PATIENT INFORMATION

Doctor you are seeing today: Jason D. Cohen, MD

PATIENT NAME ☐ Appointment Date ☐

PLEASE CHECK ☐ Male ☐ Female ARE YOU: ☐ Right ☐ Left Handed ☐ Ambidextrous

MARITAL STATUS ☐ M ☐ D ☐ S ☐ W ☐ P

BIRTHDATE ☐ AGE ☐ HEIGHT ☐ ft ☐ in WEIGHT ☐ lbs

OCCUPATION ☐

☐ FT / ☐ PT / ☐ Self-Employed / ☐ Unemployed / ☐ Retired / ☐ Disabled / ☐ FT Student / ☐ PT Student

DOCTOR INFORMATION

Referring Doctor / Athletic Trainer / Physical Therapist / Friend

Family Medical Doctor

INJURY INFORMATION

Date of injury or accident or onset of symptoms ☐

Part of body you are being seen for today ☐ Left ☐ Right ☐ Bilateral ☐

Describe your injury or the onset of your symptoms ☐ Auto Accident? ☐ Work Injury?

Have you been seen for a previous injury or symptoms for this body part? ☐ Yes ☐ No

If yes, by whom ☐

TREATMENT

Seen in ER? When ________________________ Where ______________________________

Treatments? ☐ Injection ☐ Physical Therapy ☐ NSAID / Pain Meds ☐ Brace

Tests/Scans Done? ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Where? _____________________________ Did you bring them with you today? ☐ Yes ☐ No

PAIN ASSESSMENT

Please indicate the level of your pain for the injury listed above. Please circle the number below.

0 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY ☐ None

Do you have any of the following medical problems? Please check all that apply

☐ Anemia ☐ Heart Murmur ☐ Liver Disease/Hepatitis ☐ Phlebitis/Pulmonary Emboli/Blood clots
☐ Asthma ☐ High Blood Pressure ☐ Lupus/SLE ☐ Rheumatoid Arthritis
☐ Diabetes ☐ High Cholesterol ☐ Lyme's Disease ☐ Skin Rash/Psoriasis
☐ Emphysema/COPD ☐ Irregular Heartbeat ☐ Multiple Sclerosis ☐ Stroke
☐ Gout ☐ Irritable Bowel ☐ Osteoarthritis ☐ Thyroid Disease
☐ Heart Attack /CAD ☐ Kidney Problems ☐ Osteoporosis ☐ Ulcers
☐ Cancer - Please tell us what type: ____________
☐ Other (please list) ____________

PAST SURGICAL HISTORY ☐ None

Have you ever had surgery? Please check and give the dates to all that apply.

☐ Appendix ____ ☐ Bowel/Colon ____ ☐ Breast Biopsy ____
☐ Gallbladder ____ ☐ Gynecologic ____ ☐ Heart Surgery ____
☐ Hernia Repair ____ ☐ Tonsils ____
☐ Cosmetic Surgery____________ ____ ☐Other____________ ____
(please list type) (please list body part)

☐ ORTHOPAEDIC ____________ ____
(please list all) ____________ ____
____________ ____

MEDICATIONS ☐ None

Do you take any of the following medications on a regular basis? Please check all that apply.
☐ Anti-Inflammatory ☐ Aspirin ☐ Birth Control Pills ☐ Coumadin ☐ Tylenol
Please list any prescription medications you are currently taking:

____

ALLERGIES ☐ None

Do you have any **allergies** to any medications? (Please list all that apply & your reaction)

____

Do you have an allergy to Latex? ☐ Yes ☐ No

FAMILY HISTORY ☐ None

Do your parents, siblings, or grandparents have any of the following? Please check all that apply & indicate which family member:
☐ Cancer ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Diabetes ☐ Osteoporosis ☐ Stroke
☐ Heart Disease
Do you have any deceased family members? Please check all that apply and indicate cause of death.
☐ Mother ☐ Father ☐ Sibling ☐Grandparent
Cause: ____________ ____________ ____________ ____________

SOCIAL HISTORY

(Please check all that apply)

Do you smoke tobacco? Currently: ☐ Every day? Or ☐ Some days?
☐ Former Smoker? ☐ Never smoked?

Do you drink alcohol? ☐ No ☐ Yes If Yes, how often? ___Daily ____Other ____/ week

Have you ever been treated for chemical dependence? ☐ No ☐ Yes

Education (highest level achieved): ☐ High School ☐ College ☐ Technical School ☐ Advanced Degree

Are you pregnant? ☐ No ☐ Yes

REVIEW OF SYMPTOMS ☐ **None**

(Please check all that apply)

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	☐ Vision Loss	
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 Disorder	
HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	
ALL	☐ Seasonal Allergy	☐ Other (please list): ______________________________		
LYMP	☐ Leg Swelling			
MSK	☐ Fracture	☐ Joint Swelling	☐ Sprains	☐ Dislocation
VASC	☐ Claudication			
MISC	☐ Vitamin D/Calcium Supplements		☐ Bone Density Test	

ARE YOU HIV POSITIVE? ☐ Yes ☐ No

PATIENT DEMOGRAPHICS

Patient Name ____ Preferred Name: ___________________________

Address ____ City __________________________

State _________ Zip Code ____________ Birth Date _______________ Social Security # ___________________

Phone #'s: Home ____________________ Work ____________________ Cell __________________________

****

Email address _______________________How would you like us to contact you? Phone: ___home ___cell ___work

How did you hear about our practice?: Family/Friend Brochure Yellow Pages Website Other ___________

****

Patient Employer ____

Employer's Address/Phone # ____

Please list your attorney's information (if applicable to this injury):
Name/Address/Phone#: ____

****

PRIMARY INSURANCE

Will the primary insurance subscriber/insured party be responsible for the account? Y N

Name of Insurance Plan ____

Claim Address ____

Policy # ____ Group # ______________________________________

SUBSCRIBER /INSURED PARTY INFORMATION:

Name ____ Address ____

Home phone # __________________ Date of Birth ______________ Social Security # _____________________

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Is this insurance coverage through the subscriber's employer? YES NO

Employer ____

Employer address ____ Employer phone # ______________

Effective date of Insurance ______________________________

SECONDARY INSURANCE

Name of Insurance Plan ____

Claim Address ____

Policy # ____________________________________ Group # _________________________________

SUBSCRIBER/INSURED PARTY INFORMATION:

Name ______________________________________ Address __________________________________

Home phone # ___________________ Date of Birth _______________ Social Security # _____________________

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Is this insurance coverage through the subscriber's employer? YES NO

Employer ____

Employer address ____ Employer phone # _______________

Effective date of Insurance _______________________________

GUARANTOR INFORMATION - **Please list who will be responsible for the account.**

☐ SELF ☐ SAME AS PRIMARY INSURANCE ☐ OTHER

Name ______________________________________ Address __________________________________

Home phone # ___________________ Date of Birth _______________ Social Security # _____________________

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Employer ____

Employer address ____ Employer phone # _______________

**** If this is a workers comp or motor vehicle related injury please complete the information below****

Please circle one WORKERS COMP MOTOR VEHICLE

Insurance Company ____

Adjuster/Case Manager ____ Phone # ____________________________

Address ____ Claim # ____________________________

Employer ____

PHARMACY INFORMATION

Please list your **complete** pharmacy information.

Name
Address
Phone

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 and all co-insurances are expected at the time of service. Your co-insurance 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 balance remains unpaid for more than 90 days, the patient's account may be turned over to an attorney/collection agency for collections. If your account is sent to collections, you will be responsible for all collection fees generated.

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:

1. **The privilege of insurance assignment begins when your insurance is qualified and the insurance forms received. Until that time you must pay for all services rendered.**
2. **All deductibles must be made prior to submitting your insurance claims.**
3. **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.**
4. **Due to the recent changes in our status with most insurance companies, it will be your responsibility to turn over to our office any checks and related explanations of benefits that your insurance company issues to you for services rendered with Professional Orthopaedic Associates in a timely manner.**
5. **It is our goal of this office to provide you with the finest quality of care available. If you have any questions regarding your healthcare or any of our office policies, please do not hesitate to let us know.**
6. **If it becomes necessary to utilize a collection agency due to nonpayment of your bill, you will be responsible for all fees charged by that agency as well as your balance.**

Please sign below:

I have reviewed these office policies and accept my responsibility as detailed above.

Print Name: ____

Signature: ______________________________ **Date:** ____________

I authorize my insurance company to make payments for my unpaid balance directly to:
Professional Orthopaedic Associates

I hereby authorize the release of information to and from my insurance company, attorney, school, pharmacy or any other entity involved as it is related to my care and treatment.

Print Name: ____

Signature: ______________________________ **Date:** ____________

I hereby authorize my motor vehicle insurance carrier to release information to Professional Orthopaedic Associates regarding the PIP benefits that have been paid to date on my claim.

Print Name: ____

Signature: ______________________________ **Date:** ____________

We welcome your referrals and look forward to a Doctor-Patient relationship.

PROFESSIONAL ORTHOPAEDIC ASSOCIATES

Authorization of Designated Representative to Appeal a Determination

Date: ______________________

Patient name:_________________________________

Insured ID #: _________________________________

I hereby authorize Professional Orthopaedic Associates, as my designated representative, to appeal to my insurance company, ____, on my behalf, in the

(please print name of insurance company here)

determination of services rendered by_________________________, and, as part of the appeal, I hereby

(doctor you are seeing today)

authorize ____ to disclose and furnish to my

(please print name of insurance company here)

designated representative, Professional Orthopaedic Associates, the following information:

All medical and financial information contained in my insurance file. I understand this information is privileged and confidential.

Patient Name: ___________________________________

(please print)

Legal Guardian's name: ____________________________

(please print)

Signature of Patient or Legal Guardian: ________________________________ Date: _____________

____

Signature of Professional Orthopaedic Associates Representative

ASSIGNMENT OF BENEFITS/APPOINTMENT OF ATTORNEYS

I hereby assign all rights and benefits due me from my insurance carrier to Professional Orthopaedic Associates ("POA") and authorize and empower POA to appeal a determination by a carrier to deny, reduce or terminate my benefits including, but not limited to, the filing of a lawsuit or fee arbitration. Furthermore, I authorize and direct my insurance carrier to pay the proceeds of any benefits due me directly to POA. A copy of this can be considered as an original for insurance purposes. ____ *(initials)*

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable amount of time. If for any reason any portion of the bill is not paid by my insurance carrier, I further agree to make arrangements for prompt payment of the bill. ____ *(initials)*

If I receive any payment from an insurance carrier relating to services rendered, I agree that I will hold such payment in trust for POA and I agree to send any such payment to POA within one week after I receive same. In the event my account is turned over to an attorney for collection, I agree to pay a legal and collection fee equal to 33 1/3% of the outstanding balance, plus court costs. ____ *(initials)*

I understand that should I not turn over the proceeds, an action for collection may be filed against me in which I agree to be responsible for payment of any court costs and attorney fees involved in efforts to collect the entire fee billed by the doctor, not just what has been paid to me by my insurance carrier. ____ *(initials)*

I agree that if POA treats me for any problem that is involved in litigation or involves a claim for personal injuries, I will immediately notify the Billing Department for my POA provider. At the time any settlement funds are disbursed or received, I promise to pay any and all of my provider's and POA's bills. ____ *(initials)*

I understand that my provider and POA 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. ____ *(initials)*

In the event that the doctor elects to bring a lawsuit or petition for arbitration against the insurance carrier, I assign my rights, title and interest under any section 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. My provider and POA may designate such attorney beginning thirty-one (31) days after any bill for services rendered becomes due. I agree to fully cooperate with them in the collection of any benefits from the insurance carrier including full cooperation with the chosen attorney. ____ *(initials)*

In the event this assignment is held invalid for any reason, I hereby authorize POA to appoint an attorney of its choice to represent me directly against an insurer from which I may collect any & all benefits and to bring a claim in a forum of the attorney's choice. This appointment is intended to enable the attorney to collect the bills of POA 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. ____ *(initials)*

By consenting to having a law firm of POA's choosing represent me, I understand that in such lawsuits my confidentiality may not be protected and personal information may be revealed. I authorize my provider and POA to release any and all information concerning my injury or illness and its treatment to the attorney designated by the assignee or third person that are involved in the action to collect benefits. ____ *(initials)*

I have read, understand and agree to the above. ____ *(initials)*

____ ______________________

Patient Name – please print Date

____

Patient's Signature or Signature of Parent/Legal Guardian

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 or 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 other physicians, 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 physican 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 NSAID 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 physican.

I have read and understand the above information.

PATIENT SIGNATURE: ____________________________________ DATE: ____________

AUTHORIZATION TO USE OR DISCLOSE 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:

____
____

I, _____________________________________, give permission to the practitioner/facility listed below to release any or all of my Patient Health information to Professional Orthopaedic Associates, P.A. as part of my medical care.

____
____

I, _____________________________________. give permission for Professional Orthopaedic Associates, P.A. and any of its employees to leave information related to any or all of my care at the following number:

____ Home Cell Work
(please indicate what kind of number you have listed)

Patient information to be disclosed : All **For the specific purpose of : Any**

Effective date for authorization ______/______/______ .

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

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.

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 I have the right to:

1. **Revoke this authorization by sending a 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**

Professional Orthopaedic Associates

Office Locations

Tinton Falls Office

776 Shrewsbury Ave. Suite #105 - Tinton Falls, NJ 07724 - P: 732-530-4949 - F: 732-530-3618

Toms River Office

1430 Hooper Ave. Suite # 101 - Toms River, NJ 08753 - P: 732-530-4949 - F: 732-349-7722

Freehold Office

303 West Main Street - Freehold, NJ 07728 - P: 732-530-4949 - F: 732-577-0036

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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

Toms River Surgery Center

1430 Hooper Ave. - Toms River, New Jersey

SurgiCare

901 West Main St. – Freehold, 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