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

This packet is for patients who have an active claim for MVA, Worker's 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 re-schedule 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 you 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 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 the insurance
    2. Active valid insurance card
    3. Case number or Claim number for Auto insurance or Worker's Comp
    4. Photo ID
    5. MRI films & Reports, CT Scan films & 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 the directions carefully on all medications that we prescribe.
- In addition, we must be informed of all other medications, prescription and 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 **IN PERSON** to you 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 in respect to referral and pre-authorization requirements, and 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 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 we participate with, we will bill your insurance company along the guidelines of our contract; however, we require that **ALL COPAYS 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 any amount due to you directly.
- Returned checks will be subject to **an additional $25.00 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 procedures performed at surgery centers will incur a fee of $100. This includes not following instructions; stopping of medications, food/drink restrictions and having a driver.**

I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for the 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.

Patient Print Name	Patient Signature	Date
Responsible Party Print Name (if not patient)	Responsible Party Signature (if not patient)	Date

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Important Note Regarding After Hours/Weekend Services

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 (8AM to 5PM Monday through Friday) or over the weekend, please 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.

Thank you in advance.

By signing below, you agree that you have read the above notice regarding after hours/weekend services and that you understand your responsibilities.

Patient Name	Patient Signature	Date

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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

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 this time: _____

_____

Primary Insurance Name: _____ ☐ Auto ☐ Health ☐ Workers Comp

Phone #: _____ Adjuster: _____ Ext: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber SS #: _____

Secondary Insurance Name: _____ ☐ Auto ☐ Health ☐ Workers Comp

Phone #: _____ Adjuster: _____ Ext: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber SS #: _____

Tertiary Insurance Name: _____ ☐ Auto ☐ Health ☐ Workers Comp

Phone #: _____ Adjuster: _____ Ext: _____

Claim or ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber SS #: _____

Attorney Name: _____ Firm: _____

Location: _____ Phone: _____

Employer Name: _____ Phone: _____

Emergency Contact: _____ **Phone:** _____

Are we authorized to release your medical information to the listed Emergency Contact? ☐ Yes ☐ No

Signature: _____ Date: _____

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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 the 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 placed 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 to 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		

On a scale of one to ten, with one being no pain and ten being intolerable pain, check the box that indicates 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 ☐ 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:

_____

_____

_____

_____

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

☐ Alcohol/Drug addiction ☐ Adopted ☐ Cancer – type: _____

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	☐ Right	☐ Left	
	☐ Pain	☐ Right	☐ Left	
	☐ Redness	☐ Right	☐ Left	
	☐ History of Glaucoma	☐ Right	☐ Left	

Date of last eye examination: _____

Respiratory: ☐ Cough ☐ Difficulty Breathings ☐ Pain over Ribs

☐ Other Breathing Pains: _____

Cardiac: ☐ Chest Pain ☐ Palpitations

☐ Passing out (explain): _____

Gastrointestinal: ☐ Nausea ☐ Difficulty Swallowing ☐ Bleeding ☐ Fecal Incontinence

Genitourinary: ☐ Blood in Urine ☐ Frequency ☐ Burning ☐ Incontinence

Patient Signature: _____ **Date**: _____

Physician Signature: _____ **Date**: _____

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Irrevocable Assignment of Benefits / Letter of Protection / Lien

I, _____, 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 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).

Patient's Signature: _____ Date: _____

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.

Attorney's Signature: _____ Date: _____

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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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**, 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.

Claim No.: _____ Date of Accident: _____

_____ _____
Patient/Claimant Print Name Date

_____ _____
Patient/Claimant Signature Date

_____ _____
Legal Guardian Signature (if patient is a minor, parent/guardian must sign) Date

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Authorization for Release of Information

Name of Patient: _____ **Date:** _____

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 below that you approve to receive information.	**Description of Information to be Release** Check each item below that can be given to the person/entity as indicated on the left.
☐ **Voicemail**	☐ **Results of Lab tests/x-rays** ☐ **Other:** _____
☐ **Spouse (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____
☐ **Parent (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **Medical as follows:** _____
☐ **Other (Provide Name & Phone Number)** _____	☐ **Financial** ☐ **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 arbitration 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 this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Patient/Legal Representative Name	Patient/Legal Representative Signature	Date

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Notice of Privacy Practices
Acknowledgement of Receipt

Patient Name & Address: ____

____

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

Signature: ______________________________ Date: ______________

***** You may review our Notice of Privacy Practices under "Notice of Privacy Practices" on our website at: http://www.relievus.com/forms/ or you may request a copy from the front desk. *****

◆◆◆

For Office Use Only

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

☐ An emergency existed and a signature was not possible at that time.

☐ The individual refused to sign.

☐ A copy was mailed with a request for a signature by return mail.

☐ Unable to communicate with the patient for the following reason:

____

☐ Other:

____

Prepared by: ______________________________

Signature: ______________________________ Date: ______________