NU·Spine The Minimally Invasive Spine Surgery Institute

***Please present ALL Insurance cards and Drivers License at time of visit**
COMPLETE ALL Fields as best as possible

Patient Information Sheet

Name: (First)_____ (MI)_____ (Last)_____

Date of Birth: _____ **Age:** ___ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____ **Social Security#:** _____

Home Phone: _____ **Cell:** _____ **Email address:** _____

Occupation: _____ **Employer:** _____ **Work Phone:**_____

Employer Address: _____

Pharmacy Name: _____ **Town:** _____**Phone#:**_____

Primary Care Physician: _____ **Town:** _____ **Phone#:**_____

Referring Physician: _____ **Town:** _____ **Phone#:**_____

Emergency Contact Name: _____ **Relationship:** _____**Phone#:**_____

Primary Insurance Plan:_____**ID#**_____

Address:_____

Primary Insurance Plan Holder's Name:_____ **DOB:**_____ **Relationship to patient:**_____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ **Cell phone of Plan holder:** _____

Secondary Insurance Plan: _____**ID#**_____

Address: _____

Secondary Insurance Plan Holder's Name:_____ **DOB:**_____ **Relationship to patient:**_____

Patient Release: MUST BE SIGNED BY PATIENT : I understand that Nu-Spine, LLC will prepare any necessary paperwork needed to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Nu-Spine, LLC will be credited to my account.

I understand that any person who knowingly files a statement of claim containing any false or misleading information or knowingly presents any fraudulent information such as personal identification or invalid insurance information is subject to civil and criminal penalties.

I understand and agree that all services rendered to me will be billed to my insurance and that I am responsible for payment. I also hereby authorize Nu-Spine, LLC staff to release any information pertinent to my case concerning illness, condition, or disability and treatment thereof, to any insurance company, adjuster, or attorney involved in this case. I also give permission to leave messages at the insurance companies' and/or attorneys' phone numbers regarding my file AND at the above home or work phone numbers regarding scheduling of appointments and care.

Patient Signature: _____ **Date:** _____

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If you are being seen as the result of an Auto Accident or Worker's Compensation case,
COMPLETE ALL Fields as best as possible

Auto Accident / Workers Comp

Name: (First)_____ (MI)_____ (Last)_____

Were you in an accident: ☐ Motor Vehicle ☐ Workers Comp ☐ Fall ☐ Lifting ☐ Other:_____

Date of Accident/Injury _____ **Location of Accident/Injury** _____

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other:_____

ATTORNEY INFORMATION

Attorney's Name:_____ **Attorney Phone #:**_____

Attorney's Firm:_____

INSURANCE INFORMATION

Insurance Company:_____

Claim #: _____ **Policy #:** _____

Insurance Co. Billing Address: _____

Insurance Co. City: _____ **City:** _____ **State:**_____ **Zip:**_____

Claims Rep Name: _____

Claims Rep Phone#:_____

Case Manager:_____ **Case Manager Phone:**_____

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Patient Signature: _____ **Date:** _____

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Chief Complaint

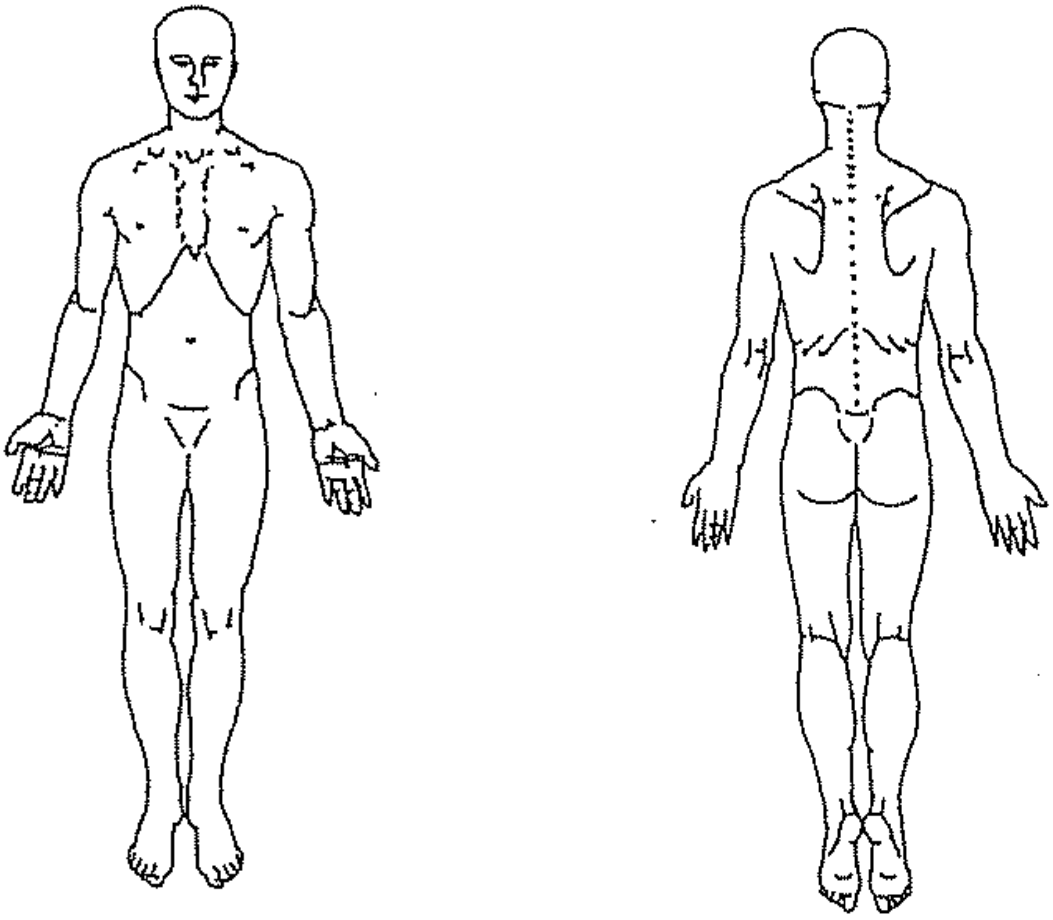
Please describe the reason(s) for your visit today: _____

_____

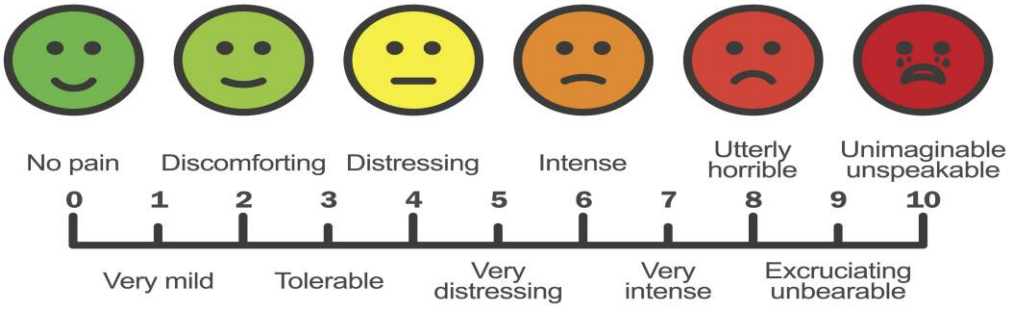
_____

Where are you experiencing pain?

- Please indicate **P** for pain, **N** for Numbness, **T** for Tingling in each area. Shade area as needed to show full area of pain
- If multiple locations please indicate where pain is most severe.



Please Indicate Pain Level



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Past Medical History

Please mark your past medical history (illnesses/ injuries/ hospitalizations etc.)

( ) Arthritis	( ) Diabetes	( ) Heart Disease	( ) Osteoporosis
( ) Asthma/ Lung Disease	( ) Gastritis or Ulcers	( ) High Blood Pressure	( ) Seizures
( ) Blood Clots	( ) Headaches	( ) High Cholesterol	( ) Stroke
( ) Cancer	( ) Head Injury / Concussion	( ) Kidney or Liver Disease	( ) Thyroid Problems

( ) Other _____

Past Surgical History

Surgery: _____ Date: _____
Surgery: _____ Date: _____
Surgery: _____ Date: _____

Allergies to medication or foods (please list all) _____
_____

Please list your history of motor vehicle accidents, back injuries, ect. (date/ did symptoms resolve/ duration of symptoms)

_____

_____

Medications (Please list all medications, over the counter drugs, vitamins and any herbal remedies**)**

Medication: _____ Dosage: _____ Frequency: _____ Date: _____
Medication: _____ Dosage: _____ Frequency: _____ Date: _____
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Medication: _____ Dosage: _____ Frequency: _____ Date: _____
Medication: _____ Dosage: _____ Frequency: _____ Date: _____
Medication: _____ Dosage: _____ Frequency: _____ Date: _____

Conservative Treatment prior to Office Visit today			
	Successful (Yes / No)	**Did you experience temporary relief?**	**Comments (Last Visit)**
Bed Rest			
Cervical Collar			
Analgesics			
Physical Therapy			
Chiropractic Therapy Name of Chiropractor:			
Pain Management Name of Dr.:			
Epidural Steroid Injection			

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Review of Systems

Please circle all that apply to your current state of health

General	Weight loss or gain	Fatigue	Fever or chills	Weakness	Trouble sleeping	Change in appetite
Skin	Rashes	Lumps	Itching	Dryness	Color changes	Hair and nail changes
Head/Neck	Head injury	Headache	Neck lumps	Neck pain	Neck stiffness	Swollen glands
Ears	Decreased hearing	Ringing in ears (tinnitus)	Earache	Drainage		
Eyes	Glaucoma	Cataracts	Flashing lights	Specks / Floaters		
Nose	Stuffiness	Discharge	Itching	Hay fever	Nosebleeds	Sinus pain
Throat	Sore throat	Hoarseness	Mouth sores	Dentures	Sore tongue	Dry mouth
Cardio-vascular	Chest pain	Leg edema (swelling)	Palpitations	Loss of consciousness		
Gastro-Intestinal	Abdominal pain	Nausea / Vomiting	Diarrhea / Constipation	Bright red blood per	Dark, black tarry stool	
Endocrine	Diabetes	Hyperthyroid	Hypothyroid	Sweating		
Respiratory	Cough (dry or wet,	Sputum (color and	Coughing up blood	Shortness of breath	Wheezing	Painful breathing
Neuro	Numbness / Tingling	Bowel / Bladder Incontinence	Seizures	Groin Numbness	Tremors	
Musculoskeletal	Hip pain	Knee pain	Shoulder pain	Back pain	Joint pain	

Social History:	**Never***	**Occasionally**	**Frequently**	**Daily**
Alcohol Use				
Tobacco (Specify:_____)				
Cigars				
Illicit Drugs (Specify:_____)				
Vape				

*If you have quit indicate when

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NU • SPINE LLC P.O. Box 11 Middletown NJ 07748

OFFICE PHONE: (732) 640-8203 info@nu-spine.com

BILLING PHONE: (732) 441-7177 Billing FAX: (732) 441-7165

Major Medical Out of Network Liability Acknowledgement

I, _____ have been informed by NU SPINE LLC that they are not participating with my health insurance carrier and therefore are out of network.

I understand that since NU SPINE LLC is a non-participating provider that all treatment rendered will apply to my out of network benefits and that I may have additional out of pocket costs such as non-covered services, deductible and/or co-insurance responsibility.

I also understand that any payments from my insurance made out in my or subscriber's name and/or sent to my address shall be immediately given to NU SPINE LLC with the appropriate endorsements and a copy of the explanation of benefits (EOB).

I furthermore understand that any payments from the insurance company deposited by me into my personal bank account with no corresponding prompt payment made by me to NU SPINE LLC can be considered theft of services, which could result in my account being referred to collections and possibly being held personally liable in a competent New Jersey court of law.

Lastly, I shall provide NU SPINE LLC with any secondary insurance coverage to cover some if not all of the balance due. If no secondary insurance is provided, I understand that I will be 100% liable for outstanding balances and agree to pay and/or negotiate the balance due.

_____ _____

(Patient/Parent/Guardian signature) (Date)

_____ _____

(Witness) (Date)

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Assignment of Benefits and Authorization

Patient:_____ Ins. Company_____

ID# / Claim #_____

In consideration of the professional services rendered by the Nu Spine LLC, and its affiliated health care providers ("Healthcare 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 Healthcare Providers, including but not limited to surgical facility fees, supplies, primary physician, assistant, anesthesia, and any other fees related to my claim, 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.

2. The authorization of Healthcare Providers to act as my agent-in-fact with regard to all aspects regarding my claim and to receive 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 Healthcare Providers to initiate, prosecute, and resolve any and all appeals and/or arbitrations and/or legal action 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 claim under the federal ERISA statutes, New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), New Jersey Healthcare Quality Act (HCQA) and personal injury claims under the New Jersey Personal Injury Protection (PIP)/No Fault statute N.J.S.A 39:6A.

4. The authorization of Healthcare 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 Healthcare 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 plan, 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 made directly to Healthcare Providers to which I might be entitled under my claims.

7. I hereby further assign to **Nu Spine LLC** all of my rights under my insurance contract, including all of my rights governed by the statutes and regulations of the Employee Retirement Income Security Act (ERISA), including, without any limitation whatsoever, my rights to "recover benefits" under ERISA Section 502(a)(1)(B), my rights to recover civil statutory penalties under ERISA Section 502(c)(1)(B); and my rights to pursue breach of fiduciary claims under ERISA Sections 502(a)(2) and 502(a)(3)

Patient Name (print) : _____ Patient Signature:_____ Date: _____

Witness Name (print): _____Witness Signature: _____ Date: _____