MEHLING ORTHOPEDICS, LLC/PLLC

TRAUMA ● SPORTS MEDICINE ● ADULT RECONSTRUCTION

Brian Mehling, MD
Pavel Yufit, MD

PERSONAL INFORMATION

Date:_____ **Patient's Social Security Number**_____

Patient Name:_____ **DOB:**_____ **Age:** _____

Check those that apply: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____ **City/St:** _____ **Zip** _____

PHONE: (H) _____ **(W)** _____ **(Cell)** _____

Email:_____

Employer Name: _____ **Occupation:** _____

Employer Address:_____ **City:** _____ **State**_____ **Zip** _____

Pharmacy Name, Address, Phone: _____

_____

In the event of an emergency, who should we contact?

Name:_____ **Relationship:** _____

Phone number:_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:

Name of Insured: _____

Relationship to patient: _____

Insured's birthdate: _____

SS#: _____

Employer:_____

Occupation:_____

Insurance Company: _____

Group#: _____ **ID#:** _____

Insurance Billing Address: _____

City/St:_____ **Zip:**_____

Insurance Co. Phone Number: _____

SECONDARY INSURANCE CARRIER:

Name of Insured: _____

Relationship to patient: _____

Insured's birthdate: _____

SS#: _____

Employer:_____

Occupation:_____

Insurance Company: _____

Group#: _____

Insurance Billing Address: _____

City/St:_____ **Zip:**_____

Insurance Co. Phone Number: _____

MEDICAL INFORMATION

Date of Injury: _____ **How did injury occur:** _____

Were you referred or did you see doctor in the hospital: _____

May we share this visit with your doctor? ☐ yes ☐ no

PRIMARY CARE PHYSICIAN: _____

Address: _____ **City/St:** _____ **Zip:** _____

Phone Number: _____

Please list any other medical conditions you have/had: _____

Please list any previous surgeries: _____

Please check any of the following childhood diseases you have had:

☐ measles ☐ German measles ☐ mumps ☐ chicken pox ☐ scarlet fever

List your current medications and/or vitamins, including frequency and dosage:

_____

Are you allergic to any medications or have you had any reactions to foods, medications and/or insect bites?

☐ yes ☐ no If yes, please list: _____

Please check if you are allergic to the following: ☐ shellfish ☐ penicillin ☐ IV contrast dye

Do you currently or have you ever smoked? ☐ yes ☐ no If yes, how many years did you smoke _____

Did you quit smoking? ☐ yes ☐ no If yes, when did you quit _____

How many alcoholic drinks do you consume each week? ☐ 0 ☐ 1-2 ☐ 2-5 ☐ 6 -10 ☐ more

Have you been unable to work, due to disability, in the past 10 years? ☐ yes ☐ no

Do you now, or have you ever had a problem with illegal drugs? ☐ yes ☐ no

Were you ever told that might have the following?

Heart condition ☐ yes ☐ no ☐ unknown

Heart murmur ☐ yes ☐ no ☐ unknown

High blood sugar ☐ yes ☐ no ☐ unknown

High blood pressure ☐ yes ☐ no ☐ unknown

High cholesterol ☐ yes ☐ no ☐ unknown

Have you ever broken bones or sustained an injury as the result of a fall? ☐ yes ☐ no

Do you have arthritis? ☐ yes ☐ no

Have you ever experienced weakness in any part of your body? ☐ yes ☐ no

Were you ever told that you have an ulcer or other stomach problems: ☐ yes ☐ no

Were you ever told that you have diabetes or are predisposed to having diabetes: ☐ yes ☐ no

What is the approximate date of your last tetanus shot: _____

WORKER'S COMPENSATION PATIENTS

Date of Injury: _____

Employer Name: _____ **Phone Number:** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Insurance Company Name: _____ **Phone number:** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Claim Number: _____

Adjuster/Case Manager Name: _____ **Phone Number:** _____

Attorney Name: _____ **Phone Number:** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

NO-FAULT PATIENTS

Date of accident/ injury: _____

Insurance Company Name: _____ **Phone number:** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Claim Number: _____

Adjuster/Case Manager Name: _____ **Phone Number:** _____

Attorney Name: _____ **Phone Number:** _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

DEMOGRAPHICS

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- □ **Decline Response**
- □ **Hispanic or Latino**
- □ **Not Hispanic or Latino**

Race:

- □ **Decline Response**
- □ **American-Indian or Alaska Native**
- □ **Asian**
- □ **Black or African American**
- □ **Native Hawaiian or Pacific Islander**
- □ **White**
- □ **Other**

Please check the statement that applies:

- □ **Decline Response**
- □ **I do**
- □ **I do not**

understand English well. The language I prefer is: _____

The highest level of education I have attained is:

- □ **GED**
- □ **High School Diploma**
- □ **College Degree**
- □ **Graduate Degree**
- □ **Other: _____**

Patient Signature: _____

Date: _____

Mehling Orthopedics
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BRIAN MEHLING, M.D., FAAOS
PAVEL YUFIT, M.D., FAAOS
Board-Certified Orthopedic Surgeons

GENERAL CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for (my/below patient's) treatment with Mehling Orthopedics, LLC ("Provider"). I hereby request Provider to provide such care and administer such diagnostic, radiological, and/or therapeutic procedures and treatment as is deemed necessary or advisable in (my/below patient's) care. This includes all routine diagnostic tests and procedures. I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatments or examinations done. I further understand that this consent allows for the exchange of medical information relevant to my care with other health care providers.

OUT-OF-NETWORK DISCLOSURE/PATIENT ACKNOWLEDGMENT OF RESPONSIBILITY

You understand that the Provider is an out-of-network provider and that, consequently, you are responsible for the difference between charges and payments made by your health plan and any co-insurance and deductible required by your health plan. The Provider cannot waive any such patient responsibility. Any recovery of funds made by us in connection with any litigation or arbitration we file against your health plan will be paid to the Provider and not to you. You specifically agree that such recovery is owed to the Provider and not to you. We will take our fees from this recovery if obtained.

FINANCIAL RESPONSIBILITY AND GUARANTEE AGREEMENT

I have requested professional services from 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. With respect to bill collections, I understand that if I do not pay what I owe, I understand that I will be in default and Provider may retain an attorney to collect the balance due to it. If Provider retains an attorney, I agree to pay Provider's reasonable attorney frees upon placement of the claim with the law firm.

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 court of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

CANCELLATION POLICY

It is important that you keep your scheduled appointments. If you are unable to do this, please call the office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged a $50.00 Cancellation Fee, and your insurance company cannot and will not reimburse for this.

I have read and understood the above policies.

Patient Name(Print)_____ Parent/Guardian Name(Print)_____

Signature (Patient/Parent/Guardian)_____ Date_____

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Hackensack, NJ 07601

www.mehlingorthopedics.com
Hilda Asitimbay 201-342-7662, ext. 303
hasitimbay@mehlingorthopedics.com
Doreen Santora, 201-342-7662

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or manage a hospital directory at this practice.
We do not create or maintain psychotherapy notes at this practice.
We will never share any substance abuse treatment records without your written permission.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective as of November 2014.

This Notice of Privacy Practices applies to the following organizations.

Mehling Orthopedics, LLC
214 State Street, Suite 101
Hackensack, NJ 07601
201-342-7662

Mehling Orthopedics, PLLC
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West Islip, NY 11795
631-893-3903

Hilda Asitimbay, hasitimbay@mehlingorthopedics.com, 201-342-7662, extension 303
Doreen Santora, dsantora@bluehorizoninternational.com, 201-342-7662

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BRIAN MEHLING, M.D., FAAOS
PAVEL YUFIT, M.D., FAAOS
Board-Certified Orthopedic Surgeons

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the Mehling Orthopedics Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____
Personal Representative (Print) Personal Representative's Signature

Relationship: _____

For Mehling Orthopedics use only:
Complete this section if this form is not signed and dated by the patient or patient's personal representative. I have made a good faith effort to obtain a written acknowledgement of receipt of Mehling Orthopedics Notice of Privacy Practices but was unable to for the following reason (please circle):

Patient refused to sign
Patient unable to sign
Other _____

_____ _____
Employee Name ***Date***

This form should be placed in the patient's medical record.

Revised December 2015

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ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Date of Loss: _____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to Mehling Orthopedics, LLC, hereafter referred to as "the medical provider" to pursue and obtain payment on my behalf. This assignment shall include, but is not limited to all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.
2. I assign to the medical provider all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my medical bills, I hereby authorize and give the medical provider power of attorney to sign any documents on my behalf to pursue a claim for personal injury protections benefits. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account or have some same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within five (5) days of receipt of same.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

   Signed: _____

   Patient's Name: _____

   Dated: _____

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Revocable Assignment Of Benefits & Authorization

I, _____ (**"Patient"**), assign to my medical provider MEHLING ORTHOPEDICS (the "**Provider**"), any and all of my rights and benefits under my insurance contract and/or my employee welfare benefit plan(s) as well as all of my rights and benefits under the **Employee Retirement Income Security Act of 1974** ("**ERISA**") and any other applicable state or federal law(s), regulation(s), statute(s), or rule(s), which are in any way related to the medical services provided to me by **Provider** at any time.

I assign to **Provider** any and all of my rights and benefits under my plan or policy as well as state and/or federal law(s), regulation(s), statute(s), or rule(s), to seek plan or policy documents, file appeals, seek statutory and other penalties, seek equitable relief, commence legal action, and directly receive payment of benefits insofar as they in any way relate to the treatment and/or services provided to me by **Provider** at any time. I assign to **Provider** any recovery, settlement, penalty, and/or other relief obtained.

I authorize **Provider** to file insurance claims on my behalf for services rendered to me at any time by **Provider**. I direct that all reimbursable payments for treatment and/or services rendered to me by **Provider** go directly to the **Provider** or any individual or entity they deem appropriate,

I authorize **Provider** to file arbitration and/or litigation in my name and on my behalf against my PIP carrier, Healthcare Carrier, Employee Welfare Benefit Plan, Workers' Compensation Plan, or any similar entity, which is in any way related to the treatment and/or services provided to me by **Provider** at any time.

I authorize **Provider** to retain an attorney of **Provider's** choice on my behalf for collection of **Provider's** bills and/or to file insurance claims on my behalf for services rendered to me. I authorize and consent to **Provider** acting on my behalf in this regard and in regard to my general health insurance coverage, and I specifically authorize **Provider** to pursue any administrative appeals conducted pursuant to any contract, plan, law or statute, including, but not limited to, **ERISA**.

Provider may affirmatively disclaim any part of this assignment and authorization at any time and for any and/or no reason(s) through writing. There is no reciprocal right on the part of the **Patient** once this document is executed. **Patient** does not retain any power, right, or ability, to revoke or withdraw any authorization or assignment. Should **Provider** disclaim any part of this assignment or authorization it shall result in the right(s) and/or benefit(s) explicitly disclaimed returning to **Patient**.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Name of Person Signing (print) Relationship to Patient

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Acknowledgement and Notice of Doctor's Lien

Name of Patient:_____

Name of Guardian or
Responsible Party if applicable: _____

Patient Address: _____
_____
_____

Date of Injury, Accident, or Onset of Illness: _____

Location of Accident or Injury: _____

To: _____
(Name of Attorney)

Address: _____
_____
_____

I do hereby authorize Mehling Orthopedics, LLC and/or Mehling Orthopedics of New York, PLLC or any related entity (collectively herinafter referred to as "doctor") to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis, etc. in regard to the injury or injuries I recently sustained as a result of _____.

I hereby grant and acknowledge a lien to the doctor to secure all sums as may be due and owing said doctor for medical service rendered to me both by reason of this injury or illness and by reason of any other bills that are due the doctor's office, and hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing said doctor and to withhold such sums from any proceeds, settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor for the full amount of his bills. And, I hereby further give a lien on any and all matters in which you represent me, to said doctor against any and all proceeds of any transaction, settlement, judgment, or verdict which may be paid to you, my attorney, or to myself, as a result of the injuries for which I have been treated or injuries in connection herewith. I agree to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of the doctor awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict which I may eventually recover. I further understand that such payment is not contingent on any insurance company or other entity or person's determination, with the exception of a recognized worker's compensation case, as to the appropriateness of services rendered and/or fees charged.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this incident, and I instruct you, my attorney, to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated:_____ _____

Patient/Guardian/Responsible Party

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor for all sums due said doctor. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney's fees and costs.

Dated:_____ _____

Print Name of Law Firm

By:_____

(Print Name) Attorney

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EMAIL AND TEXT POLICY

I, _____, (patient/guardian) hereby voluntarily provide my email and cellphone number to Mehling Orthopedics and affiliated facilities.

I agree to permit Mehling Orthopedics and their Authorized Representative to communicate with me by email and text message with respect to the medical claims submitted to my health plan and with respect to any balances due to Mehling Orthopedics after health plan and other payments received by Mehling Orthopedics and for balances not covered by my health plan, co-insurance, deductibles or any other balance deemed client responsibility.

To be clear, I am consenting to communication by email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify Mehling Orthopedics in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to Mehling Orthopedics. There are no hardware or software requirements needed to receive email communication from the Practice of their authorized representatives other than an active email account obtained from a vendor that provides such email accounts.

Mehling Orthopedics and their Authorized Representatives will not sell, share, or rent your email address or any other personal information collected on this consent.

Email address:_____

Cell phone #: _____

Patient/Guardian Signature:_____ Rev. 12.29.15