

PATIENT INFORMATION

DATE _____ NAME _____

EMAIL ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # (HOME) _____ (WORK) _____

SOCIAL SECURITY # _____ BIRTH DATE _____ AGE _____

SEX: MALE _____ FEMALE _____ MARTIAL STATUS: M _____ S _____ D _____ W _____

WHO WERE YOU REFERRED BY _____

WHAT PART OF YOUR BODY ARE YOU BEING SEEN FOR _____

DATE OF INJURY OR ONSET OF SYMPTONS _____

RIGHT _____ LEFT _____

DESCRIBE YOUR INJURY/ONSET OF SYMPTONS _____

NAME: _____ **AGE:** _____

DO YOU HAVE ANY THE FOLLOWING PROBLEMS:

ASTHMA _____ ANEMIA _____ HIGH BLOOD PRESSURE _____ STROKE _____ DIABETES _____ HEART MURMUR _____

RREGULAR HEARTBEAT _____ HEART ATTACK _____ PNEUMONIA _____ EMPHYSEMA _____

PULMONARY EMBOLI _____ HEPATITIS _____ IRRITABLE BOWEL _____ GERD _____ LIVER DISEASE _____

DIVERTICULITIS _____ RHEUMATOID ARTHRITIS _____ DEGENERATIVE ARTHRITIS _____ OSTEOPOROSIS _____

LUPUS _____ GOUT _____ KIDNEY PROBLEMS _____ PROSTRATE PROBLEMS _____ PHLEBITIS _____

MULTIPLE SCLEROSIS _____ SKIN RASHES/PSORIOSIS _____ CANCER _____ TYPE _____

SURGERY: HAVE YOU EVERY HAD SURGERY? PLEASE CHECK AND GIVE DATES TO ALL THAT APPLY.

TONSILS _____ URINARY TRACT _____ GALLBLADDER _____ GYNECOLOGIC _____ BREAST BIOPSY _____

BOWEL/COLON _____ APPENDIX _____ HERNIA REPAIR _____ ORTHOPAEDIC SURGERY _____

HEART SURGERY _____ Other _____ PLEASE EXPLAIN BELOW:

MEDICATIONS:

DO YOU TAKE ANN OF THE FOLLOWING MEDICATIONS ON A REGULAR BASIS?

ASPIRIN _____ BIRTH CONTROL PILLS _____ TYLENOL _____ COUMADIN _____ ANTI-INFLAMMATORY _____

PLEASE LIST ANY PRESCRIPTION MEDICATIONS:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? If yes, what was the reaction?

ROS:

LAST MENSTRUAL PERIOD? _____ PROBLEMS? _____

CALCIUM/VITAMIN D SUPPLEMENT? YES _____ NO _____

HAVE YOU HAD A BONE DENSITY TEST? YES _____ NO _____

GI: HEARTBURN/ULCERS _____ NAUSEA/VOMITING _____ BLOOD IN STOOL _____ HEPATITIS _____ LIVER DISEASE _____

ENDO: THYROID DISEASE _____ HEAT OR COLD INTOLERANCE _____

CON: WEIGHT LOSS _____ LOSS OF APPETITE _____

EYE: BLURRED VISION _____ DOUBLE VISION _____ ENT: HEARING LOSS _____ HOARSENESS _____ TROUBLE SWALLOWING _____

CV: CHEST PAIN _____ PALPITATIONS _____ RS CHRONIC COUGH _____ SHORTNESS OF BREATH _____

GU PAINFUL URINATION _____ BLOOD IN URINE _____ KIDNEY PROBLEMS _____

SK FREQUENT RASHES _____ SKIN ULCERS _____ LUMPS _____ PSORIASIS _____

NEU HEADACHES _____ DIZZINESS _____ SEIZURES PSY: DEPRESSION _____ DRUG/ALCOHOL ADDICTION _____

SLEEP DISORDERS _____ HEM EASY BLEEDING _____ EASY BRUISING _____ ANEMIA _____

ARE YOU HIV POSITIVE? YES _____ NO _____

PEDIATRIC HISTORY:

ARE ALL INOCULATIONS UP TO DATE? _____

BIRTH WEIGHT _____ TYPE OF DELIVERY _____ NORMAL _____ C-SECTION? YES _____ NO _____

IF C-SECTION: GROWTH AND DEVELOPMENT NORMAL: YES _____ NO _____

PLEASE EXPLAIN _____

FAMILY HISTORY:

INHERITED PROBLEMS: _____

AGE AND CAUSE OF DEATH: _____

MOTHER: _____ ALIVE _____ DECEASED _____

FATHER : _____ ALIVE _____ DECEASED _____

BROTHERS: _____ ALIVE _____ DECEASED _____

SISTERS: _____ ALIVE _____ DECEASED _____

SOCIAL HISTORY M _____ W _____ D _____ S _____

SMOKING HISTORY? _____ PKS PER YEAR? _____

SUBSTANCE ABUSE _____

HOBBIES _____ MUSIC INST _____ SPORTS _____

OF CHILDREN _____ HIGHEST LEVEL OF EDUCATION _____

EMPLOYMENT _____

HEIGHT: FT _____ IN _____ WEIGHT _____

PRIMARY INSURANCE

MANAGED CARE _____ PRIVATE INSURANCE _____ MEDICARE _____

SCHOOL INSURANCE _____ SELF PAY _____ PPO _____ POS _____ HMO _____

NAME OF INSURANCE COMPANY _____

ADDRESS _____

POLICY# _____ GROUP# _____

SUBSCRIBER NAME _____ SSI# _____ D.O.B. _____

EMPLOYER _____

SECONDARY INSURANCE

MANAGED CARE _____ PRIVATE INSURANCE _____ MEDICARE _____

SCHOOL INSURANCE _____ SELF PAY _____ PPO _____ POS _____ HMO _____ NAME OF INSURANCE COMPANY _____

ADDRESS _____

POLICY# _____ GROUP# _____

EMPLOYER _____

SUBSCRIBER NAME _____ SSI# _____ D.O.B. _____

IS THIS INJURY WORK _____ OR MOTOR VEHICLE _____ RELATED?

IF THIS IS WORKERS COMP OR MOTOR VEHICLE PLEASE COMPLETE THE INFORMATION BELOW:

INSURANCE COMPANY _____

ADJUSTER/CASE MANAGER _____

ADDRESS _____

TEL# _____ CLAIM# _____ EMPLOYER _____

ATTORNEY'S NAME _____

ADDRESS _____ TELEPHONE# _____

CHRISTOPHER D. JOHNSON, M.D

Patients with no insurance: payment is expected at the time of service. A specific Payment plan, acceptable to both you and the office may be arranged.

Patients with insurance: deductibles are expected at the time of service, Your co-Insurance is an amount, which Is not covered by your Insurance and is not always an exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility, If a patient's account balance remains unpaid for more than 90 days, and no response has been made to our office billing department, the patient's account may be turned over to our attorney for collection.

INSURANCE POLICY

We extend to our patients, the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expense.

Please note the following:

The privilege of Insurance assignment begins when your Insurance is qualified and forms are received. Until that time you must pay for services rendered.

All deductibles must be made prior to submitting any insurance Claims.

Since we do not own your Insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed up this process.

This office does not promise that an insurance company will pay the usual and customary charges of this office, nor does this office enter into any with an Insurance dispute company over the amount of the reimbursement.

It is the goal of this office to provide you with the finest quality care available, If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

WE WELCOME YOUR REFERRALS AND LOOK FORWARD TO A DOCTOR-PATIENT RELATIONSHIP THAT WORKS FOR OUR MUTUAL BENEFIT. PLEASE SIGN BELOW:

I have reviewed and am aware of the above office policies:

SIGNATURE DATE

I authorize my insurance company to make payment for any unpaid balance directly to Professional Orthopaedic Associates.

SIGNATURE DATE

I hereby authorize the release of any information relating to my care directly to my insurance company, attorney, school or any other treating specialist.

SIGNATURE DATE

MEDICAL SURVIVAL

As the years go by, I have noticed a distinct change with respect to the so-called medico-legal environment. I entered this profession in order to help people with their medical problems. I still intend to do so the best way I can. I expect from my patients an understanding of my commitment, and also their commitment. It is important during your care, that if you have questions with respect to diagnoses, your treatments, and direction of care, you bring them to my attention so that I can optimize our results. I have always been committed to non-operative care whenever possible, and recommend surgical treatment only when absolutely necessary, usually after failure of a trial of non-operative treatment. If indeed surgical treatment is recommended, I view this as an agreement between ourselves that this is the proper form of care. I will try my best to inform you of standard success rates and standard rates of recognized complications.

I _____ and/or my representative agree not to bring a "frivolous medical malpractice case or cause of action against Dr. Christopher Johnson or Professional Orthopaedic Associates". Further more should a medical malpractice case or cause of action be initiated or pursued I _____ and/or my representative agree to use an expert medical witness or (es) or adhere(s) to the guidelines and/or code of conduct defined by the Orthopaedic and Hand Specialist Societies for expert witnesses in the area(s) of medicine who would typically have a background experience to opinion on such a case. In consideration for this, I Chris Johnson, M.D. agree with the same stipulation.

I am hoping that in the near future, the doctor and patient will be able to re-assume control of healthcare, and bring to an end the current out of control situation of spiraling insurance costs, defensive medical care, early retirements of well experienced physicians, and limited availability of certain specialty services for the community. Physicians across the state and their practices face difficult decisions about their future ability to stay open and treat patients. We are being forced to become more active with respect to recommendations for our lawmakers about healthcare. New Jersey Senate had passed a compromised reform bill, but unfortunately the Assembly stripped away its most effective provisions. This environment further favors a broken medical liability system, and directly affects your access to healthcare. I would suggest that in addition to the above, you check two (2) following

Websites to find out which politicians are supporting healthcare in our Local and National environment. These would include www.njpatients.org and www.njforhealthcare.org. Let your legislators know about your choices for your own healthcare and for your own doctor. Lets work together so we can regain control of the best medical system in the world.

PATIENT'S SIGNATURE CHRISTOPHER D. JOHNSON, M.D

PROFESSIONAL ORTHOPAEDIC ASSOCIATES

DATE

AUTHORIZATION OF DESIGNATED REPRESENTATIVE TO APPEAL A DETERMINATION

NAME: _____ MEMBER #: _____

(please print)

I hereby authorize Cynthia Bennett, RMC, ACS-OR to appeal _____ (insurance company)

determination concerning _____ (description of service) on my behalf, as my designated

representative, and, as part of the appeal, I hereby authorize _____ (insurance company)

to disclose and furnish to my designated representative all medical and financial information contained in my insurance file.

I understand this information is privileged and confidential.

Signature of Member or Legal Guardian/Representative: _____

Signature of Designated Representative: _____

Name of Designated Representative: _____ (please print)

ASSIGNMENT OF BENEFITS/APPOINTMENT OF ATTORNEYS

I hereby authorize payment directly to the above named doctor as well as Professional Orthopaedic Associates of any insurance benefits otherwise payable to me for services provided to me (or a minor of whom I am the guardian) for their services.

I understand that Dr. Johnson and Professional Orthopaedic Associates may each bill for services rendered independently. I authorize this office to submit their bills to any insurance company with which I (or my spouse) have an insurance policy or any company against which I may proceed for medical expense benefits.

In the event that the doctor elects to bring a lawsuit or petition for arbitration against the insurance carrier, I assign my right, title and interest under the medical expense benefits of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim for any unpaid bills for treatment rendered for injuries I sustained in this or any accident. Dr. Johnson and Professional Orthopaedic Associates may designate an attorney of their choosing for the purpose of filing said action beginning thirty-one (31) days after any bill for services rendered becomes due. I agree to fully cooperate with them in the collection of the medical expense benefits/personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the assignee.

In the event this agreement is held invalid for any reason, I hereby authorize Professional Orthopaedic Associates to appoint an attorney of its choice to represent me directly against an insurer from which I may collect benefits and to bring a claim in a forum of his/her choice. This appointment is intended on enabling the attorney to collect the bills of Professional Orthopaedic Associates and this appointment does not authorize the selected attorney to represent me in any third party action. Further, this appointment will not conflict with any other attorney who currently represents me. I agree that if Dr. Johnson treats me for any problem that is involved in litigation or involves a claim for personal injuries, I will immediately notify Dr. Johnson's Billing Department who is my legal representative, and that I will pay Dr. Johnson's bills from any settlement which is recovered at the time of settlement.

I further authorize Dr. Johnson and Professional Orthopaedic Associates to release any and all information concerning my injury or illness and its treatment to the attorney designated by the assignee or third persons that are involved in the action to collect benefits. A photostat or copy of this authorization shall be deemed valid as original.

I have read, understand and agree to the above.

DATE: _____

Patient (or guardian if minor)

**Authorization to use or disclose protected health information
Professional Orthopaedic Associates, P.A.**

Date of request _____

Patient name _____ Date of birth _____

Address _____

****As required by the Privacy Regulations, Professional Orthopaedic Associates, P.A. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization****

I, _____, give permission for Professional Orthopaedic Associates, P.A. and any of its employees to release any or all of my Patient Health Information to the following relatives, friends or acquaintances.

Patient Health Information authorized to be disclosed: All

For the specific purpose of: Any

Effective dates for authorization ____/____/____.

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

Signature of Patient or Patient's authorized representative

Date

Authorized signature of Professional Orthopaedic Associates Staff

Date

ANTI-INFLAMMATORY MEDICATION

PATIENT NAME: _____ DATE: _____

Your doctor may prescribe a non-steroidal anti-inflammatory (NSAID) medicine to help alleviate your symptoms of pain, swelling and inflammation.

The most frequent side effects of this medication include, stomach upset, nausea and diarrhea. Ulcers or bleeding may occur without warning. It is recommended that this medicine be taken with food, which may reduce the appearance or magnitude of these side effects. Do not drink alcoholic beverages while taking this medication.

For best results, this medicine should be taken at the prescribed dose for the period of time recommended by your physician. If you take any other medications prescribed by another physician, you should consult your pharmacist prior to filling this prescription to check for drug interactions.

Should you develop any side effects with this medication, stop taking it immediately and contact your physician or this office. Patients with active ulcer disease or who are taking daily medicines for bronchial asthma must be aware that use of this medicine may result in an exacerbation of these problems. This medicine should not be taken in combination with other NSAIDs or aspirin containing medications. **Please note that commonly used over the counter medicines such as Ibuprofen, Advil, and Aleve contain non-steroidal medications that could increase the risk of stomach side effects of prescribed medication. Tylenol, however, would not increase this risk.**

For your protection, periodic blood work, within 6-8 weeks after taking this medication will be necessary to monitor any possible liver or kidney irritation.

If you are pregnant, have the flu, fever or any viral illness; **do not take** this medication. Consult your physician.

I have read and understand the above information.

PATIENT SIGNATURE: _____ DATE: _____

Welcome to All of our Patients

If your injury does warrant surgery,

please be advised that your ambulatory surgery may be scheduled at the

Shrewsbury Surgery Center

655 Shrewsbury Ave.

Shrewsbury, New Jersey

or

Toms River Surgery Center

1430 Hooper Ave.

Toms River, New Jersey

The physicians at Professional Orthopaedic Associates

have an ownership interest in the Surgery Centers.

Patients that wish to have their ambulatory surgery performed elsewhere may do so at a hospital where the physician maintains privileges.

Thank you

Professional Orthopaedic Associates