PATIENT INFORMATION

Doctor you are seeing today: Jason R. Saleh, MD

• PATIENT NAME _____ • Appointment Date _____

• AGE _____ • BIRTHDATE_____ • HEIGHT ____ ft _____ in • WEIGHT _____ lbs

•Please circle: RIGHT handed LEFT handed AMBIDEXTROUS • Please circle MALE FEMALE

•OCCUPATION _____

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

INJURY INFORMATION

• Side of the body you are being seen for today (circle one) LEFT RIGHT BILATERAL

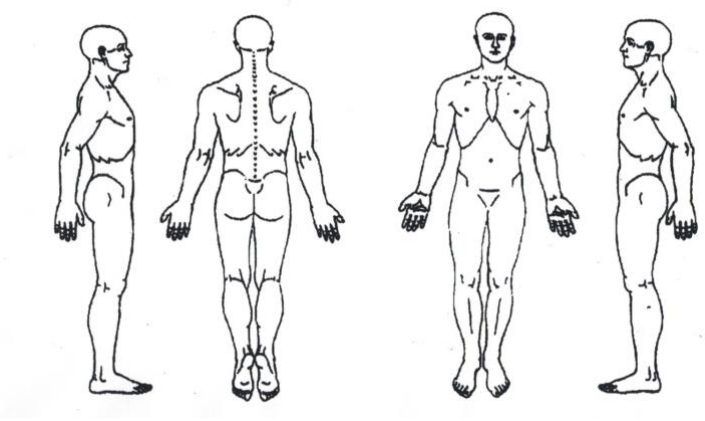
• What body part are you being seen for today (circle one) SHOULDER ELBOW KNEE OTHER _____

• Date of injury or accident or onset of symptoms _____

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

_____
_____
_____
_____

• Location of pain (place mark(s) where you have pain)



• 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

• Character of pain (circle all that apply)

SHARP ACHY DULL BURNING BURNING ELECTRIC STABBING

• What activities or positions make the pain worse?_____

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

SMOKING HISTORY

Do you smoke tobacco? Currently: ☐ Every day? Or ☐ Some days?

☐ Former Smoker? ☐ Never smoked?

DOCTOR INFORMATION

Referring Doctor / Athletic Trainer / Physical Therapist / Friend _____ Family Medical Doctor _____

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

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 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 currently being treated for Osteoporosis or have you had any testing for Osteoporosis?

☐ No ☐ Yes If **YES**, please list the treatment and/or testing you have received and when:

_____

Are you HIV Positive? ☐ YES ☐ NO

Have you received a FLU vaccination within the current flu season? **(FLU SEASON IS OCTOBER 2018 – MARCH 2019)**

☐ No ☐ Yes If **YES**, please list approximately the date you received it: _____

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 number.

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 : <u>All</u> **For the specific purpose of : <u>Any</u>**

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