COMPLETE Vein & Vascular
WWW.NJVEINDOC.COM

New Patient Demographics

Today's Date:_____

Name: _____ Date of Birth: _____ Gender: _____

Height: _____ Weight: _____ Marital Status (circle one): S M D W

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

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Emergency Contact: _____ Phone #: _____

Relationship:_____

Employer: _____ Phone #:_____

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

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Referred by: _____

Insurance Information

Primary Insurance:

Insurance Company:_____

Name of policy holder/relation: _____

Secondary Insurance (if applicable):

Insurance Company: _____

Name of policy holder/relation: _____

No-Fault Insurance or Workers Compensation:

Insurance Company:_____ Date of Accident: _____

Claim #: _____ Policy #: _____

Policy Holder's Name: _____ Phone #: _____

Attorney's Name: _____

Dr. Rehan Ali, MD
Double Board-Certified, Fellowship Trained Interventional Pain Management & Anesthesiology
1144 E. Ridgewood Ave. Floor 2, Ridgewood NJ 07450
201-336-0188

Patient Medical History

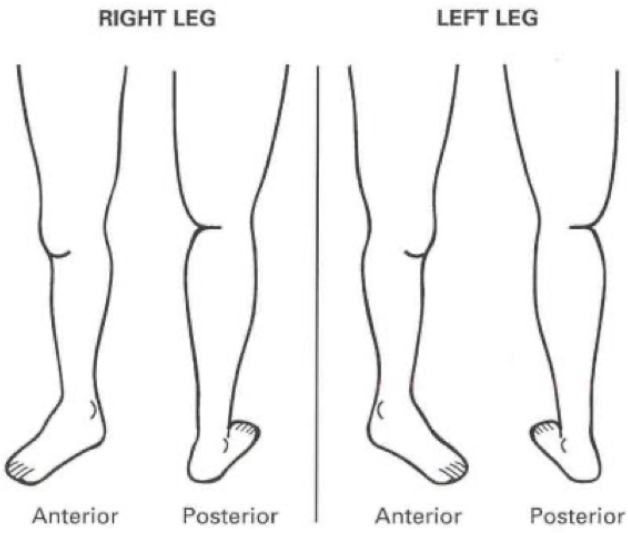
Visit Reason (in your own words):

_____

_____

_____

Please indicate on the diagram below, where your symptoms
are most severe and/or skin problem(s)



How long have you had these symptoms? Months _____ Years_____

Do you experience any of the following symptoms in your legs? Aching Tiredness/Fatigue

Itching/Burning Swollen Ankles Leg Cramps Throbbing Restless Legs Heaviness

Describe the duration of your symptoms: Constant Intermittent Always present but gets worse at times

Describe the intensity of your symptoms: Mild Discomforting Distressing Horrible Excruciating

Pick a number for your discomfort: Least 1 2 3 4 5 6 7 8 9 10 Worst

Is there anything that improves your symptoms?

_____

Is there anything that makes your symptoms worse?

_____

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Have you had previous treatments for spider or varicose veins?

_____

Do you take blood thinning medications (please circle): Aspirin Plavix

Eliquis Xarelto Coumadin Other:_____

How do you sleep at night? Poor Fair Normal Good

Have you had to cut down on normal activities because of your discomfort? Yes No

If yes, how much? Mildly Moderately Severely

Do you experience any leg cramping, heaviness, or tired legs? Yes No

Do you have any varicose veins or spider veins in your legs? Yes No

Have you had any of these medical conditions? Heart problems Asthma Kidney problems

Liver problems Arthritis Stomach ulcers Diabetes Stroke High blood pressure

Blood disorders Easy bruising Psychiatric problems Thyroid Disease High Cholesterol

List the surgeries you've had in the past: _____

_____

List all your medications: _____

Are you allergic to any medications? Yes No
If yes, please list: _____

Do you smoke? Yes No
If yes, how many packs per day? _____

Do you drink alcohol? Yes No Socially

Do you use any recreational drugs? Yes No

Please list any other pertinent facts in regards to your condition if missing from above:

_____

_____

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Authorization of Record Release

This form is used to release your protected health information when such authorization is required and complies with federal and state privacy laws.

Name: _____ **DOB:** _____

I, _____, authorize the release of all medical records to Dr. Ali.

I understand that "all" medical information includes all of my medical information including reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis B and Hepatitis C testing/treatment and/or other sensitive information.

If at any time you wish to revoke this authorization, please request so in writing. Thank you.

Patient Signature: _____ **Date:** _____

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HIPAA Authorization Form for Family Members/Friends

I, _____, give permission to all my healthcare and medical service providers and payers to disclose and release my protected health information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including, but not limited to, diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information: (Check as appropriate)
  - ☐ Mental Health Records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other/please specify _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment/treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____
  Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your healthcare providers.)

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

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Below is the patient and family responsibility as a patient at Complete Pain & Spine Institute

1. To provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations and other related to his/her health.
2. To make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
3. To follow the treatment plan established by the provider, including the instructions of health professionals as they carry out the physician's order.
4. To keep appointments and/or notify the clinic when he/she is unable to do so.
5. To assure that the financial obligations of his/her medical care are fulfilled as promptly as possible.
6. To follow Complete Pain & Spine Instutite's policies and procedures.
7. To be considerate of the rights of other patients and personnel.

The Patient Bill of Rights is an abbreviated summary of the current New Jersey law and regulations governing the rights of our patients. For more complete information, consult the NJ Department of Health regulations at www.nj.gov/health regarding NJAC 8:43 G-4, or Public Law 1989 Chapter 170.

Out of Network Disclosure

Please take notice that *Dr. Rehan Ali* is **non-participating or contracted** with any insurance provider EXCEPT Medicare. Such part or all of your upcoming visit/procedure may be considered "out-of-network". You may be personally responsible for the co-payment, co-insurance, deductible, or other charges associated with such "out-of-network" services that are not covered by your insurance carrier.

Patient Signature: _____ Date: _____
(Parent or legal guardian)

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Statement of Financial Responsibility

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Complete Pain & Spine Institute of any insurance benefits otherwise payable to me or on my behalf of the services performed by Complete Pain & Spine Institute's staff, its affiliates and subsidiaries. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Complete Pain & Spine Institute, its affiliates and subsidiaries to release medical information related to the procedure(s) as may be requested by third party payers in order to process payment of my claims.

CHARGES

I understand that the fees for anesthesia services are separate from the Surgery Center's facility fees and my surgeon's fees. I understand that Dr. Ali is only a network provider with Medicare. The payment by your insurance company may be based on your out-of-network benefits and the status of your deductible.

APPEAL, DOBI AND ARBITRATION

I consent to and authorize Complete Pain & Spine Institute to file any appeal for payment, mediation by DOBI and arbitration by an attorney on my behalf.

CREDIT POLICY

After your procedure, a claim will be filed with your insurance carrier. You will be notified when an action by your insurance company has been taken. At all times, you are fully responsible for any and all deductible, co-pays and co-insurance. Your insurance contract is between you and the insurance company. It is your responsibility to question your insurance company about delays in payment, amount of payment and/or denial of coverage, as well as any requirements to have a second surgical opinion and pre-certifications if any funds are owed, payment will be expected within 30 days of the receipt of the notice.

If your insurance company issues payment to you, you are responsible to send Complete Pain & Spine Institute the full payment along with a copy of the Explanation of Benefits that came with your insurance company check. In the event that you do not forward your insurance payment in a timely manner and we are forced to utilize the services of a collection agency and/or an attorney, you will be responsible for all of the costs of collection *in* addition to the amount originally owed by you.

I HAVE READ AND UNDERSTAND THE TERMS OF THIS FINANCIAL RESPONSIBILITY STATEMENT

Patient Signature: _____ Date: _____
(Parent or Guardian if minor/dependent)

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ASSIGNMENT OF BENEFITS

Patient's Name: _____

I irrevocably assign to Complete Pain & Spine Institute of my rights and benefits under any insurance contracts for payment for services rendered to me by Complete Pain & Spine Institute. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by Complete Pain & Spine Institute to be released to Complete Pain & Spine Institute. I irrevocably authorize Complete Pain & Spine Institute to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Complete Pain & Spine Institute. I irrevocably authorize Complete Pain & Spine Institute to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize Complete Pain & Spine Institute to obtain counsel and enter legal or other actions on my behalf and/or in my name, including the arbitration/dispute resolution process, to collect such sums due if should sums not be paid within the legally prescribed time frame. In the event that Complete Pain & Spine Institute elect to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier. I irrevocably assign my rights title, and interest under the medical expense benefits and/or PIP section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of Complete Pain & Spine Institute choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize Complete Pain & Spine Institute to appoint any attorney of its choice to represent me directly against an insurer from which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended on enabling the attorney to collect the bills of Complete Pain & Spine Institute. The undersigned patient does hereby agree and acknowledge that he/she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to Complete Pain & Spine Institute upon receipt of the same.

A photocopy of this assignment shall be valid as the original. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature: _____ Date: _____

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YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU
You have the following rights regarding medical information we maintain about you:

Rights to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.
To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed healthcare professional chosen by the Privacy Officer will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Complete Pain & Spine Institute.
To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if you ask us to amend information not created by us, unless the person that created the information is no longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Rights to an Accounting of Disclosures. You have the right to request an "account of disclosures". This is a list of the disclosure we made of medical information about you.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, and/or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
We are not required to agree to your request, if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example disclosure to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing to the Office Manager. We will not ask you the reasons for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We have the right to deny your request.

Right to a Paper Copy of the Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the notice at any time. Even if you have agreed to receive this notice electronically you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any front desk person.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effect for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. Each time you register at our clinic for treatment or healthcare services as an outpatient, we will offer you a copy of the current protocol.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION
Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.