ATLANTIC ORTHOPAEDIC ASSOCIATES

91 S. Jefferson Road Suite 201 Whippany, NJ 07981 ph) 973-599-9779 fax) 973-599-1179

WELCOME TO OUR OFFICE

Dear Patient,

Welcome to our office! This sheet includes some helpful information that you will need to know before your first visit. In order to accept a new patient, we must collect a significant amount of information. We apologize for the inconvenience, but this information is necessary for your medical evaluation and our billing process. If you have any additional questions or concerns regarding your upcoming visit, please do not hesitate to contact our office. We are here to help you in answering any questions you may have.

★★★ **You can also e-mail any questions you may have to questions@aoatrauma.com** ★★★

OFFICE HOURS:

Monday's	9:00am – 5:00pm
Tuesday's	10:00am – 6:00pm
Wednesday's	9:00am – 5:00pm
Thursday's	9:00am – 7:00pm
Friday's	9:00am – 4:00pm

PATIENT HOURS:

Dr. Schenk	Tuesday	3:00 pm – 7:00 pm
	Wednesday	9:00 am – 12:00 pm
	Thursday	2:00 pm – 5:00 pm
Dr. Grob	Monday	9:00 am – 3:00 pm
	Thursday	3:00 pm – 7:00 pm
Dr. Spinnickie	Monday	9:00 am – 12:00 pm
	Tuesday	3:00 pm – 7:00 pm

WHAT TO BRING TO YOUR INITIAL OFFICE VISIT: When coming into the office for the first time please be sure to bring the following: photo i.d., insurance card(s), and if you were involved in a motor vehicle accident please be sure to bring a copy of your police report.

FEES AND PAYMENTS: We accept checks, cash, or Visa, MasterCard & American Express.

OFF-HOUR CALLS: The doctor's service is available for emergency calls only at night and on weekends. If you request a return call, call-blocking must be removed from your phone to receive this return call.

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Richard S. Schenk, MD Patricio Grob, DO Anthony O. Spinnickie, MD

PATIENT INFORMATION

PATIENT'S NAME (First) _____ **(Last)** _____

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

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

Sex: ☐**M** ☐**F** **Marital Status:** ☐**Single** ☐**Married** ☐**Separated** ☐**Divorced** ☐**Widowed**

MAILING ADDRESS (If Different): _____

HOME PH ( ) _____ **WORK PH ( )** _____ **CELL PH ( )** _____

PATIENT'S EMPLOYER: _____ **OCCUPATION:** _____

EMPLOYER'S ADDRESS: _____

NAME OF SPOUSE/PARENT: _____ **DOB:** _____ **SOCIAL SECURITY #:** _____ - _____ - _____

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

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

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

HOW WERE YOU REFERRED TO US: **NAME:** _____

☐ **Physician** ☐ **Friend** **ADDRESS:** _____ **CITY**_____ **ST**_____

☐ **Yellow Pages** ☐ **Newspaper** **ZIP:** _____ **TELEPHONE: ( )**_____

Signature: _____ Date: _____

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PAST MEDICAL HISTORY

NAME: _____ DATE: _____/_____/_____

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

   _____

   _____

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

   _____

   _____

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

   _____

   _____

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

   _____

   _____

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

   _____

   _____

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

   _____

   _____

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

   Arthritis _____ Gout _____ Ulcers_____

   Diabetes_____ High Blood Pressure_____

SIGNATURE_____

Relationship to Patient (Self, Mother,etc.) _____

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INSURANCE INFORMATION

PRIMARY HEALTH INSURANCE: _____ ID #: _____

NAME OF INSURED: _____ DOB: _____ SSN#: _____

SECONDARY INSURANCE COMPANY: _____ ID #: _____

NAME OF INSURED: _____ DOB: _____ SSN #: _____

**** PLEASE EXPLAIN HOW AND WHERE YOUR INJURIES OCCURRED:***

_____

_____

_____

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

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

DATE OF ACCIDENT: _____ CLAIM #: _____ POLICY #: _____

NAME & ADDRESS OF AUTO/WC CARRIER: _____

NAME OF CASE MANAGER: _____ PHONE #: ( ) _____ (EXT)

NAME OF ADJUSTER: _____ PHONE #: ( ) _____ _____ (EXT)

Signature: _____ **Date:** _____

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ASSIGNMENT OF BENEFITS

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

_____

(NAME OF AUTO INSURANCE CARRIER GOES ON THE LINE ABOVE).

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

_____.

(DATE OF ACCIDENT)

PATIENT NAME: _____

ADDRESS: _____

_____

TELEPHONE: (_____ **)** _____ **-** _____

X _____

(PATIENT SIGNATURE)

WITNESS NAME: _____

ADDRESS: 91 S. JEFFERSON ROAD

SUITE #201 - WHIPPANY, NJ 07981

TELEPHONE: (973 **)** 599 **-** 9779

X _____

(WITNESS SIGNATURE)

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Please Be Aware:

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

1. Name of doctor in our office who issued the prescription.
2. Name and spelling of the medication.
3. Dosage taken (how many milligrams, etc.), and how it is taken (i.e.: 2 a day with food).
4. Pharmacy phone number.
5. Prescription number (found on bottle of your prescription).
6. Advise of any allergies.

Please be aware that some controlled substances (such as Percocet) cannot be called into the pharmacy. The state of New Jersey requires that the original prescription must be picked-up from our office. Your prescription will be ready for pick-up within 48 hours of your request.
**Please make sure you are up-to-date on your follow-up appointments before requesting a refill. Prescriptions will not be refilled if a patient continues to miss scheduled appointments.*
**Prescriptions are always refilled at the discretion of your physician.*

DISABILITY FORMS: We will be happy to fill out your disability forms at NO CHARGE to you, we just ask that you give 7-10 BUSINESS days for your forms to be completed. You will receive a call from us once they are complete, at which time they can be mailed to your home or disability address, or we can fax them.
****OUR DOCTORS CAN NOT FILL OUT ANY FORMS DURING YOUR OFFICE VISIT!***

By signing, I agree that I have read the above:

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

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FINANCIAL POLICY

We participate with the following insurances:
Medicare
Motor Vehicle Insurance
Workers Compensation

We treat many patients who have insurance providers with which we do not participate. We are pleased to look at each situation and work with our patients so the financial aspect of their treatment will not be a burden.

Payment Information:
-If your insurance company does not pay the bill in full, or pays based on their usual and customary fees, the balance will be billed to you.

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

-Please be aware that we do not bill secondary insurances. Our office will be more than happy to provide you with all the necessary forms for you to submit to your secondary carrier.

Workers Compensation & No Fault / Auto: Your insurance will be verified prior to your visit. Any deductible or co-payments will be billed to you after your insurance pays. All office visits will be pre-authorized with your insurance company before your visit. 72 hours are required before authorization/approval can be obtained.

Payment Options:
Cash
Check
Money Order
Visa, MasterCard, American Express

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

Accounts 90 days passed due will be sent to collections. If an account is sent to an attorney for collections/suit, reasonable attorney's fee's, costs of collection, and any interest accumulated will be added to the unpaid balance.

I have fully reviewed this financial policy and agree to honor the terms outlined. I further authorize disclosure of portions of the patient record which are requested by the insurance company (these may be necessary to determine reimbursement)

_____ _____

Responsible Party Signature Date

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PATIENT NAME: _____

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.

USES AND DISCLOSURES:

- TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or may be consulted by staff members.
- PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.
- HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of the Practice of AOA. For example, information on the services you received may be used to support budgeting, and financial reporting, and activities to evaluate and promote quality.
- LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government-mandated reporting.
- PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
- OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION:

*Appointment reminders. Your health information will be used by our staff to send or call you with appointment reminders.

*Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

*Fund Raising: We WILL NOT release your information to support any fund-raising efforts.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information

- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

ATLANTIC ORTHOPAEDIC ASSOCIATES PRACTICE DUTIES:

- We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
- We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Maria Muha. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Maria Muha

c/o Atlantic Orthopaedic Associates, LLC
91 S. Jefferson Road – Suite 201
Whippany, NJ 07981

- If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.
- You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE: This notice is effective on or after April 1, 2003

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I, the undersigned, acknowledge having received and read the NOTICE OF PRIVACY PRACTICES. I understand that my private health care information will be used for Treatment, payment, and health care operations.

PATIENT NAME: ________________________________

SIGNATURE: ____________________________________ DATE: _______________________

If you refuse to sign this authorization, Atlantic Orthopaedic Associates, LLC will not deny you any treatment except Research-related treatment or treatment that you have requested for the purpose of disclosure to others.

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RICHARD S. SCHENK, MD

Diplomate of the American Board of Orthopaedic Surgery

Fellow of the American Academy of Orthopaedic Surgeons

Member of the Orthopaedic Trauma Association

PATRICIO GROB, DO

Board Certified: American Osteopathic Board

Member of the Orthopaedic Trauma Association

Fellowship Trained in Spine Surgery

ANTHONY O. SPINNICKIE, MD

Board Eligible: American Board of Orthopaedic Surgery

Fellowship Trained in Orthopaedic Trauma

Member of the Orthopaedic Trauma Association

PRIVACY PRACTICES

PATIENT NAME: _____

WITNESS: _____

DATE: _____

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

_____

_____

_____

_____

_____

_____

_____

_____

(On the lines above, please write the names of family members, friends, or personal attorneys that may call our office on your behalf. If someone is to call our office on your behalf and is not named in the lines above, we will not be able to share any medical information with them.)

SIGNATURE: _____

(PATIENT / OR REPRESENTATIVE)