applies to all protected health information as defined by federal regulations.

I have received Central Jersey Orthopaedic Specialist, P.A. notice of Privacy Policies.

____ ______________________

Patient/Parent or Legal Guardian Signature *Date*

Patient Contact Permission

This information will allow us to contact you in regards to all medical results, inquiries and office/medical related issues.

Please list telephone numbers that we may use to contact you:

1. __________________________________ (Home/Work/Cell) Leave Message: Y/N
2. __________________________________ (Home/Work/Cell) Leave Message: Y/N
3. __________________________________ (Home/Work/Cell) Leave Message: Y/N

Short term release of information for Today's Visit Only___/___/____

Please list the names of any persons to whom you give us permission to discuss anything concerning your medical & financial status (i.e. relative, spouse, partner, friend)

IF THE NAME IS NOT LISTED WE WILL NOT DISCUSS OR RELEASE ANY INFORMATION

Name ______________________________ Name _________________________________

Name ______________________________ Name _________________________________

Patient Name: ____ Date: _________________

Signature: _____________________________________ Relationship (if not patient) __________

Central Jersey Orthopaedic Specialist P.A.

SYMPTOM SURVEY

Patient Name: ____ Date of Birth__________________

Please check any of the following symptoms that you may have experienced or are being treated for:

CONSTITUTIONAL
__Fatigue
__Insomnia at night
__Hyperactive
__Restless
__Sleepiness during the day

PSYCHOLOGICAL
__Anxiety
__Depression
__Irritability
__Forgetfulness
__Mood swings

HEAD/EARS
__Bleeding from mouth teeth
__Discharge from ears
__Earache
__Ear infection
__Headache/Sever Headache
__Itchy ear
__Ringing in ear

SKIN
__Acne
__Blemishes
__Eczema
__Hives
__Rashes
__Rosy Checks

NASAL/SINUS
__Nose Bleed
__Post Nasal Drip
__Runny Nose
__Sinus Pain
__Sneezing
__Stuffy Nose

HAND DOMINANCE
__ Right
__ Left

MUSCULOSKELETAL
__Arthritis (diagnosed)
__Back pain Neck
__Back pain Mid
__Back pain Low
__Buttock pain
__Fracture/Joint injuries
__Joint Pain/Aching
__ Leg Cramping worst after
__walking
__Leg Pain
__Mass
__Muscle Aches/stiffness
__Muscle Weakness
__Poor balance
__Sacral/coccyx pain
__Stiff Joints/pain/swelling/redness
__Stiff Muscles
__Thigh pain
__Tingling Numbness
__Trigger Finger

DIGESTIVE
__Bloating Sensation
__Blood in stool/bladder
__Constipation
__Diarrhea
__Gas
__Heartburn/Esoph. Reflux
__Intestinal Pain/Cramps
__Nausea
__Painful Elimination
__Stomach Pains/Cramps
__Vomiting

WEIGHT MANAGEMENT
__Binge Drinking
__Binge Eating
__Fluctuating Weight
__Food Cravings
__Purging (all methods)
__Water Retention

CARDIOVASCULAR
__Chest Pain or Angina
__Dizziness
__Fainting/Stroke/Convulsion
__Fluttering or Flip Flop
__Heart attack, Rheumatic fever
__Heaviness in Chest
__High Blood Pressure
__Indigestion like Pain
__Intermittent Jaw Pain
__Irregular Heartbeat
__Light Headedness
__Palpitations
__Pounding in Chest
__Sensations of Choking
__Shortness of Breath
__Tightness
__Tingling in Arm
__Weak Spells

REPIRATORY
__ Asthma
__ Bronchitis/Pneumonia
__Coughing
__Lung disease

ENDOCRINE
__Diabetes
__Thyroid Disease
__Other

Height _____________ Weight ____________ Blood Pressure ____________

Patient Signature ____ Date ______________

Physician Signature ___________________________________ Date __________________

CJOS Orthopaedic History (page 1 of 2)

Name: ________________________________ **Today's Date:** ____________________

SS#________________________________ **Date of Birth:** ____________________

Chief Complaint

Why are you seeing the doctor today? ____

____

Current problem is the result of a (n): Check all that apply

☐ Car Accident ☐ Work Accident ☐ Slip and Fall ☐ Other ________

Medication	Dose	Frequency	Reason for Medication

Allergies:

Have you had the following immunizations or Vaccines? ☐ Influenza ☐ Pneumonia ☐ Shingles
If no, which immunizations are due? ____

____

Past Medical History

Surgeries/Hospitalizations	year	Complications

Have you ever had general anesthesia? No Yes
Have any problems with anesthesia? No Yes

If Yes Describe: ____

CJOS Orthopaedic History (page 2 of 2)

Name: ___________________________________ Today's Date: _____________________

SS#___________________________________ Date of Birth: _____________________

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother(mom)				
Grandfather(mom)				
Grandmother(Dad)				
Grandfather(Dad)				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Social History

☐Work in the home ☐Employed(occupation______________) ☐Student ☐Retired

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Children? ☐No ☐Yes #____________

Do you live alone? ☐No ☐Yes ____________

Exercise? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

What type of exercise? ____

History of substance abuse? ☐No ☐Yes What? ___________________________________

Smoke Currently? ☐No ☐Yes _____Packs per day for____years.

Quit Smoking? ☐This year ☐>1year ☐>5years ☐>10years

Drink alcohol? ☐Socially ☐1-2 X/week ☐1-2 X/month ☐1-2 X/year ☐Daily

Patient Signature:___________________________________ Date:___________________________

Reviewed By: ______________________________________MD Date: _______________________

Central Jersey Orthopaedic Specialists, P.A.
Authorization for Release of Information To Specified People

Long Term Release of Information

PATIENT NAME: ____
LAST FIRST MI MAIDEN OR OTHER NAME
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ ACCOUNT #: ____
MO DAY YR
ADDRESS: ____ CITY: _________________________ STATE: _____ ZIP: ___________

DAY PHONE: ____ EVENING PHONE: ____

I hereby authorize Central Jersey Orthopaedic Specialists, PA to release information from my entire medical record & billing info to the following individuals for the purpose of continuing care.

Information to be released:

- ❑ History and physical exam
- ❑ RX
- ❑ Progress notes
- ❑ Lab reports
- ❑ X-ray reports/films
- ❑ Billing info

Other: _________________

I specifically authorize the release of information relating to:
❑ Substance abuse (including alcohol/drug abuse)
❑ Mental health (including psychotherapy notes)
❑ HIV related information (AIDS related testing)
X____
Signature of Patient or Legal Guardian Date

PURPOSE OF DISCLOSURE:

❑ Changing Physicians ❑ Consultation/ Second Opinion ❑ Treatment ❑ Continuing Care ❑ Legal ❑ School
❑ Insurance ❑ Workers Compensation ❑ Other (Please Specify):____

1. I understand that this authorization will expire on _____________________ (Print the Date this Form Expires) or 6 months after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that I requesting to release this information to:

____

____

____

____

For the purpose of:

____

- By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
- I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it
- I understand that by signing this authorization my medical records will not be sold, but under certain circumstances a fee may be charged in accordance with the New Jersey Statue.

____________________________________ _________ OR ____ _________
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

____________________________________ _________ ____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

10/7/13

Central Jersey Orthopaedic Specialists, P.A.

Directions to South Plainfield Office

Route 78 East or West – EXIT 40 TO HILLCREST ROAD

West - make right off exit onto Hillcrest Road

East - make left onto Hillcrest Road

Continue on Hillcrest Road (down hill). At bottom of hill "T" in the road, make right turn onto Watchung Circle. Take 3rd road off circle, Somerset Street. Go approx. 1 mile, just before you come to Route 22 West make left turn onto Route 22 overpass. At bottom of overpass make left turn onto Somerset Street. Continue for approximately 2.8 mile to our office. Somerset Street turns into Park Ave.

Route 287 North from Staten Island Route 440 Exit 4

‡ **Take** Exit 4, Durham Ave. Continue on Durham 0.4 miles. Proceed for a total of 5 lights. Bear right at intersection of Valley National Bank continuing over bridge. To Hamilton Blvd, go approx. 1.3 miles (Hamilton turns into Lakeview Ave) for an additional 0.4 miles. At 5th light turn right onto Maple Avenue (just before Spring Lake Park) and go approx. 1.1 miles. At light turn left onto Park Ave. We are approx. 0.2 miles on your right just past Dunkin Donuts.

Route 287 South Exit 4

Exit at Edison exit #4 (Lean Line Sign) and make right. At first light make a left onto Hadley Road (Red Lobster). Proceed to Durham Road (2nd light). Make a left turn onto Durham and proceed from * as above to Maple Ave.

Route 22 West

Follow sign to "The Plainfields", make right turn (Midas Muffler) after overpass and go over Route 22. At bottom of overpass make a left turn onto Somerset Street and

* follow Somerset Street until it becomes Park Avenue. Follow Park Avenue past Muhlenberg Regional Medical Center to #1907 (just before Dunkin' Donuts) on left side.

Route 22 East

Make right turn at sign "The Plainfields" or Somerset Street (VIP Honda on corner) and proceed above from *.

Parkway North or South Exit 131

Exit at 131 (Iselin/Metuchen). Make a right at exit and go to 1st light. Make a right turn onto Wood Ave. At next light make a left turn onto Oak Tree Road. Proceed to Park Avenue (A&P, McDonalds). Make a right onto Park Avenue and proceed to #1907 (just past Dunkin' Donuts).

Turnpike North Exit 10

Take NJ Turnpike to Exit 10 – to Route 287 north and follow directions above from ‡

Route 1

Plainfield Avenue to Stelton Road. Make right onto Hadley Road (at Middlesex Mall). Continue straight to Durham Road. Make left onto Durham (follow directions from 287 at ‡

From New Brunswick

Route 1 North to 287 North‡

From Newark/Elizabeth

Route 1 south to Green Street (Iselin/Edison Exit). This will become Oak Tree Road. Continue straight to Park Avenue. Make right onto Park, continue straight, 1907 just past Dunkin' Donuts on right.