Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____

Parent/Responsible Party: _____ Parent SS#: _____

Patient SS#: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Number: _____

Work Phone: _____ E-mail address: _____

Marital Status (circle one) Single Married Widowed Separated Divorced

Race: _____ Preferred language: _____ Sex - Male /Female

Occupation: _____ Employment Status (circle one) Employed F/T Student P/T Student

Employer/School: _____

Employer/School Address: _____

Who referred you? _____

Family Physician: _____

Address: _____

Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

211 Essex Street, Suite 101, Hackensack, NJ 07601
Phone: (551) 999-6433 Fax: (551) 500-2070
www.rajanmd.com

rajan
ORTHOPAEDICS AND SPORTS MEDICINE

INSURANCE INFORMATION

Type of Coverage (Circle One): Health Workers Comp Auto Accident Slip & Fall None/Self Pay

Date of Injury: _____ State Accident Occurred: _____

Primary Insurance: _____

Claim/ID Number: _____ Group Number: _____

Insurance Address/Zip: _____ Phone: _____

Adjustors Name: _____

Adjustors Phone: _____ Adjustors Fax: _____

Policy Holder Name: _____ Relationship Self Spouse Parent Other

Birth Date: _____ SS#: _____

Address: _____ Phone: _____

Responsible Party/Employer: _____

Address: _____

Secondary Insurance: _____

Claim/ID Number: _____ Group Number: _____

Insurance Address/Zip: _____ Phone: _____

Policy Holder Name: _____ Relationship: Self Spouse Parent Other

Birth Date: _____ SS#: _____

I HEREBY AUTHORIZE AND GUARANTEE PAYMENT FOR ALL SERVICES RENDERED INCLUDING INSURANCE BENEFITS MADE PAYABLE TO ME OR ON MY BELHALF TO RAJAN ORTHOPAEDICS & SPORTS MEDICINE FOR ANY SERVICES FURNISHED BY SIVARAM RAJAN M.D. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYBLE FOR RELATED SERVICES. IN THE EVENT THAT MY ACCOUNT BECOMES DELINQUENT FOR MORE THAN 30 DAYS, I ALSO AGREE TO PAY A FINANCE CHARGE 1.5% PER MONTH ON ANY BALANCE DUE, AS WELL AS ALL REASONABLE COLLECTION COSTS NOT TO EXCEED 50% COURT COSTS, ATTORNEY FEES AND INTEREST FEES ACCRUED WITH THE COLLECTION OF THIS ACCOUNT.

Patient Signature: _____ Date: _____

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MEDICAL INFORMATION

Patient Name: _____ DOB: ____/____/____ Age: _____

Height: _____ feet _____ inches Weight: _____ lbs.

Who referred you (Doctor/Family/Friend/Online)?_____

Primary Physician: _____

Address: _____

Phone: _____ Fax: _____

Pharmacy: _____ Pharmacy Phone #: _____

SOCIAL HISTORY

Tobacco Use: ☐ no ☐ yes ☐ former, year quit: _____ Illicit/Recreational Drugs Use: ☐ no ☐ yes

Consume Alcohol: ☐ no ☐ yes, frequency: _____

Occupation:_____

Circle one: Single / Married / Divorced

Are any of these only accessible by stairs at home (If so, circle): Bedroom / Bathroom / Shower

Do you live alone?: ☐yes ☐no Do you drive?: ☐yes ☐no

ALLERGIES (Please check all that apply below) Do you have any allergies? Yes _____ No _____

☐ Antibiotics (Name) _____ ☐ Drug Allergies (Name) _____

☐ Adhesives ☐ Iodine/Shellfish ☐ Hay fever/Seasonal ☐ Local or General Anesthesia

☐ Sulfa ☐ Latex ☐ Contrast Dye ☐ Other _____

PAST MEDICAL HISTORY (Please check all that apply)

☐ Asthma ☐ Stroke ☐ Pulmonary Embolism ☐ Liver Disease

☐ Hypertension ☐ Heart Disease ☐ Blood clots ☐ HIV/AIDS

☐ Bleeding Disorder ☐ Reflux ☐ Ulcer (gastric/bowel) ☐ Hepatitis C

☐ Diabetes ☐ Cancer ☐ Thyroid Disorder ☐ Other Hepatitis

☐ Kidney Disease ☐ Recurrent Infections ☐ Sleep Apnea

☐ Circulation/Vascular Disorders

☐ Pulmonary Disease (COPD/Emphysema)

☐ Other: _____

PAST SURGICAL HISTORY (Please list any past surgical procedures)

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

PRESENT MEDICATIONS (Please list proper name) ☐ No Medications

Name of Medication	Dosage	Name of Medication	Dosage
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Use space below if needed:

Rajan
ORTHOPAEDICS AND SPORTS MEDICINE
211 Essex Street, Suite 101, Hackensack, NJ 07601
Phone: (551) 999-6433 Fax: (551) 500-2070
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Date: _____

Patient Name: _____

Is the condition work related? ☐ no ☐ yes

Is the condition auto related? ☐ no ☐ yes

Is there a law suit pending? ☐ no ☐ yes

If injury was caused by an accident, how did the accident occur?

_____

_____

HISTORY OF PRESENT INJURY Explain the nature of your visit.

Location: Body part _____ ☐ Left ☐ Right ☐ Both

(Circle those that apply): pain instability numbness weakness
When did this begin? Date: _____

If there was an injury, please describe the injury in your own words:

_____

_____

Please be advised that this information will be forwarded to your insurance carrier to help expedite your claim.

Patient's Name: _____

Patient's Signature: _____

RAJAN ORTHOPAEDICS & SPORTS MEDICINE

Sivaram Rajan, M.D.
211 Essex Street Suite 101
Hackensack, NJ 07601

(551) 999-6433 Fax: (551) 500-2070

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by request.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

In addition, Federal law precludes us from sharing information about your medical services (including treatment, payment, insurance details, appointment scheduling, etc) without your written consent. Please provide us with the names and telephone numbers of people with whom are at liberty to share your information.

Please include your spouse, family members or other authorized representative(s).

Thank you.

NAME: _____

PHONE: _____

NAME: _____

PHONE: _____

NAME: _____

PHONE: _____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE IN RELATION TO THE ABOVE?

YES ( ) NO ( )

PATIENT NAME (PLEASE PRINT): _____

PATIENT SIGNATURE OR PARENT/GUARDIAN OF MINOR CHILD: _____

DATE: _____

MEDICARE ACKNOWLEGEMENT:

I request that payment of authorized Medicare benefits be made either to me or to Rajan Orthopaedics and Sports Medicine for any services furnished to me by Rajan Orthopaedics and Sports Medicine. I authorize any holder of medical information about me to release to the Health Financing Administration and its agents any information needed to determine these or the benefits payable for related services. _____ **Initials**

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS:

I hereby authorize and direct payment of my medical benefits to Rajan Orthopaedics and Sports Medicine on my behalf for any services furnished to me by the providers. _____ **Initials**

PATIENT ACKNOWLEDGEMENT:

I attest that all information provided to Rajan Orthopaedics and Sports Medicine is accurate. If any information changes, I will inform Rajan Orthopaedics and Sports Medicine. _____ **Initials**

INDIVIDUAL'S FINANCIAL RESPONSIBILITY:

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

  _____ **Initials**

MOTOR VEHICLE INSURANCE ASSIGNMENT OF BENEFITS:

I irrevocably assign to, my medical provider, all of my rights and benefits under my insurance contract for payment for services tendered to me. I authorize you to file insurance claims on my behalf for services tendered to me. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills, I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "Benefit denial appeals process" as set forth in the NJ Administrative Code. _____ **Initials**

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other healthcare provider, including hospitals, diagnostic centers, etc. I specifically authorize such healthcare provider to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

_____ **Initials**

ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

Assignment of Benefits

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any payments) under my health insurance policy or benefit plan to **Rajan Orthopedics & Sports Medicine** (collectively, the "Providers") with respect to any and all medical/facility services provided by the Providers to me for all dates of service. It is specifically intended by this assignment of benefits to assign to the fullest extent permitted under the law any and all of my rights, including without limitation, the right of one or more of the Providers to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State law rules, regulations and requirements, (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator to timely produce or respond to requests (including appeals) for all information relating to any plan documents describing the rights under any insurance policy or benefit plan as required by any applicable Federal or State law, (iii) to endorse for me any checks made payable to me for benefits and claims collected toward my account, and/or (iv) to bring any appeal, lawsuit or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination of benefits under any insurance policy or benefit plan.

Should this assignment be prohibited under my policy/plan, please disclose to Provider in writing such anti-assignment provision, otherwise this assignment shall be effective notwithstanding any anti-assignment clause in any policy/plan.

Designated Authorized Representative

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including the Law Offices of Cohen and Howard) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits from any third-party payor under my insurance policy or benefit plan, including the right to penalties, interest and attorney fees.
2. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and private health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPPA.
3. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
4. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
5. The right of my Authorized Representative to pursue any rights, claim or cause of action through litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

Release of Private Health Information

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third-party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name: _____ Date: _____

Patient Signature: _____