PROGRESSIVE PAIN MANAGEMENT

www.progressivepain.com

DEMOGRAPHICS

Name (First, Middle Initial, Last):_____

Address: (No P.O. Box): _____

_____

_____

Date of Birth (mm/dd/yyyy): ____/ ____/ _____

SSN: _____/ _____/ _____

Gender: M☐ F☐

Marital Status: S☐ M☐ D☐ W☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Occupation: _____

Employer: _____ Employer Address: _____

Referring MD: _____ Primary MD: _____

Emergency Contact: _____ Emergency Phone: _____ Relationship: _____

How did you hear about our office? _____

Is your visit related to: (✓) Worker's Comp☐ Motor Vehicle Accident☐ Other☐

Important: Please tell us who referred you to this office: _____

WC or MVA Insurance Name: _____

WC or MVA Address: _____

Adjuster/ Case Manager Name: _____ Claim Number: _____

Phone: _____ Date of Accident (mm/dd/yyyy): ____/ ____/ _____

Body Part(s) Injured: _____

Attorney Name: _____ Phone: _____ Fax: _____

Attorney Address: _____

Primary Health Insurance: _____ Effective Date (mm/dd/yyyy): ____/ ____/ _____

Health Insurance Address: _____

Member ID Number: _____ Group Number: _____

Policyholder's Name: _____ Referral Required: Yes☐ No☐

Policyholder's Date of Birth (mm/dd/yyyy): ____/ ____/ ____ SSN: ____-____-____ Relation to Insured:_____

Deductible: $_____ Co-pay: $_____ Policyholder's Employers: _____

Secondary Health Insurance: _____ Effective Date (mm/dd/yyyy): ____/ ____/ _____

Health Insurance Address: _____

Member ID Number: _____ Group Number: _____

Policyholder's Name: _____ Referral Required: Yes☐ No☐

Policyholder's Date of Birth (mm/dd/yyyy): ____/ ____/ ____ SSN: ____-____-____ Relation to Insured:_____

Deductible: $_____ Co-pay: $_____ Policyholder's Employers: _____

Please bring driver's license and insurance card along with you to your appointment.

Appointment Date (mm/dd/yyyy): _____/ _____/ _____

Name: _____ **Age:** _____ **Gender:** ____ **Weight:** _____ **Height:**_____

Where is your pain? _____

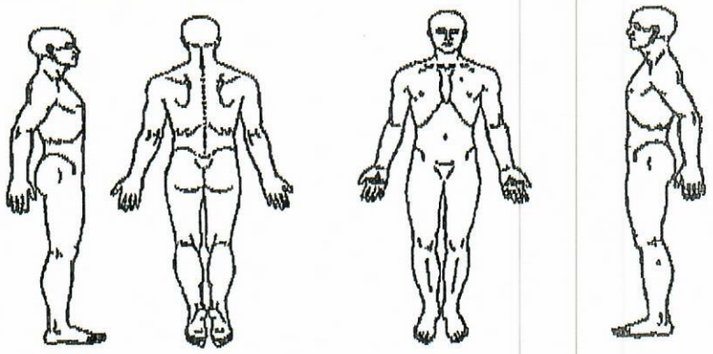
Pain Scale: Please circle the number that represents your current level of pain

1 2 3 4 5 6 7 8 9 10

Please indicate on the diagram the type of pain and where it is occurring:

P = Pain
B = Burning
T = Tingling
N = Numbness
W = Weakness

Is your pain...(check one)
☐ Constant (100% of the time)
☐ Frequent (75% of the time)
☐ Intermittent (50% of the time)
☐ Occasional (25% of the time)



When is your pain at its worst? _____ **When is your pain at its best?** _____

How long have you been in pain? _____

How would you describe your pain? Sharp / Aching / Burning / Throbbing / Shooting / Electric / Indescribable

Other (please describe) _____

What worsen your pain? Standing / Walking / Sitting / Activity / Bending / Twisting / Lying Down

Other (please describe) _____

What eases your pain? Medication / Sitting / Lying Down / Standing / Physical Therapy / Heat / Ice / Chiropractic treatment

Other (please describe) _____

Does your pain affect any of the following? Concentration / Work / Daily Activities / Physical Activity / Appetite / Sleep

Other (please describe) _____

How many bowel movements do you have per week? _____

Do you have harden stool? Yes / No **Do you have abdominal bloating?** Yes / No

Are you currently using any laxatives? Yes / No If so, what type? _____

Have you ever had a back brace? Yes / No **Have you ever had a Tens Unit?** Yes / No

What treatment have you had for your pain (please be specific):

Physical Therapy (when, how long, where): _____

Chiropractor (when, how long, with whom): _____

Acupuncture (when, how long, with whom): _____

Injections (when, with whom): _____

Surgery (when, with whom): _____

Have you, or do you have any of the following:

☐ Muscle Pain	☐ Weakness
☐ Respiratory Distress	☐ Chills or Fever
☐ Throat Pain	☐ Colored or Thickened Mucus
☐ Cough	☐ Wheezing

Have you been prescribed medicine in the last 6 months? Yes / No

Does bladder cancer run in your family? Yes / No

Have you, or do you have burning, itching, and or discolored urination in the last 6 months? Yes / No

Do you have kidney problems? Yes / No **Have you ever had Urinary tract infection?** Yes / No

Main Pharmacy Name: _____ Phone: _____

PAST MEDICAL HISTORY – Please complete ALL sections

Cardiac (circle all that apply):
Hypertension Hypercholesterolemia Coronary heart disease/MI Irregular heart beat Atrial fibrillation/flutter
Internal cardia defibrillation/pacemaker Peripheral vascular disease Other:_____

Pulmonary (circle all that apply):
Smoker Asthma COPD/Emphysema Sleep apnea Lung cancer Other:_____

Gastrointestinal (circle all that apply):
GERD Gastritis Gastric ulcer Irritable bowel disease Hepatitis Liver cirrhosis Other:_____

Renal (circle all that apply):
Renal insufficiency Renal failure Kidney stones Other:_____

Endocrine (circle all that apply):
Diabetes Diabetic peripheral neuropathy Grave's Disease Hypothyroid Other:_____

Musculoskeletal (circle all that apply):
Osteoarthritis Rheumatoid arthritis Grave's Disease Sjogren's disease Degenerative join disease
Fibromyalgia Lyme's disease Other:_____

Neurological (circle all that apply):
Stoke TIA Migraines Seizure disorder Multiple sclerosis Alzheimer's disease Dementia Other:_____

Psychiatric (circle all that apply):
Depression Anxiety Bipolar Schizophrenia Panic disorder Post traumatic stress disorder
History of alcohol/drug abuse Other:_____

Hematological (circle all that apply):
Anemia Low platelets Bleeding disorder Blood clots Leukemia Lymphoma Other:_____

SURGICAL HISTORY

Please list past surgeries:

DATE	SURGERY

SOCIAL HISTORY

Do you currently smoke tobacco?

☐ Yes ☐ No ☐ Ex-Smoker

If yes, how many packs/day? _____ For how many years? _____

If ex-smoker, when did you stop? _____

Do you currently drink alcohol?

☐ Beer ☐ Wine ☐ Liquor

How much per day? _____ How much per week? _____

Do you currently use illicit drugs? _____

Are you currently working?

☐ Yes ☐ No ☐ Full-time ☐ Part-time

What is your occupation? _____

FAMILY HISTORY

Condition	Family Member
High blood pressure	
Lung disease	
Cancer (what type?)	

Diabetes
Bleeding problems
Problems with anesthesia
Other:

MEDICATION

Medication	Dose/Frequency

ALLERGIES

Allergy	Reaction

IMAGING STUDIES

Please indicate the date(s) of each procedure:

MRI_____ CT Scan_____ X-Ray_____ EMG_____

Other: _____

OTHER SYMPTOMS

Have you recently had any of the following problems or symptoms?

Unexpected weight gain	☐ Yes ☐ No	Unexpected weight loss	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	Fainted spells	☐ Yes ☐ No	Arm / Leg swelling	☐ Yes ☐ No
Breathing difficulties	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Nausea or Vomiting	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No	Painful urination	☐ Yes ☐ No
Difficulty urinating	☐ Yes ☐ No	Loss of bowel control	☐ Yes ☐ No	Bloody stool	☐ Yes ☐ No
Loss of bladder control	☐ Yes ☐ No	Rashes or lesions	☐ Yes ☐ No	Bruising easily	☐ Yes ☐ No
Joint pain	☐ Yes ☐ No	Difficulty walking	☐ Yes ☐ No	Vision changes	☐ Yes ☐ No
Depression / Anxiety	☐ Yes ☐ No	Headaches / Migraines	☐ Yes ☐ No	Seizures / Stroke	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No	Anemia	☐ Yes ☐ No

PROGRESSIVE
PAIN MANAGEMENT

AUTHORIZATION FOR DISCLOSURE OF SENSITIVE HEALTH INFORMATION

Including HIV/AIDS, Hepatitis, and Other Communicable Diseases

In accordance with applicable federal and New Jersey state laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), N.J.S.A. 26:5C-1 et seq., and N.J.A.C. 8:43G-15.3, this office is required to obtain your informed consent before the disclosure or use of certain sensitive health information. This includes, but is not limited to, information regarding Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B or C, Tuberculosis (TB), and other communicable diseases that may pose a risk to healthcare personnel during the course of clinical care.

To ensure the safety of our healthcare team and to provide you with the highest standard of medical care—particularly during procedures that involve injections, exposure to bodily fluids, or other forms of direct patient contact—it is necessary for your treating providers and clinical staff to be aware of any such medical conditions.

By signing below, you authorize this medical practice, its healthcare providers, and clinical personnel to access, use, and, when appropriate, disclose your health information relating to communicable diseases, including HIV/AIDS and hepatitis, solely for the purposes of medical treatment, infection control, clinical safety protocols, and other healthcare operations as permitted by law.

This authorization is voluntary and may be revoked at any time in writing, except to the extent that action has already been taken in reliance on it. Refusal to sign this authorization may affect the ability of clinical staff to implement certain safety protocols during your care.

All disclosures made under this authorization will remain confidential and will be protected under applicable federal and state privacy laws.

Patient Name (Printed): _____

Date of Birth: _____

Signature of Patient or Authorized Representative: _____

Relationship to Patient (if applicable): _____

Date: _____

DESIGNATION OF DISCLOSURE – please fill in & sign

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that **Progressive Pain Management** may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care, in that case, **Progressive Pain Management** will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply):

You can disclose my health information as described below:

1. ☐ OK to leave message with detailed information at my home/cell number: (____) _____-_____
- ☐ On my answer machine
- ☐ With my spouse
- ☐ With anyone answering my phone
- ☐ Leave message with call back numbers only

2. ☐ OK to leave message with detailed information at my work number: (____) _____-_____
- ☐ OK to leave message with call back numbers only

3. ☐ OK to fax to my work fax number: (____) _____-_____
- ☐ OK to fax to my home fax number: (____) _____-_____

4. ☐ OK to email. Email address: _____
- ☐ OK to text to my cell phone number: (____) _____-_____

I designate the persons listed below as persons involved with my health care of payment relating to my health care for the purpose of **Progressive Pain Management** making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that **Progressive Pain Management** will not disclose health information to any person not designated except in case of an emergency.

Name: _____ Last 4 digits of his/her SSN or DOB (required as identifier) _____
Name: _____ Last 4 digits of his/her SSN or DOB (required as identifier) _____
Name: _____ Last 4 digits of his/her SSN or DOB (required as identifier) _____

The following person(s) are NOT authorized to receive my Patient Health information:

Name: _____ Name: _____

Name: _____ Name: _____

Signature: _____ **Print name:** _____
Patient or Authorized Representative

Date (mm/dd/yyyy): _____/_____/_____

PRACTICE POLICIES – PAGE 1 OF 2

Thank you for choosing **Progressive Pain Management**. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

We are happy to bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service as well as all required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company within ninety days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If you have HMO coverage, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure.

All patients are expected to pay at the time of service. We accept checks, money orders, MasterCard, Visa, American Express and Discover. **Self-pay patients are required to pay in full at the time of service. If your insurance plan requires a copayment, it is payable at the time of service.** If for any reason a payment is dishonored by your bank, there will be a $35.00 service fee added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

We are participating providers for many plans. However, we encourage you to use your out-of-network benefits for all other carriers. You will be required to show your insurance card and driver's license 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. In the event that your insurance carrier issues payment directly to you, it is your responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to **Progressive Pain Management**.

Filing a secondary claim is a courtesy to the patient.
We will only submit to your secondary carrier if they have electronic submission. If there is no response the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We will not file tertiary insurance, but will provide a claim to you upon requires. You are responsible for all tertiary balances.

PRACTICE POLICIES – PAGE 2 OF 2

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections. **You are responsible for any interest, agency, and legal fees associated with collections, which could total up to 50% of the balance owed.**

We do accept **Workers Compensation and Personal Injury cases**. We will only file these claims with your regular insurance if a written denials from the workers compensation or personal injury carrier is received. **We accept liens only for services provided in our office.** All necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports, or other paperwork will require a minimum fee of $15.00, paid in advance, related to the amount of the preparation involved. Please allow 5 business days for completion.

Appointments

Please be sure to provide a telephone number where you can be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment.

We require 24 hours notice if you intend to cancel your appointment. Should you cancel, reschedule or fail to appear for an appointment twice without 24-hour notices, we reserve the right to charge a no-show fee.

If you are scheduled for a procedure at a facility/Surgery Center and cancel without notifying our office 24-hour prior, a cancellation fee of $150.00 will be billed to you directly. You will incur a fee of $75 for "No Show" for In office procedures and $50 for "No Show" for office visits.

If you are late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 30 minutes in advance of your appointment to complete the necessary forms. **Failure to do so will result in the rescheduling of your new patient visit.**

HIPPA Privacy

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of the offices of Progressive Pain Management. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke in writing any consent for release of your health care information except to the extent that the office has already made disclosures with your prior consent. Because of the privacy regulations we are not a liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an ***Access to Medical Records*** form. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we will not discuss these concerns without your written permission. Our ***Notice of Privacy Practices*** provides information on your rights and is available on our website. We encourage you to read it in full. If you have any questions regarding our notice and if we change our notice, you may obtain a copy of the revised notice by contacting us at 732-493-2040 or by visiting our website at ***www.progressivepain.com.***

Authorization to Release Information and Assignments of Benefits

I hereby assign all medical and/or surgical benefits to which I entitled, including Medicare, Blue Shield, HMO's and commercial insurance to **Progressive Plan Management. I understand that I am fully responsible for all charges whether or not they are covered by said insurance.** I hereby authorize assignee to release any information necessary to secure payment on my behalf.

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, prescriptions, over-the-counter and supplements that you are taking. **We will not refill controlled medications in advance of their refill date nor will we mail prescriptions. The must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make appointments, *we require a 3 day notice of a medication refill.***

Psychological Evaluations

Because of the nature of our treatment, there may be occasions when the physician determines that that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or dorsal column stimulator placements. We reserve the right to discontinue care if you fail to obtain an evaluation as requested.

Staff

We require our staff to address our patients with professionalism and we ask that our patients do the same in return. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. **We will document your record and depending on the severity of the situation, you may be discharged from the practice.**

We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I have read and understand the above policies and agree to abide by them. I further understand that failure to do so may result in my discharge from the practice.

(Please sign this form in office)

Signature:_____ Print name: _____

Patient or Authorized Representative

Date (mm/dd/yyyy): _____/_____/_____

CONSENT FOR MEDICATION MAINTENANCE THERAPY FOR INTRACTABLE PAIN – PAGE 1 OF 2

I wish to try pain management with **medication maintenance therapy**. This therapy consists of the chronic administration of opioid (narcotic) medications for pain control. The principal opioid medications are morphine, fentanyl, tapentadol, propoxyphene, pentazocine, butorphanol, butalbitol, oxycodone, hydrocodone, hydromorphone and codeine. These medications are controlled substances and are subject to a variety of legal constraints as to their prescription, use and distribution.

I understand **opioids** are likely to induce **physical dependence** and that abrupt withdrawal is likely to cause symptoms such as abdominal and muscle cramps, irritability, nausea, vomiting, sweats, chills and generalized aching. In some individuals severe withdrawal reaction may be life threatening. I understand that these medications may be safely discontinued when tapered slowly and that even graduation discontinuation may lead to increased sensitivity to pain. I understand that if I am pregnant or become pregnant while taking opioid medications, my child would be physically dependent on the opioids and withdrawal can be life threatening for a baby.

I understand that I am likely to become **tolerant** to these medications and that I will probably require increasing doses to achieve adequate pain relief. I understand the **physical dependence** and **tolerance** are difference from **addiction**, which refers to psychological dependence on medication for purposes other than pain relief.

I agree to receive prescriptions for these medications only from **Progressive Pain Management** while I remain under their care and to inform other treating physicians regarding the medications I receive for pain management.

I understand that it is **illegal to furnish controlled substances prescribe for my use to any person (family or non-family) for any reason. I further understand that furnishing these medications is equivalent to narcotic distribution which is a felony in this country.** I agree to take strict precautions to prevent unauthorized access to my medications.

I understand that these medications used to treat pain may impair alertness and coordination and **that it is illegal to operate a motor vehicle when ability to drive is impaired by such** and I agree to comply with such prohibition.

I understand that opioid medications may cause variety of side effects including, but not limited to, nausea, vomiting, constipation, dry mouth, fluid retention, weight gain, weight lost, suppression of the immune system, suppression of thyroid function, suppression of menstrual cycle, suppression of male hormone, itching and allergic reactions.

I understand that the effects of sedatives, muscle relaxants and mind-altering medications or chemical may dangerously increased when administered to a patient of opioid medications. I agree to inform other physicians as to which medications I am taking and to request that they consult with **Progressive Pain Management** regarding the co-administration of medications that may affect alertness or consciousness.

CONSENT FOR MEDICATION MAINTENANCE THERAPY FOR INTRACTABLE PAIN – PAGE 2 OF 2

Please fill in & sign

I agree to adhere strictly to medical instructions and laws governing the use of these medications and **to refrain from the use of illegal drugs or alcohol.** While on these medications, I authorize **Progressive Pain Management** to test my blood or urine for the presence of illicit substances without prior notice and agree to submit to psychiatric or drug abuse evaluation should **Progress Pain Management** request it.

I am responsible for my pain medications. I agree to take medication only as prescribed and to contact my pain clinic physician before making any changes. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the physician that there **is no improvement to my daily function or quality of life** from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed and non-prescribed by the physician.

I understand that increasing my dose without the close supervision of my physician could lead a drug overdose, causing a severe sedation, respiratory depression and death.

Prescriptions can only be written for one-month supply and will be filled at the same pharmacy. Refill requests shall be made during regular office hours, and **can be picked up only in person.** Refills will not be made at night, on holidays or on weekends.

Refill prescriptions are not made if I "run out early" or "lose a prescription" or "spill" or "misplace my medication". I am responsible for taking the medication to the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. I will call at least one week in advance to schedule an evaluation or pickup for my prescriptions.

My signature below signifies that I have read each article in this document and agree to abide by its requirements. **I understand that failure to do so will lead to termination of this treatment.**

Signature:_____ **Date (mm/dd/yyyy):** _____/_____/_____

Signature:_____ **Date (mm/dd/yyyy):** _____/_____/_____

Physician Certification:
I have reviewed the above document with the patient whose signature appears above. I believe that this patient suffers from the condition(s) indicated in my evaluation note, that this condition causes severe pain and that this patient is a candidate for pain management with opioid medications in the short term.

Physician's Signature:_____ **Date (mm/dd/yyyy):** _____/_____/_____

Patient Pain Management Agreement (see pg. 12)

I am aware that failure to follow any of these agreed statements might result in Dr. Brian Bannister and practitioners in his office not providing on-going treatment:

I, _____, agree to undergo pain management care and follow up by Dr. Brian Bannister and practitioners in his office. My diagnosis is _____. I agree to the following:

- I will not accept any narcotic prescriptions from another doctor during the period that I am under Dr. Bannister's care
- I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause withdrawal syndrome
- I understand that I must always keep my medications in a safe place
- ***I understand that Dr. Bannister and practitioners in his office will not supply additional refills for the prescriptions of medications that are lost***
- If my medications are stolen, **we will refill the prescription one time only** if a copy of the police report of the theft is submitted to the practice
- I will not share my prescription medication with anyone
- I will only use one pharmacy unless that pharmacy is out of the medication prescribed
- I will keep my scheduled appointments with Dr. Bannister and practitioners in his office unless I give notice of cancellation 24 hours in advance
- I agree to refrain from use of illicit drugs.

Either party may terminate this agreement at any time if there is cause to believe non-compliance with the terms above or if I have falsely misrepresented my pain or fail to comply with the terms of this agreement.

Patient's Signature & Date: _____

Physician's Signature & Date: _____

Updated October 4 2023

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.* 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, _____, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] 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 or the Chapter 32 Independent Arbitration System, 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)

* 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.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

dobiihcaparb 10/18

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by [ ] and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

dobiihcaparb 10/18

PLEASE SIGN THIS FORM IN THE OFFICE AND RETURN TO RECEPTION

MONMOUTH COUNTY
PAIN MANAGEMENT

Authorization to Release Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I entitled, included Medicare, Blue Shield, HMO's and commercial insurance to Monmouth County Pain Management. I understand that I am fully responsible for all charges whether or not they are covered by said insurance. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

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, prescriptions, over-the-counter supplements that you are taking. We will not refill controlled medications in advance of their refill date nor will we mail prescriptions. These must be given to you in person at the time of your appointment. If there is an unavoidable reason that you cannot make it to appointments, we require a 3 day notice of a medication refill.

Psychological Evaluations

Because of the nature of our treatment, there may be occasions when the physician determines that a psychological evaluation is necessary. For example, many health care plans require evaluations prior to intrathecal pump or dorsal column stimulator placements. We reserve the right to discontinue care if you fail to obtain an evaluation as requested.

Staff

We require our staff to address our patients with professionalism and we ask that our patients do the same in return. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation and notify their immediate supervisor or practice manager. We will document your record and depending on the severity of the situation you may be discharged from the practice.

We are committed to providing the best possible treatment and ask for your cooperation in following our policies.

I have read and understand the above policies and agree to abide by them. I further understand that failure to abide by these policies may result in my discharge from the practice.

Signature: _____ Print Name: _____

Patient or Authorized Representative

Date (mm/dd/yyyy): ____/____/_____