Relievus™

Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

This packet is for patients who have an active claim for MVA, Workers' Comp, and slip & fall injury

Our Commitment to You

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must reschedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.

If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that your keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration form and several other forms be completed by you.
- We are sorry, but due to the high fax volume we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
    1. Referral, if required by insurance
    2. Active valid insurance card
    3. Case number or claim number for auto insurance or workers' comp
    4. Photo ID
    5. MRI films and reports, CT scan films and reports, bone scan reports
    6. EMG reports
    7. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, etc.)
    8. List of current medications
    9. Auto insurance policy declaration page (PIP coverage)

Medication Policy

- It is important to your health that you follow directions carefully on all medications that we prescribe.
- In addition, we must be informed of all other medications, prescription or over-the-counter.
- We will **NOT** refill controlled medications in advance of their refill date.

- We will **NOT** mail prescriptions.
- We will **NOT** prescribe any opioid (narcotic) medications at the first visit.
- They must be given to you **IN PERSON** at the time of your appointment.
- If there is an unavoidable reason that you cannot make an appointment, we require a 3-day notice for a medication refill.

Financial Policy

- We are committed to providing you with the best possible care.
- We expect that you have an understanding of your responsibilities under your insurance contract with respect to referral and preauthorization requirements as well as your deductible, co-pay, and coverage limits.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at the time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans with which we participate, we will bill your insurance company along the guidelines of our contract. However, we require that **all co-pays or deductibles be paid at the time of service.**
- If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse to you directly any amount due.
- Returned checks will be subject to **an additional $25 service fee**.
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.

Missed Appointments

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.
- **Missed appointments for procedure performed at surgery incurs a fee of $100. This includes not following instructions - stopping of medications, food/drink restrictions, and a driver.**

I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for this account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney's fee, court cost, and related collection fees incurred.

_____ X _____ _____

Patient Name Signature Date

PATIENT INFORMATION

Last Name: _____ First Name: _____ SEX: M F

If patient is a minor, name of parent or guardian accompanying patient:_____

Relationship to patient: _____ Phone # (if different): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ 2nd Phone: _____ Email: _____

Date of Birth: _____ SS#: _____ married single divorced widowed (circle one)

Referred by: _____ Phone: _____ Location: _____

Family Doctor: _____ Phone: _____ Location: _____

INSURANCE

Date of accident:(If applicable): _____ Type of Accident: _____

Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at the time.

_____

Primary Insurance Name: _____ Auto Health W/C (circle one)

Phone #: _____ Adj.: _____ Ext.: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Secondary Insurance Name: _____ Auto Health W/C (circle one)

Phone #: _____ Adj.: _____ Ext.: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Tertiary Insurance Name: _____ Auto Health W/C (circle one)

Phone #: _____ Adj.: _____ Ext.: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Attorney Name: _____ Firm: _____

Location: _____ Phone: _____

Employer Name (If W/C injury): _____ Phone: _____

Emergency Contact: _____ Phone: _____

Are we authorized to release your medical information to the listed emergency contact? Yes or No (circle)

SIGNATURE: _____ DATE: _____

IRREVOCABLE ASSIGNMENT OF BENEFITS / LETTER OF PROTECTION / LEIN

I / ME/ MY, _____, the insured and/or beneficiary of the policy of _____ insurance providing medical benefits to me, do hereby authorize you, Relievus, medical benefits due to me under the terms of the applicable policy(s) issued by our company(s). Payment is authorized upon receipt of the itemized statement for services rendered. This insurance policy was in full force and effect at the time services were rendered. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me, the insured. A photocopy of this assignment shall be valid as the original.

I authorize Relievus to obtain legal counsel by and through any law firm of their choosing and to enter into legal (PIP Arbitration) or other action to collect such sums due it, should sums not be paid within the legally prescribed time period. I do hereby promise full and complete cooperation with Relievus' legal counsel, including attending any type of medical examination (IME), deposition, arbitration, or court proceeding. I understand that should I fail to cooperate with the legal counsel, I may be held personally responsible to Relievus for any expense not covered by this assignment / letter of protection (hereinafter referred to as an "LOP") and/or expenses not recovered due to my failure to cooperate.

Authorization to Release Medical Records

The undersigned hereby consents and authorizes the release of any and all medical records, reports, films, etc. directly to Relievus and/or their designated legal counsel, directly from _____ or any and all hospitals, diagnostic facilities, or physicians that have rendered medical treatment, diagnostic testing, or any type of medical services to the undersigned as a patient.

Authorization to Release Information

_____ is hereby authorized to release to Relievus and /or their designated legal counsel all or any part of my medical record, billing information, insurance policy information, EOBs, and any information contained in my PIP file.

Financial Responsibility

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by Relievus. I hereby agree to immediately forward said check(s) to Relievus upon receipt of same. It is understood and agreed that should I receive benefit checks and fail to forward any benefit checks to Relievus, Relievus does maintain the right to request checks from me and initiate any and all collections efforts against me. If such action is taken by Relievus, I agree to be responsible for any and all benefit checks received plus any and all reasonable collection cost incurred including, but not limited to, attorney fees, interest, expert fees, and court costs.

Letter of Protection / Attorney Directive / Irrevocable Assignment

I hereby irrevocably authorize my attorney _____, Esquire to pay directly to Relievus sums as may be due and owing for services rendered by Relievus, and to withhold such sums from any bodily injury policies, disability, medical payment benefits, no-fault benefits, health and accident benefits, workers' compensation benefits, or any other insurance benefits obtained to reimburse the undersigned, or from any settlement, verdict or judgment which may be paid to me or my attorney as a result of the injury or illness for which I have received service from Relievus.

I irrevocably assign to Relievus all rights and benefits under my insurance contracts for the payment of services rendered by Relievus. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Relievus be released to Relievus and/or their legal counsel. I irrevocably authorize Relievus to file insurance claims on my behalf for service rendered to me. I irrevocably direct that all such payments go directly to Relievus. I irrevocably authorize the above medical provider, and/or their legal counsel, to be preset at all legal proceedings with regard to my Personal Injury Protection (PIP) benefit, including but not limited to Examinations Under Oath (EOU), depositions, whether there is pending litigation or not (e.g. Arbitrations or Court Proceedings).

DATE: _____ PATIENT'S SIGNATURE: _____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agree to withhold such sums from any settlement, verdict, or judgment as may be necessary to fully protect Relievus' rights to be compensated for services rendered and related to the above-captioned claim/case. This agreement is irrevocable.

DATE: _____ ATTORNEY'S SIGNATURE: _____

Note: Attorney, kindly sign and date one copy and return as soon as possible to the address listed above as an acknowledgment of this document.

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Relievus provides care for chronic problems. As such, our patients are not expected to require urgent care or immediate contact with this practice after hours. If you have an urgent medical problem after regular business hours (8:00 AM to 5 PM Monday through Friday) or over the weekend, you should do one of the following:

- Contact your primary care physician
- Go to an urgent care center
- Go to the emergency department of the nearest hospital

It is permissible that you obtain medications from these physicians for any acute pain or new injury that you have.

It is your responsibility to contact us within the next two business days to inform us of any changes, additions, or deletions made to your narcotic regimen. All non-narcotic changes should be reported at your next office visit.

_____

Patient Name

_____

Patient Signature

_____

Date

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Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Relievus, is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information Check each person/entity that you approve to Receive information.	**Description of information to be released** Check each that can be given to person/entity on the left in the same section.
o Voice Mail	o Results of lab tests/x-rays Other_____
o Spouse (provide name & phone number) _____	o Financial o Medical as follows:_____
o Parent (provide name & phone number) _____	o Financial o Medical as follows:_____
o Other (provide name & phone number _____	o Financial o Medical as follows:_____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
If you have any questions about this Notice please contact
Relievus

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care service.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our web site www.relievus.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1.Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when have the necessary permission from you to disclose your protected health information. For example, your protected health information is provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pay for the health care services we recommend for you such as; making a determination of eligibility or coverage of insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your health information, as necessary, to contact you to remind you of your appointment and, if you are unavailable, we may leave the information with another member of your household or on your voice mail.

We will share your protected health information with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclosed your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits land services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contract and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and Disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your physician may, using professorial judgment, determine whether the disclosure is in your

best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on out professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object: We may use or disclose your protected health information in the following situation without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such or disclosures.

Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency got activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit program, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state law.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviation, tract products; to enable product recalls; to make repairs replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such

disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purpose include (1) legal processes and otherwise required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises or the practice, and (6) medical emergency (not on practice's premises) and it's likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to reasonable anticipation of death. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purpose.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state law, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected information in the course of providing care for you.

Required Uses and Disclosure: Under the law, we must make disclosure to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

2. Your Rights:

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as

we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have the decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not or disclose any part of your protected health information for the purpose of treatment, payment or health operation. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by (**describe how patient may obtain a restriction.)**

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purpose. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain; restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

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(**Relievus**)
Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature _____ Date _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- o An emergency existed and a signature was not possible at that time.
- o The individual refused to sign.
- o A copy was mailed with a request for a signature by return mail.
- o Unable to communicate with the patient for the following reason:

  _____

- o Other:_____

  _____

Prepared by _____

Signature _____

Date _____

Relievus™

Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

PATIENT NAME: _____ DATE: _____

TREATING PHYSICIAN:

☐ _____, M.D. ☐ _____, M.D. ☐ _____,M.D.

HISTORY OF PRESENT ILLNESS:

I am a _____year-old ☐ male ☐ female
and I was involved in a(n): ☐ automobile accident ☐ slip and fall accident ☐ injury at work
☐ other _____

My injury occurred on: _____/_____/_____

If an automobile accident-related injury, (check all that apply):
☐ I was the driver ☐ I was a passenger sitting in the: ☐ front seat ☐ back seat

Were you wearing a seatbelt? ☐ yes ☐ no Did you hit your head? ☐ yes ☐ no
Did you lose consciousness? ☐ yes ☐ no Were you dazed? ☐ yes ☐ no

The car I was riding in was hit:
- ☐ in the rear
- ☐ on the driver's side
- ☐ on the passenger's side
- ☐ in the front
- ☐ other _____

The other car:
- ☐ ran a stop sign
- ☐ ran a red light
- ☐ lost control
- ☐ pulled out into my car
- ☐ other

_____

Did you go to the hospital after the accident? ☐ yes ☐ no (if yes, answer A, B, C, D, and E)

A. By ambulance? ☐ yes ☐ no
That day? ☐ yes ☐ no The next day? ☐ yes ☐ no

B. Were you place on a backboard? ☐ yes ☐ no With a neck brace? ☐ yes ☐ no

C. Which hospital did you go to?

_____

D. Were x-rays taken? ☐ yes ☐ no If yes, taken of my:

_____

E. Were you admitted to the hospital overnight? ☐ yes ☐ no

If you did not go the hospital, where and when did you first seek medical treatment?

_____

_____

Since the accident, have you had problems with headaches? ☐ yes ☐ no

Which part of the head? _____

How often? _____

How long do they last? _____

Nausea:	☐ yes	☐ no	Vomiting:	☐ yes	☐ no
Sensitivity to sound:	☐ yes	☐ no	Sensitivity to light:	☐ yes	☐ no
Memory loss:	☐ yes	☐ no	Difficulty concentrating:	☐ yes	☐ no
Confusion:	☐ yes	☐ no			
Blurry vision:	☐ yes	☐ no	☐ right ☐ left		
Ringing in ears:	☐ yes	☐ no	☐ right ☐ left		
Hearing loss:	☐ yes	☐ no	☐ right ☐ left		

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PATIENT NAME: _____ DATE: _____

On a scale of one to ten, with one being no pain and ten being intolerable pain, circle the number that would indicate your average pain level.

1 2 3 4 5 6 7 8 9 10

SINCE THE ACCIDENT, WHICH STATEMENTS BEST DESCRIBE YOUR PAIN? (check all that apply)

☐ I have pain in my neck. ☐ The pain radiates into my arm(s)/hand(s) on the: ☐ left ☐ right
☐ I have weakness in my: ☐ right arm/hand ☐ left arm/hand
☐ I have numbness in my: ☐ right arm/hand ☐ left arm/hand

☐ I have pain in my back. ☐ The pain radiates into my leg(s)/foot on the: ☐ left ☐ right
☐ I have weakness in my: ☐ right leg/foot ☐ left leg/foot
☐ I have numbness in my: ☐ right leg/foot ☐ left leg/foot

CURRENT TREATMENT:

I go to physical therapy or a chiropractor _____ times per week.
Check the best answer: ☐ I have had some improvement. ☐ I have had no improvement.
☐ I have had minimal improvement. ☐ I am no longer receiving therapy.

PAST TRAUMA:

Have you ever had an injury like this before? ☐ yes ☐ no

If yes, explain:
_____

_____

_____

_____

PAST MEDICAL HISTORY:

☐ diabetes ☐ high blood pressure ☐ asthma ☐ thyroid disease ☐ lung disease ☐ heart disease
☐ kidney disease ☐ other
_____

PAST SURGERIES:

☐ tonsils ☐ appendix ☐ gall bladder ☐ tubal ligation ☐ hysterectomy ☐ back surgery
☐ neck surgery ☐ carpal tunnel release ☐ hernia repair ☐ heart surgery
☐ other
_____

MEDICATIONS:

_____

_____

_____

Relievus™

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PATIENT NAME: _____ DATE: _____

DRUG ALLERGIES:

Are you allergic to any medications? ☐ yes ☐ no If yes, list all:

_____

_____

DIAGNOSTIC STUDIES:

Have you had any x-rays, MRIs, cat scans, bone scans, EEGs, EMG/NCVs (nerve tests)? ☐ yes ☐ no

If yes, please list all tests completed and where they were done.

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ yes ☐ no How much? _____ packs per day.
Do you drink alcohol? ☐ yes ☐ no How much? _____

Since the accident, I have been:
☐ working as a _____ ☐ I have not been able to return to work
☐ full time ☐ part time ☐ light duty
☐ homemaker ☐ unemployed, but usually work as
_____

FAMILY HISTORY:

☐ diabetes ☐ high blood pressure ☐ cardiac disease ☐ cancer – type
_____ ☐ alcohol/drug addiction ☐ adopted

REVIEW OF SYSTEMS:

Do you have any of the following?

General: ☐ weight loss/gain ☐ fatigue ☐sleep dysfunction

Head: ☐ headaches ☐ dizziness ☐ confusion

Skin: ☐ rash ☐ color changes ☐ abnormal hair growth ☐ nail changes

Ears: ☐ decreased hearing ☐ right ☐ left
☐ pain in ears ☐ right ☐ left
☐ ringing in ears ☐ right ☐ left
☐ blood or drainage ☐ right ☐ left

Eyes: ☐ decreased vision ☐ right ☐ left
☐ double vision
☐ pain ☐ right ☐ left
☐ redness ☐ right ☐ left
☐ history of glaucoma ☐ right ☐ left
Date of last eye examination _____

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PATIENT NAME: _____ DATE: _____

Respiratory: ☐ cough ☐ difficulty breathing ☐ pain over ribs ☐ other breathing pain _____

Cardiac: ☐ chest pain ☐ palpitations ☐ passing out (explain) _____

GI: ☐ nausea ☐ difficulty swallowing ☐ bleeding ☐ fecal incontinence

GU: ☐ blood in urine ☐ frequency ☐ burning ☐ incontinence

PATIENT SIGNATURE _____

REVIEWING PHYSICIAN'S SIGNATURE _____

Rev. 05/11/12

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ASSIGNMENT OF BENEFITS

I, _____, the insured and/or beneficiary of the policy or policies of _____ Insurance proving medical benefits to me, do hereby authorize you to pay directly to Relievus, Advanced Spine and Pain, LLC., medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company.

Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due, should sums not be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider including attending of any type of Deposition, Arbitration, or Court proceeding. I irrevocably authorize the above medical provider, and/or their legal counsel, to be present at all legal proceedings with regard to my Personal Injury Protection (PIP) benefits, including but not limited to Examinations Under Oath (EOU), depositions, whether there is pending litigation or not (e.g. Arbitrations or Court proceedings). I understand that if I fail to cooperate with legal Counsel, I may be held personally responsible to the medical provider for any expenses not covered by this assignment. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original. Should any penalties be applied to the provider as per N.J.A.C. 11:3-4.9 the provider agrees to hold the patient harmless of payment of such penalties.

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by the provider. I hereby agree to immediately forward said checks to the provider upon receipt of the same. It is understood and agreed that should I not forward any benefits to the provider, the provider does maintain the right to request checks from me and initiate any and all collections efforts. If such action is taken by the provider, I agree to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and Court costs.

I irrevocably assign to above company or provider all rights and benefits under any insurance contracts for payment of services rendered to provider. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by provider to be released to provider. I irrevocably authorize provider to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to provider. I irrevocably authorize provider to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Claimant: _____
(Patient name please print)

Legal Signature: _____
(if a minor, parent or guardian must sign)

Patient Signature: _____

Date: _____

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Appendix 7 -Waiver of Liability Statement
(Rev. 105, Issued: 04-20-12, Effective: 04-20-12, Implementation: 04-20-12)

WAIVER OF LIABILITY STATEMENT

_____	_____
Enrollee's Name	**Medicare HIC Number**
_____	_____
Provider	**Date**
_____	_____
Health Plan	**ID Number**

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR 422.600.

_____	_____
Patient Signature	**Date**

Relievus™

Out of Network Contract

Thank you for choosing Relievus as your healthcare provider. The medical services you seek imply an obligation on your part to ensure payment in full is made for services received. You are entering an "Out of Network" contract with Relievus. This "Out of Network" contract is your advanced notice that you will be financial responsible for for any "Out of Network" balances applied by your carrier for services rendered. This is your notice that we will bill your "Out of Network" plan as a courtesy, however if balances are not paid in full your appointments may be canceled and/or rescheduled.

1. You acknowledge and agree to all FINANCIAL POLICIES of Relievus. Questions about these policies may be addressed to the Patient Accounts Staff. These policies may be changed from time to time by Relievus, without notice. If there is any conflict between the FINANCIAL POLICIES and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, the FINANCIAL POLICIES shall control.

2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for payment of the out of network benefit at the time the services are billed to you.

3. You understand and acknowledge that your health benefits have certain limitations, such as non-covered services. Non-covered services are those which your health insurance plan will not apply towards your benefits. Relievus is not a participating provider with your health plan _____. Therefore, you may be financially responsible for any course of treatment that is non-covered as well as your out of network co-insurance and deductible.

4. You acknowledge that this policy was fully explained to you.

Additional Charges. Patients may incur and are responsible for the payment of additional charges at the discretion of Relievus including but not limited to: (i) charges for returned checks; (ii) charges for copying and distribution of patient medical records; (iii) charges for extensive forms preparation or completion.

This guaranty shall be a continuing, absolute and unconditional guaranty, and shall remain in force and effect until any and all said Indebtedness shall be fully paid. There shall be no obligation on the part of Relievus at any time to first exhaust its remedies against patient.

I have discussed the treatment protocol with my physician and chose to obtain the services irrespective of my benefit coverage. I agree to be financially responsible for any and all related charges as an out of pocket expense. I understand that I am expected to pay any balances incurred, unless I have entered into an alternative repayment plan with the practice.

Patient Name Printed: _____ Date: _____

Patient Signature: _____

Physician Signature: _____