ATLANTIC PEDIATRIC ORTHOPEDICS

PATIENT INFORMATION

PATIENT NAME: _____ (LAST FIRST MIDDLE)

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____

HOME PHONE #: (_____) _____-_____ PARENT CELL #: (_____) _____-_____

SEX: (circle one) FEMALE MALE EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: _____-_____-_____

PRIMARY CARE PHYSICIAN: _____ REFFERRED BY: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: _____ (LAST FIRST MIDDLE)

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX: (circle one) FEMALE MALE

HOME PHONE #: (_____) _____-_____ WORK PHONE #: (_____) _____-_____

CELL PHONE #: (_____) _____-_____ SOCIAL SECURITY #: _____-_____-_____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION: COMPANY: _____

CITY: _____ PHONE # : _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE # : _____

CONTRACT (ID) #: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP #: _____

COPAYMENT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE # : _____

CONTRACT (ID) #: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP #: _____

COPAYMENT: $ _____ INSURED'S DATE OF BIRTH: _____/_____/_____

ATLANTIC PEDIATRIC ORTHOPEDICS

PATIENT HEALTH INFORMATION

Today's Date: _____

Last Name: _____ MI _____ First_____

Condition / Reason for visit:_____

_____

Date of Injury/Accident or Onset of Condition: _____

Was patient seen in the Hospital _____or EMO _____
Name of Hospital _____ or EMO _____

Was patient seen by Dr. Stankovits in the Hospital or Emergency room? Yes ____ No ___
If "Yes" Date of treatment _____Hospital_____

Please circle: School Injury Motor Vehicle Other
School name _____ Sport Team_____
Coach name _____ Phone# _____
Brief description of accident or injury:_____

_____

Past Illnesses: _____

_____

Prior Surgeries & Dates: _____

_____

Current Medications: _____

_____

Allergies:

_____

1131 BROAD STREET SUITE 202 SHREWSBURY, NJ 07702 T# 732-544-9000 F# 732-544-9099

ATLANTIC PEDIATRIC ORTHOPEDICS

Insurance Authorization and Financial Responsibility

Please know that our office will do its utmost to assist you with your insurance processing, however, you, as the responsible party for the patient must obtain all necessary referrals and pre-authorizations. Any incorrect or incomplete insurance information will result in reduced benefits and add to the patient's financial burden. As are responsible to know your insurance coverage.

I authorize Atlantic Pediatric Orthopedics, P.A. and Dr. Stankovits to furnish information concerning my illness and treatment to any insurance company. I further assign to the physician all payments the insurance carriers are obligated to make on my behalf for medical/surgical services rendered by Dr. Stankovits and this office.

I authorize to us or disclosure of the above-named patient's health information.

Signature: _____ **Date:** _____

Name of Legal Guardian and relationship to patient:

_____

1131 BROAD STREET SUITE 202 SHREWSBURY, NJ 07702 T# 732-544-9000 F# 732-544-9099

ATLANTIC PEDIATRIC ORTHOPEDICS

Patients' Bill of Rights

- YOU have the right to respectful care, and to be treated respectfully.
- YOU have the right to be informed about your diagnosis, to know what your treatment options are, and know what the potential outcomes of each treatment may be.
- YOU have the right to know the name of those treating you.
- YOU have the right to refuse treatment permitted by law. You can refuse treatment and still receive alternative care.
- YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone else unless you give your expressed consent to release information.
- YOU have the right to review your medical records; if necessary have the information explained to you.
- YOU have the right to know what alternative medical care may be available to you.
- YOU have the right to know what your treatment may cost you.
- YOU are responsible for providing all information about your past care, illness and medications to your physician when he/she is trying to find the best possible treatment for you.
- YOU are responsible for being considerate of the needs of others in the office.
- YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plus for seeking treatment with the doctor.

Signature: _____ **Date:** _____

Patient Name: _____

1131 BROAD STREET SUITE 202 SHREWSBURY, NJ 07702 T# 732-544-9000 F# 732-544-9099

ATLANTIC PEDIATRIC ORTHOPEDICS

I hereby authorize Dr. Lawrence Stankovits to submit claims, on my behalf, to the insurance company providing benefits and provided to Dr. Lawrence Stankovits, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

I hereby irrevocably designate, authorize and appoint Dr. Lawrence Stankovits as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered. This power of attorney shall automatically terminate, without formal action being taken, as soon as Dr. Lawrence Stankovits has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby instruct and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue all payment check(s) and correspondence directly to Dr. Lawrence Stankovits and Atlantic Pediatric Orthopedics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. I understand under applicable ERISA, state and/or federal regulatory guidelines that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I under my rights per state and federal ERISA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Dr. Lawrence Stankovits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, governmental agency or attorney involved in this case. I authorize Dr. Lawrence Stankovits or appointed business associates by the provider to be my personal representative, which allows them as my legally binding authorized representative to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any State or Federal agency that has jurisdiction over my insurer and/or benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of my stated plan benefits based on billed charges, within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any penalties or fines levied against my insurance company will be paid to Dr. Lawrence Stankovits for acting as my personal representative.

I authorize Dr. Lawrence Stankovits to provide medical care reasonable and at the standard of care as required by state law.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____

Name of Patient/Guarantor

_____ _____

Signature of Patient/Guarantor Date

ATLANTIC PEDIATRIC ORTHOPEDICS

Dear Patient,

We will be submitting a claim directly to insurance carrier. However, we are ***not*** in-network; therefore, your insurance company may make a payment directly to you.

DO NOT CASH THE INSURANCE CHECK

Instead, please indorse the back of the check and write "Payable to Atlantic Pediatric Orthopedics" below your signature. You must send the insurance check to Atlantic Pediatric Orthopedics, P.O. Box 283, Rumson, NJ 07760 as soon as you receive it. The check must be sent within 10 days of receipt otherwise 5% interest will be charged monthly to your account.

FORWARD A COPY OF EXPLANATION OF BENEFITS

All payments will be accompanied by an Explanation of Benefits (EOB). The EOB explains how your carrier arrived at the amount of money they issued. Failure to provide this copy to us may impact the balance we consider to be your remaining obligation.

Please contact us with any questions you have.

Sincerely,

Elaine Carola

Billing

(908)461-0383

X_____ _____

PATIENT SIGNATURE OR PARENT SIGNATURE DATE

PRINT NAME_____

1131 BROAD STREET SUITE 202 SHREWSBURY, NJ 07702 T# 732-544-9000 F# 732-544-9099

ATLANTIC PEDIATRIC ORTHOPEDICS

Insurance Complaint/Appeal Authorization

I, _____, authorize Atlantic Pediatric Orthopedics to file an appeal to my Insurance Company and or complaint to the Insurance Commissioner, for any reason, on my behalf.

Patient name: _____

Signature: _____ **Date:** _____

Print name: _____

Policy holder name: _____

Relationship to the patient: _____

1131 BROAD STREET SUITE 202 SHREWSBURY, NJ 07702 T# 732-544-9000 F# 732-544-9099

ATLANTIC PEDIATRIC ORTHOPEDICS

OUT-OF-NETWORK ("OON") SURPRISE BILL PROTECTION DISCLOSURE

DISCLOSURE(S) TO COVERED PERSON(S) REGARDING OUT-OF-NETWORK TREATMENT

Please read carefully before you sign

I certify that I have insurance and/or employee health care benefits coverage which provides both In- Network (INET) and/or Out of Network (ONET) benefits. I certify that I have been informed that the referenced Provider organization and/or its associated Providers are Out-of-Network (ONET) as required under the Out-Of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act, P.L. 2018, c. 32 ("Act").

I understand and acknowledge that the Act was to limit a covered person's financial responsibility to the network level cost-sharing as applied to the allowed amount/charge when inadvertent and/or involuntary services are rendered by Providers who are not members of a managed care network (i.e., PPO Network).

I understand and acknowledge that "a covered person's cost-sharing liability under the Act is based upon the application of network cost-sharing, not a network level reimbursement amount." (Bulletin NO. 18-14) The transparency and claims processing provisions apply to all carriers operating in New Jersey consistent with the Administrative Simplification provisions mandated under numerous State and Federal healthcare regulations as detailed within this disclosure/notification.

I understand and acknowledge that the Provider has, to the extent feasible and appropriate, verified eligibility, obtained preauthorization and informed me of my financial responsibility for specific service(s) prior to or at the point of care consistent with the Health Information Technology for Economic and Clinical Health Act. Pub. L. No. 111-5, 1234 Stat. 226 and the Department of Health and Human Services Regulations, 45 C.F.R. § 160 et seq. (collectively, "HIPAA").

I certify that I knowingly, voluntarily, and specifically selected the referenced ONET Provider(s) with full knowledge that the provider is ONET with respect to my health benefits plan and consent to the treatment plan the Provider may recommend.

I authorize the use of my signature on all my insurance and/or employee health care benefit claims processing including but not limited to, requesting data, verifying eligibility, adjudication and appeals consistent with section 1104(b)(2) of the Affordable Care Act. This includes signatures in compliance with the E-Sign Act and Uniform Electronic Transactions Act.[1] A photocopy, computer generated, or any other reproduction of this signature and assignment/authorization is to be considered valid, and the same as if it was the original.

I have read this express assignment/authorization and it has been explained to me prior to the Provider submitting my healthcare claims for reimbursement.

Patient Name: _____ Patient Date of Birth: _____

Subscriber's Employer: _____

Parent/Authorized Rep Name (Printed): _____

Parent/Authorized Rep Signature: _____

Date: _____ Staff Acknowledgement (for office use only): _____

[1] 15 U.S.C.A. § 7001(a)(2)

ATLANTIC PEDIATRIC ORTHOPEDICS

HIPAA AUTHORIZATION AND ESIGNATURE CONSENT DISCLOSURE

I understand that I (patient), or an authorized representative, must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alphanumeric date (e.g., January 1, 2006) unless the signature is on file. I understand that in lieu of signing the claim, that I may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements" (see. Rev. 10540, 06-11-21)[1] I understand that the authorization is effective indefinitely unless I, or my representative revokes this arrangement. **Note: I understand that this can be a "Signature on File" and/or computer generated.**

I understand that my healthcare plan is required: 1) to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care; 2) be comprehensive, requiring minimal augmentation by paper or other communications; and 3) provide for timely acknowledgment response. I understand this also includes but is not limited to status reporting that supports a transparent claims and denial management process (including adjudication and appeals), describing all data elements (including reason and remark codes) in unambiguous terms. (see. Section 1104 ACA)

I understand and acknowledge that the Provider has, to the extent feasible and appropriate, verified eligibility, obtained preauthorization, and informed me of my financial responsibility for specific service(s) prior to or at the point of care consistent with the Health Information Technology for Economic and Clinical Health Act. Pub. L. No. 111-5, 1234 Stat. 226 and the Department of Health and Human Services Regulations, 45 C.F.R. § 160 et seq. (collectively, "HIPAA").

I certify that I knowingly, voluntarily, and specifically agreed to the use of my signature on all my insurance and/or employee health care benefit claims submission(s) consistent with the regulations explained to me within this **HIPAA Authorization and Electronic Signature Consent Disclosure**. This includes signatures in compliance with the E-Sign Act and Uniform Electronic Transactions Act. A photocopy, computer generated, or any other reproduction of this signature and assignment/authorization is to be considered valid, and the same as if it was the original.

This form is intended to protect patients from surprise medical bills and increase transparency by requiring certain health care facilities and insurers to disclose certain required information.

Patient Name: _____ Patient Date of Birth: _____

Subscriber's Employer: _____

Parent/Authorized Rep Name: _____

Parent/Authorized Rep Signature: _____

Date: _____ Staff Acknowledgement (*for office use only*): _____

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

UnitedHealthcare® Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID number	
Member's Street Address	City	State	Phone
Name of Individual/Company/Law Firm being designated as the authorized representative			
Designated Representative's Address	City	State	Phone
Provider of Service			
Date(s) of Service or Proposed Service			

I, _____, do hereby name
Print the name of the member who is receiving the service or supply

_____
Print the name of the person who is being authorized to act on the member's behalf
to act as my authorized representative in requesting (*check all that apply*)
☐ a complaint ☐ an appeal ☐ documents
from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member	Date
If person signing this authorization is not the member, describe relationship to the Member(i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority

OXFORD HEALTH PLANS®
A UnitedHealthcare Company

HIPAA MEMBER AUTHORIZATION

Except as otherwise permitted or required by applicable federal and state laws and regulations, Oxford must obtain an authorization before using or disclosing protected health information ("PHI"). Upon receipt of a valid authorization for its use and/or disclosure of PHI, Oxford will make such use and/or disclosure in a manner consistent with such authorization.

To: **HIPAA Correspondence**
P.O. Box 7081
Bridgeport, CT 06601-7081

Member Name: _____

Member I.D. Number: _____ Telephone: _____

Address: _____

Description of PHI: A description of the PHI to be used or disclosed:

_____

_____

Persons Authorized to Use or Disclose: The person(s), class of persons, or entity to whom Oxford is authorized to make the use or disclosure:

_____

_____

Description of each Purpose to Use or Disclose: A description of each purpose of use or disclosure (the statement "at the request of the Member" is sufficient):

_____

_____

Does the person(s), class of persons, or entity named above that Oxford is authorized to make the use or disclosure to also have the authority to file an appeal and/or grievance on behalf of the Member?

(check one) ☐ Yes ☐ No

Expiration:

This authorization will expire:

☐ Remain in place until_____. (*Date*)

☐ On occurrence of the following event (which must relate to the Member or to the purpose of the use and/or disclosure being authorized):

_____

_____

Revocation:
I understand that I may revoke this authorization at any time by giving written notice of my revocation to the HIPAA Member Rights Unit at the address provided below. I understand that any revocation of this authorization will *not* affect any action Oxford took in reliance on this authorization before Oxford received my written notice of revocation. I also understand that any revocation of this authorization will not result in my disenrollment from Oxford or denial of my eligibility for benefits.

HIPAA Member Rights Unit
48 Monroe Turnpike
Trumbull, CT 06611

Note the following:

- As an Oxford Member, your decision to sign this Authorization is voluntary and said decision will not impact treatment, payment, enrollment or eligibility for benefits under your Oxford coverage plan.
- If you instruct Oxford to release all of your PHI, please be aware that such release may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to alcohol or drug abuse, genetic testing, psychiatric care and behavioral or mental health services and treatment.
- The PHI disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal and state laws and regulations.

Signature:

I have read and understand the contents of this document and am hereby providing my agreement to the terms of this Authorization.

Signature *: _____

Print Name: _____

Date: _____

* If a personal representative of an Oxford Member signs this Authorization, please provide a description and any available documentation of the authority to act in this capacity.

_____

_____

_____