



30B Vreeland Road Suite B-120 Florham Park, NJ 07932 ph) 973-599-9779 fax) 973-599-1179

Richard S. Schenk, MD Anthony Spinnickie, MD Patricio Grob, DO Donald Adams, DO

PATIENT INFORMATION

PATIENT'S NAME: (first) _____ (last) _____

AGE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY _____ - _____ - _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PH: () _____ - _____ CELL PH: () _____ - _____

EMAIL ADDRESS: _____

MARITAL STATUS: SINGLE MARRIED SEPERATED DIVORCED WIDOWED

SEX ASSIGNED AT BIRTH: M F GENDER IDENTITY: M F OTHER _____

EMPLOYER: _____ OCCUPATION: _____

WORK PH: () _____ - _____ EMPLOYER ADDRESS: _____

NAME OF SPOUSE / LEGAL GUARDIAN: _____

PHONE #: () _____ - _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ - _____ - _____

SPOUSE / GUARDIAN'S EMPLOYER: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

PHONE #: () _____ - _____ RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: () _____ - _____

NAME OF PHARMACY: _____ PHONE #: () _____ - _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____



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PAST MEDICAL HISTORY

1. Please list any serious illnesses in your lifetime, (give dates, if known):

2. Please list any prior surgeries (names and dates of operations):

3. Please list any fracture(s) or dislocation(s):

4. Please give the names of treated conditions/and physicians being treated at the present time:

5. Please list names and dosage(s) of any medications you are now taking:

6. Please list any allergies, particularly to any medications:

7. If you have had any of the following, please give the date of onset:

Arthritis _____ Gout _____ Hypertension _____

Diabetes _____ High Blood Pressure _____ Ulcers _____

SIGNATURE: _____ DATE: _____



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INSURANCE INFORMATION

HEALTH INSURANCE (Primary): _____ ID#: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

SSN: _____ - _____ - _____ INSURANCE COMPANY (Secondary): _____

ID#: _____ NAME OF INSURED: _____

DATE OF BIRTH: _____ SSN: _____ - _____ - _____

ARE YOUR INJURIES A RESULT OF A WORK RELATED ACCIDENT? Y / N

ARE YOUR INJURIES A RESULT OF A MOTOR VEHICLE ACCIDENT? Y / N

ARE YOUR INJURIES A RESULT OF A MOTORCYCLE ACCIDENT? Y / N

DATE OF ACCIDENT: _____ POLICY #: _____

CLAIM #: _____

NAME & ADDRESS OF AUTO OR WORKERS COMPENSATION CARRIER : _____

NAME OF ADJUSTER: _____ PH#: () _____ - _____ (EXT) _____

NAME OF CASE MANAGER : _____ PH#: () _____ - _____ (EXT) _____

PLEASE EXPLAIN HOW AND WHERE YOUR INJURIES OCCURRED: _____

HAVE YOU RETAINED THE SERVICES OF AN ATTORNEY AS A RESULT OF YOUR ACCIDENT? Y / N

ATTORNEY NAME: _____ PH#: () _____ - _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____

OFFICE POLICIES

PRESCRIPTION REFILLS: Due to the increased number of refill prescriptions being requested in our office, we must strictly enforce a 48 hour notice policy for all prescription refills. Prescriptions will be filled within 48 hours after your request has been made. Calls for prescription refills should always be made during our usual business hours. Absolutely no refills will be called in on the weekends or after office hours. Always provide the following information when calling for a refill:

**Name of doctor in our office who issued the original prescription*

**Name, spelling, and dosage of the medication*

**Pharmacy name and phone number*

**Any other physicians who are prescribing pain medication*

Please be aware that some controlled substances cannot be called into the pharmacy. The State of New Jersey requires that the original prescription be given directly to the pharmacist in order to fill the request. Your prescription will be ready for pick up within 48 hours of your request. Please make sure that you are up to date on your follow-up appointments with your treating doctor before requesting a refill. Prescriptions requests will not be refilled if a patient continues to miss scheduled appointments. Prescriptions are always refilled at the discretion of your physician and should only be taken as directed.

DISABILITY FORMS: We will be happy to fill out your disability forms at no charge to you, we ask that you please allow 7-10 BUSINESS days for your forms to be completed. You will receive a call from us once they are completed, at which time they can be mailed or faxed to your home or disability address provided.

*****OUR DOCTORS CANNOT FILL OUT ANY FORMS DURING YOUR OFFICE VISIT*****

By signing, I agree that I have read and understand the above office policies:

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

If we do not participate with your insurance, you will be expected to pay at the time of service.

Please be advised that if we are a non-participating provider with your insurance, the carrier may send payment directly to you for services rendered. The Practice asks that you endorse the insurance check to Atlantic Orthopaedic Associates and forward the check and the Explanation of Benefits (EOB) to us within 10 business days of receipt. For bookkeeping purposes, we ask that you send the actual check from the insurance company rather than you depositing the payment and re-issuing the funds to us from your private bank account. This will assist us in appealing to the insurance carrier on your behalf should they not pay in full.

Payment Information:

We will appeal to the insurance on your behalf if payment is not appropriate for emergency services rendered. If your insurance company does not pay the bill in full, or pays based on their usual and customary fees, the balance due will be billed to you. You may be responsible for coinsurance, deductibles and unpaid balances.

Workers Compensation and PIP/Auto: Your insurance will be verified prior to your visit for pre-authorization. All office visits will be pre-authorized by your insurance carrier before your visit. The insurance companies require 72 BUSINESS hours for authorization of treatment. For PIP claims, any deductible and/or co-payments will be billed to you after your insurance pays their portion.

Payment Options: Cash, Check, Money Order, Visa, Mastercard, and American Express. There will be a fee added to any returned or cancelled checks.

Patients who do not show up for a scheduled appointment without notice will be charged a \$100.00 no-show fee. Please call with at least 24 hour notice if you are unable to keep your appointment.

I understand that I am financially responsible for all bills incurred while under the care of Atlantic Orthopaedic Associates, LLC. In the event my account is not paid in full, I shall be liable for any and all costs associated with recovery of payment including but not limited to a 50% fee added to the outstanding balance if my account is forwarded to a collection agency or to an attorney for legal proceedings.

I have fully reviewed this financial policy statement and agree to honor the terms outlined.

I further authorize disclosure of portions of the patient record which are requested by the insurance carrier (These may be necessary to determine reimbursement).

Patient Signature

Date



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HIPAA RELEASE

DATE: _____

PATIENT NAME: _____ DOB: _____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL INFORMATION TO THE FOLLOWING:

(Please write in the names of any family members, friends, or personal attorneys that may call our office on your behalf. If someone is to call our office on your behalf and is not specifically authorized by you below, we will not be able to share any information or speak with them)

You may contact me and leave information via:

- Home phone: () -
- Cell phone: () -
- Work phone: () -
- Email address: _____

SIGNATURE: _____

(PATIENT / OR REPRESENTATIVE)

ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN AND TRANSFER TO ATLANTIC ORTHOPAEDIC ASSOCIATES, ALL RIGHTS IN
ANY AND ALL CLAIMS WE HAVE, OR MAY HAVE AGAINST:

(NAME OF INSURANCE CARRIER)

FOR PAYMENT OF INSURANCE CLAIMS MADE BY ATLANTIC ORTHOPAEDIC ASSOCIATES
FOR SERVICES RENDERED TO ME AS A RESULT OF THE INJURIES SUSTAINED ON

(DATE OF INJURY)

I AUTHORIZE AOA TO SUBMIT APPEALS, ON MY BEHALF, FOR ANY UNPAID CHARGES FOR
SERVICES RENDERED TO ME AND BILLED TO ABOVE-MENTIONED INSURANCE CARRIER. I
AUTHORIZE ATLANTIC ORTHOPAEDIC ASSOCIATES TO RELEASE MEDICAL RECORDS FOR APPEALS
AND INDEPENDENT ARBITRATION OF CLAIMS.

PATIENT NAME: _____

WITNESS NAME: _____

ADDRESS: _____

ADDRESS: 30B Vreeland Rd. Suite B-120
Florham Park, NJ 07932

TELEPHONE: (_____) _____ - _____

TELEPHONE: (973) 599 - 9779

X _____
(PATIENT SIGNATURE)

X _____
(WITNESS SIGNATURE)