One Oak Medical

ONE OAK MEDICAL

Patient Information: (PLEASE PRINT)

Last Name: _____ First Name: _____ Middle: _____

Sex: ____M ____F Date of Birth: ____/____/____ Age:____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home # ( )_____-_____ Cell# ( )_____-_____ Work # ( ) _____-_____

Email: _____@_____.com

Occupation: _____ Patient's Employer_____

Primary Care Physician: _____ Phone #: ( )_____-_____

Pharmacy #: _____ Phone #: ( )_____-_____

Insurance Information (PLEASE GIVE INSURANCE CARD AND ID TO RECEPTIONIST)

Type of Insurance: _____Medical _____ MVA/AUTO _____ Workers Comp _____Self Pay_____

Subscriber Name: _____ Subscriber DOB: _____

Employer Name of Subscriber_____

Primary Insurance ID: _____ Group # _____

Subscriber: _____ Self _____Spouse _____ Child _____ Other

Secondary Insurance ID#: _____ Group# : _____

Subsciber: _____ Self _____ Spouse _____ Child_____ Other

In Case of Emergency :

Name Of Relative or Friend _____ Phone #: ( ) _____-_____

The Above is true to the best of my knowledge, I authorize One Oak Orthopedic & Spine to provide myself or my child with reasonable and proper medical care according to today's standards.

X_____ Date: _____

Parent/ Guardian Signature

One Oak Medical

Reason for Consult

Was Injury/ Pain a result of an accident? _____ Yes or _____No

If yes, please indicate if _____ Auto _____ Job Related _____ Other

Date of Injury or onset: _____/_____/_____ Having Since _____/_____/_____

Which body part is the site of Injury: _____ Side: ____ Right _____ Left

Attorney Information:

Name: _____ Phone#:( )_____-_____

Describe the events of the Injury/accident: _____

_____

Have you been treated for this injury previously and if so please indicate what treatment and the results? _____

_____

Have you had any diagnostic testing (MRI, CT, XRAY) for this problem? If so, please list the type of testing:

_____

_____

List any major surgeries (please indicate dates and procedures): _____

_____

PLEASE GIVE ALL REPORTS/CD/FILMS FROM PRIOR TESTING TO THE FRONT DESK.

I hereby authorize the release of medical information necessary to process my insurance claim. This includes chart notes, reports, billing statements, intake forms and any other information to my attorney, health care providers and insurance company. I have stated all medical conditions and if there any changes I will keep my practitioner informed.

X_____ Date:_____

Patient /Guarantor Signature

Please check any of the following that pertain to you	Yes or No	Family Histor (list family member)	List any surgeries related to pain
Lupus			
Sickle Cell			
Anemia			
Thyroid Disorder			
Gout			
Lyme Disease			
Heart Disease			
Angina			
Cancer			Type of Cancer:
Joint Injuries (arthritis, etc.)			
Recurrent Headaches			
High Cholesterol			
Hepatitis			
Asthma, Emphysema			
Tuberculosis			
Bleeding Disorder			
High Blood Pressure			
Diabetes			Type A _____ Type B _____
Epilepsy/ Seizures			
Congestive Heart Failure			
Heart Arrhythmia			
Heart Stents			
Heart Murmur			
Blood Injuries/Fractures			Body Part (s):
Kidney/Liver Disorder			Type of disorder:
Alcohol/Drug Abuse			How often? How long?
Other:			

Current Medication: _____

_____

List any medications that you are allergic: _____

If yes, what was reaction? _____ Redness _____ Swelling _____ Rash _____Hives _____ Other

Are you Allergic to Latex? Yes or No

Do you smoke? Yes or No If yes how many Packs a day? _____ How many years have you been a smoker? _____

One Oak Medical

_____ [Patient Name]
_____ [Insurer]
_____ [Claim #/ID#]

ASSIGNMENT OF BENEFITS & AUTHORIZATION TO PURSUE APPEAL &/OR LITIGATION OF HEALTH CARE BENEFITS

In consideration of the professional services rendered by **One Oak Medical** and its affiliated health care providers, ("Health Care Providers"), I, hereby irrevocably direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for health insurance benefits with regard to the above-captioned claim to Health Care Providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claims, pursuant to my rights under state and/or federal law including but not limited to the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).

2. The authorization of Health Care Providers to act as my agent-in-fact with regard to all aspects regarding the above-captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim as a substitute beneficiary under my policy of health insurance whether fully funded or self funded.

3. The authorization of Health Care Providers to initiate, prosecute., and resolve any and all appeals and/or arbitrations and/or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer, outside reviewing entities or agencies as well as arbitrations and litigation matters in state or federal court including but not limited to claims under the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), and New Jersey Healthcare Quality Act (HCQA).

4. The authorization of Health Care Providers to obtain and/or disclose any Private Health Information as contemplated by HIPAA limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.

5. The authorization of Health Care Providers to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, the federal Department of Labor as it relates to ERISA plans, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.

6. The authorization for payment of any and all insurance benefits directly to Health Care Providers to which I might be entitled under the above-captioned claim.

_____	_____
(Print Name of Patient)	(Print Name of Witness)
_____	_____
(Signature of Patient)	(Signature of Witness)
_____	_____
(Date of Signature)	(Date of Signature)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

One Oak Medical

342 Hamburg Turnpike Suite 202 Wayne, NJ 07470
Tel: 973-870-0777 Fax: 888-972-9734

Patient Protection & Advocacy Policy

Affordable Care Act (ACA) Discount Disclosure
You Are Protected From Any Unexpected Costs And Bills

Dear Patient:

1. As your Patient Advocate (PA), we offer the highest quality care and safety possible at the **most affordable cost to you**, regardless of whether you are covered by an in-network or out-of-network health plan.
2. We offer an **Affordable Care Act Discount (ACA Discount)** under our Corporate Compliance Policy to anyone who qualifies, on a case by case basis. **You only pay what you can afford or are willing to pay** for your deductible and co-insurance, as outlined in your plan cost-sharing obligations, based on your medical need. Most people may qualify and **your satisfaction is guaranteed**.
3. Our Affordable Care Act (ACA) Discount is **similar to or even much better than all PPO discounts**, as our **ACA Discount is available for both in-network and out-of-network providers and facilities**.
4. Once you qualify, **you will NOT receive ANY unexpected invoices, bills or collection letters FROM US**, even if your insurance denies your claims.
5. As your Patient Advocate and Authorized Representative, and under the federal health reform law PPACA (Patient Protection and Affordable Care Act, or ACA), we may appeal all of the claim denials or delays on your behalf, which is strictly in compliance with the federal health reform law, PPACA.
6. As your Patient Advocate, **your best interest is our best interest**. To ensure that you also get this kind of ACA Discount from other providers known to us or affiliated with us, we will inform you of these facilities and/or providers, **so you may also receive the best care possible along with the ACA Discounts and Savings.**
7. With your informed choice, we will refer you to a provider who may also offer a compliant ACA Discount and ensure that **you are always protected from any unexpected costs and bills** under the federal health reform law (PPACA).
8. As your Patient Advocate, we want **you to be fully protected from any unexpected costs and bills from any providers, unless otherwise authorized by you.**
9. You always have freedom of choice to receive healthcare from any provider you choose. However, we can not speak for, or guarantee anything on behalf of other providers we don't know or are not affiliated with, regarding their discount or collection policies. You are advised to contact them directly before scheduling your next appointment(s) or medical procedure(s).
10. **If you are willing to be protected from any unexpected costs and bills,** feel free to apply for our Affordable Care Act Discount under our Corporate PPACA Indigency Policy. "*Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount*". Your satisfaction is guaranteed.

I have read and fully understand this Patient Protection & Advocacy Policy. My questions are fully answered.

Patient Name (print)	Signature of Patient	Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA ☐ ☐ — PICA ☐ ☐

PATIENT AND INSURED INFORMATION — **CARRIER**

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. / 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED ____ DATE ____	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.