# DeFabio Spine and Sports Rehab, LLC

*Chiropractic Acupuncture Nutrition*

308 Springfield Avenue Berkeley Heights, NJ 07922 • 908-771-0220 • 908-771-0114

## CONFIDENTIAL PATIENT INFORMATION

**Patient Information** **Today's Date _____**

Patient Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

E-mail _____ Preferred Language _____

Marital Status: ☐ S ☐ M ☐ W ☐ D Ethnicity ___Hispanic/Latino ___Non-Hispanic/Latino

Race _____ Gender ____M ____F ____Left Handed ____Right Handed

Smoking status __Never __Former __Current __How much? _____ SS# _____

Referred By _____ Primary MD _____

Employer/School _____ Occupation _____

Employer/School Address _____

Emergency Contact _____ Emergency Contact Phone Number ___-___-____

**Reason For Today's Visit**

List present complaints and injuries _____

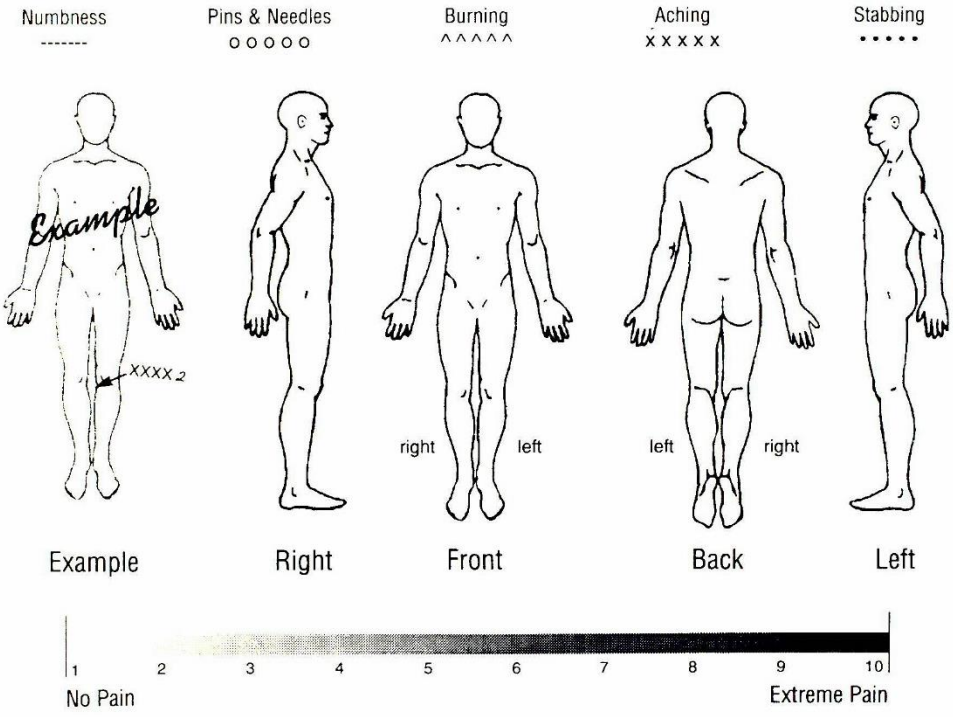
_____

How long have you had this condition? _____ Does it bother you occasionally/frequently/constantly?

Who else have you seen for this condition? _____

What did they recommend? _____

**Pain Scale**




**Patient Signature for Consent to evaluate and treat today: _____**

# DeFabio Spine and Sports Rehab, LLC

## 2019 Insurance Information and Assignment Authorization

**Patient's Name** _____ **Date** _____

**Patient's Social Security # ___/___/___ Insurance Company** _____

**Insurance Policy #** _____ **Group #** _____

**Assignment Authorization and Agreement**

I agree to provide the office with any **information, initial or follow up referral forms** prior to seeing the Doctor that are necessary for treatment or payment and

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable and mailed to:

   DeFabio Spine & Sports Rehab, LLC
   308 Springfield Avenue
   Berkeley Heights, NJ 07922

2. I understand this if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.
4. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**
5. A photo copy of this form shall be as valid as the original.

_____ _____

Patient's Signature Date

**Patient's Notice of Privacy Practices**

I, _____, acknowledge I was given a copy of DeFabio Spine & Sports Rehab's Notice of Privacy Practices, with complete understanding and I had all my questions answered to my satisfaction.

I am authorizing DeFabio Spine & Sports Rehab, LLC to have my name displayed in the office in the form of a 'sign-in sheet' and a 'patient referral sign'.

☐ Yes ☐ No

I may be contacted in the following manner:

☐ E-mail address_____ via defabiochiropractic@gmail.com, a non-encrypted server

☐ Best telephone number to contact me _____

☐ OK to leave a detailed message ☐ Leave a message with a call back number only

☐ I authorize _____access to release my health records

Relationship to patient: _____

_____ _____

Patient's Signature Date

**New Jersey Department of Banking and Insurance**

# CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

## APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.[1] This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

## INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims' arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

## CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [Dr. Donald DeFabio] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

[1] If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

# DeFabio Spine and Sports Rehab, LLC

***Chiropractic Acupuncture Nutrition***

308 Springfield Avenue Berkeley Heights, NJ 07922 • 908-771-0220 • 908-771-0114

# Payment Policy

To pay your balance once your insurance company has processed your visit, a current credit card needs to be on file with authorization of payment. Once the insurance claim is processed your credit card will be charged the balance and an itemized receipt will be mailed to you.

## Payment Authorization

I hereby authorize DeFabio Chiropractic Associates to automatically charge my credit card for:

1 The allowable balance due after my insurance payments are made.
2 For insurance payments sent directly to me.
3 For my co-payment when due.
4 For non-covered services.

A copy of the itemized statement and credit card receipt will be provided for your records.

Would you like a copy of your receipts?
□Yes □No

Name_____ Date_____

Signature_____ Zip code _____

MC Visa #_____ Expiration Date____
CVS___

Am Ex #_____ Expiration Date____
CVS___

**<u>All information is confidential and secure.</u>**