DeFabio Spine and Sports Rehab, LLC

Donald C. DeFabio, DC, CES, DACBSP, FACO, ICCSP
Board Certified Chiropractic Orthopedics and Sport Injury, Corrective Exercise Specialist

308 Springfield Avenue Berkeley Heights, NJ 07922 • 908-771-0220 • 908-771-0114

CONFIDENTIAL PATIENT INFORMATION

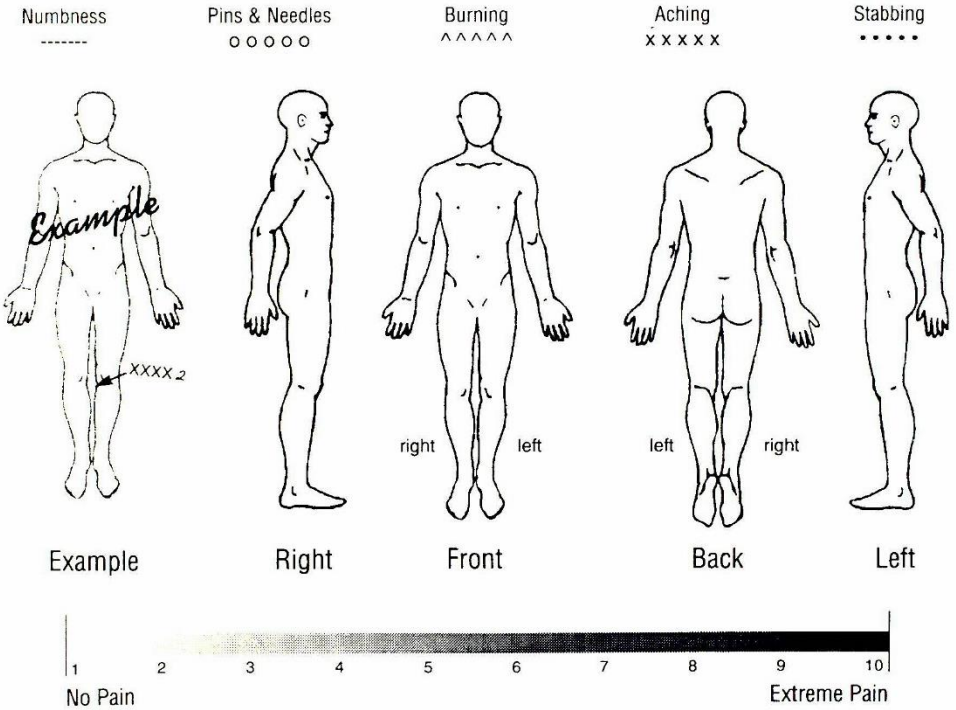
Patient Information **Today's Date** _____

Patient Name _____ Date of Birth _____
Street Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
E-mail _____ Preferred Language _____
Marital Status: ☐ S ☐ M ☐ W ☐ D Ethnicity ___Hispanic/Latino ___Non-Hispanic/Latino
Race _____ Gender ____M ____F ____Left Handed ____Right Handed
Smoking status __Never __Former __Current __How much? _____ Occupation _____
Referred By _____ Primary MD _____
Employer/School _____ Occupation _____
Employer/School Address _____
Emergency Contact _____ Emergency Contact Phone Number ___-___-____

Reason For Today's Visit

List present complaints and injuries _____
_____
How long have you had this condition? _____ Does it bother you occasionally/frequently/constantly?
Who else have you seen for this condition? _____
What did they recommend? _____

Pain Scale



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2017 INSURANCE INFORMATION & ASSIGNMENT AUTHORIZATION

Patient's Name _____ **Date** _____

Patient's Social Security # _____

Insurance Information

Person financially responsible for this account _____ Responsible person's relationship to Patient _____

Insurance Subscriber _____

Insurance Subscriber's relationship to Patient _____

Insurance Subscriber's Birthdate _____

Insurance Subscriber's Social Security # _____

Insurance Company _____

Insurance Policy # _____ **Group #** _____

Is this condition due to an accident? ☐ Yes ☐ No

Date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Compensation ☐ Other

Attorney Name (if applicable) _____

Assignment Authorization and Agreement

I agree to provide the office with any **information, initial or follow up referral forms** prior to seeing the Doctor that are necessary for treatment or payment and

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable and mailed to:

   Dr. Donald C. DeFabio
   308 Springfield Avenue
   Berkeley Heights, NJ 07922

2. I understand this if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.
4. **I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.**
5. A photo copy of this form shall be as valid as the original.

_____ _____
Patient Signature Date

_____ _____
Signature of Responsible Party If Other Than Patient Date

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Patients Written Acknowledgement of DeFabio Spine & Sports Rehab's

NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I was given a copy of DeFabio Spine & Sports Rehab's Notice of Privacy Practices, fully understand same and have had all my questions answered to my satisfaction.

I am authorizing DeFabio Spine & Sports Rehab, LLC to have my name displayed in the office in the form of a 'sign-in sheet' and a 'patient referral sign'.

☐ Yes ☐ No

I may be contacted in the following manner:

☐ E-mail via drdd@defabiochiropractic.com or defabiochiropractic@gmail.com, a non-encrypted server

☐ E-mail address_____

☐ Home/Cell telephone number _____

☐ OK to leave a detailed message

☐ Leave a message with a call back number only

☐ Work telephone number _____

☐ OK to leave a detailed message

☐ Leave a message with a call back number only

_____ _____

Patient's Signature Date

_____ _____

Privacy Officer's Signature Date

NOTICE OF PRIVACY PRACTICES

DeFabio Spine and Sports Rehab, LLC (DSSR) is committed to maintaining the privacy of your protected health information (PHI), which is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and the care and treatment you receive from our practice. In addition, this Notice describes your rights to access and control your PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. **Please read this notice carefully** and if you should have any questions or concerns about this Privacy Notice, please do not hesitate to contact our privacy officer, **Sally Messig,** at **DSSR, 308 Springfield Avenue, Berkeley Heights, NJ 07922, (908) 771-0220**
This office is required by law to abide by the terms of this Notice of Privacy Practices as well as abiding any other applicable state laws that may govern privacy practices and/or scope of the practice of chiropractic. Our office may change and/or modify the terms of this notice at any time and the new Notice will be effective for all PHI that we obtain at that time. Our office and/or doctors will provide you with a copy of our Notice of Privacy Practices and make a good faith effort to obtain your written acknowledgment of our Notice, no later than the date of your first service delivery. We will also keep you notified of any changes to our Notice of Privacy Practices and if requested by you our office will provide you with an updated copy of same.

USES AND DISCLOSURES OF PHI:

Our office may use and disclose your PHI for health care delivery purposes, which is known as treatment, payment and health care operations (TPO). Your PHI may be used and disclosed by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the doctor's practice. It should be noted that even though our list of uses and disclosures of your PHI is fairly comprehensive, it is difficult to take into account each and every possibility of how your PHI may be used or disclosed. We can assure you that your doctor and our office staff will do everything possible to maintain the confidentiality of your PHI. Listed below are some of the more common types of uses and disclosures of your PHI that our office is allowed to make without your consent and/or authorization.

Treatment- Your PHI may be used and disclosed for the coordination or management of your health care and related services among health care providers or by a health care provider with a third party, consultation between health care providers regarding you or the referral of you from one provider to another.

Payment-Your PHI may be used and disclosed for payment which encompasses the various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums to fulfill their coverage responsibilities and provide benefits under the plan and to obtain reimbursement for the provision of health care.

Health Care Operations-Your PHI may be used and disclosed for healthcare operation for certain administrative, financial, legal and quality improvement activities that are necessary to run its business and to support the core functions of treatment and payment.

Emergency Situations-Our office and/or Doctors may use or disclose your PHI in an emergency treatment situation. If an emergency situation happens to arise we are not required to obtain a written acknowledgement from you of our Notice of Privacy Practices until after the emergency situation has ended.

Minimum Necessary Standard-Our office and/or Staff will make reasonable efforts to limit the use and disclosure of and requests for your PHI to the minimum necessary to accomplish the intended purpose.

Employee Limitations-Your doctor will also limit the use and disclosure of your PHI to members of his/her workforce to those who may need access to your PHI for TPO.

Public Health Purposes and Activities-Your PHI may be disclosed to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability which would include reporting of disease or injury, reporting vital events like births or deaths and conducting public health surveillance, investigations or interventions. In addition, your PHI may be disclosed for public health activities like child abuse or neglect, quality, safety or effectiveness of a product or activity regulated by the FDA and persons at risk of contracting or spreading disease as well as workplace medical surveillance. Again, this information will be limited to the minimum amount necessary to accomplish the public health purpose.

Business Associate Contract-A business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity, i.e.: health care provider, health care plan or clearinghouse. Your PHI may be used or disclosed to a business associate provided we obtain satisfactory assurances from the business associate that the business associate will safeguard your PHI it receives or creates from any misuse and will use the information only for the purposes for which it was engaged to do and not for the business associates independent use or purposes, except as needed for proper management and administration of the business associate.

Research Purposes-Your PHI may be used or disclosed for research purposes, which has been de-identified and/or you have authorized the use and disclosure of your PHI.

Worker's Compensation Purposes-Due to the variability among State laws, the Privacy Rule permits disclosure of your PHI for purposes as authorized by and to the extent necessary to comply with worker's compensation laws without your authorization and no minimum necessary determination is required.

Marketing Purposes-Your PHI may be used and disclosed for marketing purposes if it is in the form of a face-to-face communication or a communication involving a promotional gift of nominal value by the covered entity, i.e.:health care provider, health care plan or clearinghouse. Marketing is defined as making a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This type of marketing has certain exceptions, which do not require authorization for the use and disclosure of your PHI and are listed as follows: 1) A communication is not marketing if it is made to describe a health-related product or service that is provided by or included in a plan of benefits of the covered entity making the communication, 2) a communication is not marketing if it is made for the treatment of the individual, 3) a communication is not marketing if it is made for case management or care coordination for an individual or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual. Note: Besides the above exceptions, any other form of marketing would require your authorization to use and disclose your PHI.

Personal Representative-Your PHI may be used and disclosed, under State law; to a person who is authorized to act on your behalf in making your health care related decisions.

Legal Proceedings-Your PHI may be disclosed if requested by any judicial or administrative proceedings, court order, a subpoena, law enforcement purposes etc.

Miscellaneous Uses and Disclosures of PHI-We may use a sign-in sheet at our front desk so our staff can easily see who is seeking care. We are allowed to use and disclose your name in the waiting room when your doctor is ready to see you. We may use and disclose your PHI to contact you to remind you of your appointment. We are also allowed to use and disclose your name and address to send you a newsletter about our practice and services we offer. In addition, we may send you information about products or services that we feel may benefit you.

PATIENT RIGHTS TO ACCESS AND CONTROL THEIR PHI

The Privacy Rule allows you certain rights with regards to your records, which are as follows: **You have the right to review and receive copies of your records as it relates to your own care.** Your request would have to be put in writing and the law requires that your doctor respond within 30 days of your request. In addition, your doctor is allowed to deny you access to your records, but only if it is going to cause you harm or someone else harm. If your doctor denies you access to your records, the denial has to be referred to a health care review professional, which would be the privacy officer who was designated. Your doctor is allowed to charge a copy fee, which should not exceed State allowance.

You have the right to request that the use and disclosure of your PHI be restricted. This means you have the right to request restrictions on how your doctor will use or disclose your PHI about TPO. Your doctor is not required to agree to your request for restriction, but would be bound by any restrictions to which you and your doctor agree.

You have the right to request to receive confidential communications from your doctor by alternative means or at an alternative location. Your doctor must accommodate your request, provided it is reasonable, and you clearly state that not doing so could endanger you.

You have the right to request amendments (changes) to your records. If changes are made to your record it does not mean that your doctor will destroy his/her records or your doctor will rewrite their records. It means that you can add an addendum to your current records to reflect your requested changes. Your doctor has the right to deny or reject your request to change your records, but you have the right to submit a statement in the medical record that you disagree. Your doctor also has the right to add to the record a rebuttal statement. **You have the right to receive your doctor's Notice of Privacy Practices.** The law requires that your doctor provide you in writing their policy on how they are protecting and using your PHI.

You have the right to revoke an authorization. The revocation can be done at any time provided it is in writing. There is an exception to the revocation; that is if your doctor has taken an action in reliance on the use or disclosure indicated in the doctor's Authorization Notice.

PATIENT'S RIGHT TO FILE A COMPLAINT

If you believe that we have violated any of your Privacy Rights, you can file a written complaint with our Privacy Officer (please see our Privacy Officer to obtain a complaint form). Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. In addition, you can also file a written complaint, either on paper or electronically, with the Office of Civil Rights (OCR). Please note that the Privacy Law prohibits our office from taking any retaliatory actions against you.

ASSIGNMENT OF BENEFITS/ERISA AUTHORIZATION FORM

DeFabio Spine and Sports Rehab, LLC

Financial Responsibility

I have requested professional services from Dr. Donald C. DeFabio, DC ("Provider") on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during the course of said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.[1] This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, PRINT NAME, by marking [√] (or [x]) and signing below, agree to:

[1] If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

☐ representation by Dr. Donald DeFabio in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

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Payment Policy

To pay your balance once your insurance company has processed your visit, a current credit card needs to be on file with authorization of payment. Once the insurance claim is processed your credit card will be charged the balance and an itemized receipt will be mailed to you.

Payment Authorization

I hereby authorize DeFabio Chiropractic Associates to automatically charge my credit card for:

1 The allowable balance due after my insurance payments are made.
2 For insurance payments sent directly to me.
3 For my co-payment when due.
4 For non-covered services.

A copy of the itemized statement and credit card receipt will be provided for your records.

Would you like a copy of your receipts?

□Yes □No

Name_____ Date_____

Signature_____

MC Visa #_____ Expiration Date____
CVS___

Am Ex #_____ Expiration Date____
CVS___

All information is confidential and secure.