PATIENT INFORMATION

NORTH JERSEY PEDIATRIC Orthopedics

Date:

Patient Full Name: Sex: Date of Birth: Age:

Home Phone: Cell Phone: Work Phone:

Address: City: State: Zip:

Child SSN #: Ethnicity: *(Prefer not to answer)*

Parents Names:

Referred by: *Family members treated by Dr. Avella*

PEDIATRICIAN'S INFORMATION

Pediatrician's Full Name: Pediatrician's Phone #:

Address: City: State: Zip:

Reason for Today's Visit:

Please Select: **Right** **Left** **Both** **Spine**

Date Problem Began: How did this ocur?

Please select one if applicable: School Accident Chronic Condition Sport Injury Noticed at Birth

Were you seen in the ER? Date of Visit: Which ER?:

Patient Information Height: Weight: Last Menstrual Period (date):

List Any Patient Allergies: Are you pregnant?: Yes No

Medical History: **(Check all that apply)**

- Asthma
- Seasonal Allergies
- Cerebral Palsy
- ADHD
- Emotional or Psychiatric Disorder
- Fractures
- Sprains
- Dislocation
- Bone or Joint Infections
- Scoliosis

List any Regular Medications Here:

Does the patient smoke? Do any family members smoke?

Please document any unlisted Medical Problems:

Please document any surgeries:

Birth History Birth Weight:

Please select delivery presentation type: Head First Breech Twin C-Section

In ICU after delivery?

Please list any peri-natal complications:

Print

Insurance Information

Primary Insurance Information

Primary Insurance Company Name: Phone Number:

Subscriber ID Number: Group Number:

Ins. Co. Address: City: State: Zip:

Person Responsible for Account (Guarantor): Phone Number:

Relationship to Patient: Guarantor's Birth Date: SS#:

Address: City: State: Zip:

Employer: Work Phone #: Occupation:

Business Address: City: State: Zip:

Secondary Insurance Information

Secondary Insurance Company Name: Phone Number:

Subscriber ID Number: Group Number:

Ins. Co. Address: City: State: Zip:

Person Responsible for Account (Guarantor): Phone Number:

Relationship to Patient: Guarantor's Birth Date: SS#:

Address: City: State: Zip:

Employer: Work Phone #: Occupation:

Business Address: City: State: Zip:

Assignment and Release

I hereby authorize payment directly to Dr. Avella, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: **Date:**

Print

PAYMENT FOR SERVICES POLICY AND PROCEDURE

I understand that my insurance policy with my insurance company is an arrangement between me and my insurance company, and acknowledge that I am responsible, and agree to make payment of my co-pay, co-insurance and applicable deductible amounts to North Jersey Pediatric Orthopedics, P.A. immediately as and when each are demanded by North Jersey Pediatric Orthopedics, P.A.

Initial: _____

I further understand and acknowledge that North Jersey Pediatric Orthopedics, P.A. is an out-of-network provider and it is my responsibility to ensure that I have obtained proper authorization and referrals for the services that I will be receiving from North Jersey Pediatric Orthopedics, P.A.

Initial: _____

I understand that my insurance policy is a contract between me and my insurance carrier. North Jersey Pediatric Orthopedics, P.A. is not a party to that contract. North Jersey Pediatric Orthopedics, P.A. bills my insurance company as a courtesy to me. Nevertheless, I am responsible for payment regardless of my insurance company's decision to deny coverage or to reimburse less than the allowable charge.

Initial: _____

I hereby authorize North Jersey Pediatric Orthopedics, P.A. to appeal any denial of coverage by my health care provider for services rendered by North Jersey Pediatric Orthopedics, P.A. to my child. I further understand and acknowledge that any payment issued by my insurance carrier for services rendered by North Jersey Pediatric Orthopedics, P.A. as a result of this appeal must be remitted to North Jersey Pediatric Orthopedics, P.A. In the instance my appeal is denied, I remain responsible for all payments due and owing North Jersey Pediatric Orthopedics, P.A. for services rendered.

Initial: _____

I further understand and agree that I am responsible to pay for those services and orthotics, supplies or equipment that are not part of my insurance policy, and/or for which my insurance company denies coverage for any reason.

Initial: _____

I hereby request without imposing any obligation on North Jersey Pediatric Orthopedics, P.A. that my insurance company be billed for the services that I have or will receive in the future at North Jersey Pediatric Orthopedics, P.A. In exchange for not having to pay in advance for those services (or portion of services) that I am receiving which are, or may be covered by my out-of-network benefits, I agree to forward North Jersey Pediatric Orthopedics, P.A. all checks and explanations of benefits that I receive from any of my insurance companies related to services that I have received at North Jersey Pediatric Orthopedics, P.A. within five (5) days of receiving them, and further agree that if I fail to forward any such payment, I will be held fully responsible for payment of the amount I receive from my insurance companies for such services, plus interest of 18% per year calculated on a daily basis at a rate of .0495%, payable beginning five (5) days from the date that I receive such payment from my insurance companies, plus all attorneys' fees and costs incurred by North Jersey Pediatric Orthopedics, P.A. for collection of such amount(s) from me. In the event that I fail to turn over my insurance payments mailed directly to me, and the account is turned over to a collection agency, I will be held responsible for all collection costs, including but not limited to attorneys' fees.

Initial: _____

I have read and initialed the aforementioned Payment for Services Policy and Procedures and fully agree to all its terms and conditions.

Signature: _____ Date: _____

Please print your name: _____ Print

NORTH JERSEY PEDIATRIC ORTHOPEDICS, P.A.
140 Chestnut Street
Ridgewood, NJ 07450
Telephone: (201) 612-9988
Fax: (201) 445-9050

YOUR INSURANCE COMPANY

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way we can possible know, or keep

up to date with each program's provisions.

- Some programs require a specific facility to be used for your MRI, CT Scans, ultrasounds or blood tests.
- Some programs require per-authorization, while others do not.
- Some insurance companies require PATIENTS notify them of hospital admissions or trips to the Emergency Room.

IT IS YOUR RESPONSIBILITY TO KNOW

Whether this office participates with your particular plan or program.
To advise this office of your program's requirement in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

OUT OF NETWORK COVERAGE

You should be aware that in the event an out of network insurance plan covers all or part of your treatment, payment for some may be mailed directly to you. As courtesy to our patients we file insurance. However, we will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covers charges, secondary insurance or other matters regarding payment.

RECORDS

You, the patient are entitled to any and all records that pertain to your medical condition. For medical/legal reason we never release the original records. Records are only released to the patient or someone that the person specifically designates. Copies of the office assessments, outside test results, and e-rays are available. If you would like to view your records or obtain copies of your records the office will comply with your request within 30 days after a written release is received. Please note that there is a fee for copying records and x-rays.

PATIENT PRIVACY

In order to protect your privacy and in accordance with Federal Law, we do not leave confidential medical information on answering machines or with anyone other than the patient or patient's legal guardian without prior authorization. Please read and sign below acknowledging receipt of this policy.

Please indicate below your preference:

- ☐ We may leave detailed messages on this answering machine #:
- ☐ Do not leave detailed messages on any answering machine.
- ☐ Permission to fax medical instructions to my child's school.

Signature: _____ Date: _____

Please print your name: _____ Print

CREDIT CARD AGREEMENT AND AUTHORIZATION FORM

Name on Card: _____ DOB for Cardholder: _____

Patient Name: _____ Relationship to Patient: _____

Type of Card: ☐ Visa ☐ MasterCard ☐ AmEx

Account Number: _____

Expiration Date: _____

Security Code: _____

Billing Address: _____

Phone Number: _____

The purpose of this form is to authorize North Jersey Pediatric Orthopedics, P.A. ("North Jersey Pediatric") to retain a valid credit card number on file. This form will be kept confidential and only authorized staff will have access to this information.

By signing this form, you authorize North Jersey Pediatric to charge your credit card ONLY under the following conditions:

North Jersey Pediatric reserves the right to charge the credit listed above for the total amount of any payment issued by your insurance carrier for the services rendered which you receive but do not forward to North Jersey Pediatrics within thirty (30) days of issuance. In this instance, North Jersey Pediatric will charge your credit card the amount covered by your insurance carrier for services rendered. North Jersey Pediatric shall not be responsible for providing you with additions notice before such charges are processed.

Payment for each visit is due at the time of check-out. The amount of payment due and owing for each visit varies based upon the diagnosis code, a determination which cannot be made before the physician's evaluation. You are required to make the payment for each visit upon check-out. By signing below you are also authorizing North Jersey Pediatric to charge the below credit card in the amount for the visit today, in the instance that you leave this office without checking out. This amount varies depending upon the diagnosis but shall not exceed $1,500.00. North Jersey Pediatric shall not be responsible for providing you with additional notice before such charges are processed.

NOTHING IN THIS AGREEMENT SHALL PROHIBIT NORTH JERSEY PEDIATRIC FROM PURSUING COLLECTION OF ANY MONIES THAT COME DUE AND OWING FOR SERVICES RENDERED WHICH MAY NOT BE COVERED BY YOUR INSURANCE CARRIER, INCLUDING BUT NOT LIMITED TO, DEDUCTIBLES, COINSURANCE, COPAYMENTS OR OTHER SERVICES RENDERED.

Having read this form and talked with the physician and/or staff, my signature below acknowledges that I voluntarily give my authorization and consent providing the requested information for my credit card to be charged accordingly for the conditions listed above.

I understand that this form is valid until _____ unless I cancel through written notice to North Jersey Pediatric. Cancellation will not be sufficient until all outstanding claims are paid for services already rendered.

Signature: _____ Date: _____ Print