The Advanced Spine Center

PATIENT INFORMATION:

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SOCIAL SECURITY #
STREET ADDRESS/ P.O. BOX		CITY	STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE	SEX ☐M ☐F	MARITAL STATUS ☐M ☐W ☐S ☐D ☐CU	
EMAIL ADDRESS	PHONE # TO BEST CONTACT YOU: ☐Home ☐Work ☐Cell	ETHNICITY ☐ **Latino/Hispanic** ☐ **Other** ☐ **Not Reported/Refused**			
PRIMARY PHYSICIAN, ADDRESS & PHONE NUMBER			RACE		
REFERRING PHYSICIAN, ADDRESS & PHONE NUMBER			LANGUAGE		
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	

GUARANTOR/RESPONSIBLE PARTY: (If different from above)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY #	
STREET ADDRESS/ P.O. BOX		CITY	STATE	ZIP	
EMAIL ADDRESS	HOME PHONE	WORK PHONE	CELL PHONE		
EMPLOYER	EMPLOYER STREET ADDRESS		CITY	ZIP	

EMERGENCY CONTACT:

NAME	PHONE	RELATIONSHIP
NAME	PHONE	RELATIONSHIP

INSURANCE/POLICY HOLDER INFORMATION: (Please present insurance cards to receptionist)

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐M ☐F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Parent ☐Child ☐Other		CO-PAY AMOUNT

SECONDARY INSURANCE:

PRIMARY INSURANCE	EFFECTIVE DATE	POLICY HOLDER NAME	SEX ☐M ☐F	POLICY HOLDER BIRTHDATE
POLICY NUMBER	GROUP NUMBER	RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Parent ☐Child ☐Other		CO-PAY AMOUNT

PHYSICIAN TREATING YOU TODAY:	REFERRED BY:

IS THIS INJURY/ACCIDENT RELATED TO: ☐ WORK ☐ MOTOR VEHICLE ☐ SCHOOL ☐ OTHER	
DATE OF INJURY/ACCIDENT	CLAIM NUMBER

I the undersigned give my authorization to treat and assign directly to Advanced Spinal Care & Associates LLC "dba: The Advance Spine Center", all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature of patient or patient's representative

Date

The Advanced Spine Center

160 E. Hanover Avenue, Suite 201
Morristown, NJ 07960

89 Sparta Avenue, Suite 250
Sparta, NJ 07871

720 US 202/206 North, Bldg. 2
Bridgewater, NJ 08807

Mailing Address: P.O. Box 2266, Morristown, NJ 07962 Phone (973) 538-0900 Fax (973) 538-0909

PATIENT FINANCIAL RESPONSIBILITY, CONSENT & ASSIGNMENT OF BENEFITS FORM

(Revised November 15, 2017)

Date: _____

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. As a courtesy, Advanced Spinal Care & Associates LLC "dba: The Advanced Spine Center" agrees to accept the ALLOWABLE amount determined by my insurance carrier for all claims processed properly. For participating insurance plans, I understand that I am responsible for referrals, authorizations and/or any specific requirements to the plan. Information on participation status is available upon request. Also I understand that I am responsible for payment of any co-payment, coinsurance and/or deductible applied against claims submitted whether for in-network or out-of-network benefits. I further understand that it is my responsibility to assure all claims are processed by my carrier and to appeal any claim determined by The Advanced Spine Center to be paid unfairly or inequitable as determined by usual payment received from other carriers for similar services. I also agree to remit payment at the time of the visit or upon receipt of bill for coinsurance / deductible.

I understand that I am financially responsible to The Advanced Spine Center for any charges not covered by health care benefits. It is my responsibility to promptly notify The Advanced Spine Center of any changes in my health care coverage and any other personal or contact information provided to the practice. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by The Advanced Spine Center and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for professional services received. Any outstanding balance for which a patient is responsible is due within 30 days of billing. Any patient balance that has gone 90 days without being paid in full is subject to immediate collection process. Services that are transferred to collection status shall accrue interest at the rate of 1% per month or the maximum rate allowable by law, whichever is less, on any outstanding balance calculated from the date payment was originally due. In the event that payment is not timely made, I understand that The advanced Spine Center may retain an attorney to assist in the collection process; and that I shall be financially responsible for any and all cost and fees incurred by The Advanced Spine Center in collecting or attempting to collect any amounts due and owing, including but not be limited to reasonable attorney fees, costs, and expenses whether or not a lawsuit has been filed. A returned check fee of $35.00 will be applied to any account for checks returned to us for insufficient funds.

_____
Initials

Assignment of Benefits

I hereby give my authorization to treat and assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to The Advanced Spine Center, including but not limited to, my right to appeal and sue for reimbursement and benefits. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to The Advanced Spine Center for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I understand and agree that should my insurance carrier(s), including medicare, private insurance and any other health/medical plan, issue payment direct to me instead of The Advanced Spine Center, all such payments shall be expressly held in trust by me for the benefit of The Advanced Spine Center; and I shall immediately endorse and tender said payment over to The Advanced Spine Center.

I hereby assign my rights, title and interest under the medical expense section and/or PIP section of my insurance policy to The Advanced Spine Center to bring a lawsuit or arbitration against my insurance carrier(s). This allows The Advanced Spine Center to retain an attorney of their choice to filing litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against my insurance carrier, or any other company, against which I may proceed for medical expense benefits. Unless revoked, this assignment is valid for all administrative and judicial reviews under the Patient Protection and Affordable Care Act, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

_____
Initials

Charles A. Gatto, M.D. Spine Surgery
Jason Lowenstein, M.D. Pediatric/Adult Scoliosis Spine Surgery
George S. Naseef, M.D. Spine Surgery
Jamie DiGraziano Physician Assistant
Matthew Hirschhorn Physician Assistant
Sarah J. Ries Physician Assistant

Authorization to Release Information

I hereby authorize The Advanced Spine Center to: (1) release any information necessary to insurance carriers, their employees and/or agents, regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment, including but not limited to filing arbitration/litigation in The Advanced Spine Center's name on my behalf; and (3) allow a photocopy of my signature to be used to process insurance claims.

I further authorize The Advanced Spine Center to release my medical records and/or information regarding my care to the following **friend** or **family member**:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The above authorizations will remain in effect until revoked by me in writing. Any revocation has prospective effect only. I have requested medical services from The Advanced Spine Center on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I have been informed whether my services will be reimbursed at an out-of-network level. I knowingly, voluntarily and specifically select The Advanced Spine Center as my medical provider.

_____ _____

Patient/Responsible Party Signature Date

_____

Print Name Patient/Responsibility

The Advanced Spine Center

160 E. Hanover Avenue, Suite 201
Morristown, NJ 07960

89 Sparta Avenue, Suite 250
Sparta, NJ 07871

720 US 202/206 North, Bldg. 2
Bridgewater, NJ 08807

Mailing Address: P.O. Box 2266, Morristown, NJ 07962 Phone (973) 538-0900 Fax (973) 538-0909

Prescription Policy and Refill Request Procedures

Please call 3 business days before your medication is due to be refilled. This will allow us ample time to fulfill your request.

1. Please call the office at (973) 538-0900 between the hours of 9:00am and 4:00 pm Monday – Thursday and Fridays 9:00 – 12:00 Noon.
2. All refills called in after 2:00 pm **will not be** addressed until the next business day.
3. Please give all relevant information whether speaking to a person or leaving a message:
    A. First and last name and your date of birth
    B. Phone number where you can be reached
    C. Name of the medication and dosage information
    D. Pharmacy name and number

    Please be advised that you are to only use 1 pharmacy to fill your medications.
4. Any medications that need to be hand written may be picked up in the Sparta office on Tuesdays or the Cedar Knolls office on Fridays. **Prescriptions will NOT be mailed.**
5. All patients must have a follow-up appointment scheduled with the doctor within **90 days** when receiving Schedule II narcotics as mandated by New Jersey State Law. All others must have a follow up appointment scheduled as mandated by the doctor.
6. **You may NOT receive narcotics from multiple physicians.**
7. You must take the medication as prescribed by the doctor. You may **NOT** vary the dosage without authorization from the doctor.
8. **Any unauthorized alterations or modifications to a prescription are cause for immediate discharge from the practice.**

    Please note that you are responsible to make sure that you DO NOT run out of your medications on weekends or holidays.

I hereby understand and will comply with the above set refill request and prescription policy. Any violation of the above set rules will result in the immediate cessation of services provided to you by Advanced Spinal Care & Associates LLC ("The Advanced Spine Center".

Pharmacy Name: _____ Pharmacy #: _____

Sign: _____ Date: _____

Doctors Initials: _____

YOUR DOCTOR(S) INFORMATION

PATIENT FIRST NAME:	PATIENT LAST NAME

PRIMARY CARE PHYSCIAN		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Office Phone:	Fax:	

CARDIOLOGIST		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Office Phone:	Fax:	

PULMONOLOGIST		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Office Phone:	Fax:	

OTHER SPECIALIST		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Office Phone:	Fax:	

OTHER SPECIALIST		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Office Phone:	Fax:	

OTHER SPECIALIST		
First Name:	Last Name:	
Address:		
City:	State:	Zip:
Office Phone:	Fax:	
*If you have additional doctors, please list them on the supplementary form provided at the end of this document		