Collegiate Orthopaedics & Sports Medicine Institute
Robin M. Gehrmann, MD
345 Main Street
Madison, NJ 07940
P: 973-200-7370 F:973-822-7905

TODAY'S DATE: ____/____/_____

Patient Information PLEASE PRINT

Last Name:_____ First Name: _____ Middle:_____

Email:_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Sex: ☐ M ☐ F Date of Birth:____/____/_____ Age:____ Social Security #:_____-____-_____

Street Address:_____ Apt./Floor:_____

City:_____ State:_____ ZIP Code:_____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Occupation:_____ Employer:_____

Employer Address:_____ Driver's License #:_____

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

Pharmacy Name: _____ Phone: (_____) _____-_____

Insurance Information PLEASE GIVE INSURANCE CARD TO RECEPTIONIST

Type of Insurance: ☐ Worker's Comp. ☐ MVA _____ ☐ Other (please specify):_____

Subscriber Name: _____ Subscriber's DOB:____/____/_____

Primary Insurance ID #:_____ Group #:_____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Secondary Insurance ID #:_____ Group #:_____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

In Case of Emergency Contact

Name of Relative or Friend:_____ Phone: (_____) _____-_____

Name of Relative or Friend:_____ Phone: (_____) _____-_____

The above information is true to the best of my knowledge. I authorize Collegiate Sports Care LLC to provide myself or my child with reasonable and proper medical care according to today's standards. I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claims. I understand that Collegiate Sports Care LLC has the right to refuse or accept AOB. If I receive any payment from my insurance carrier relating to any services rendered, I agree to hold such payment in trust for Collegiate Sports Care LLC and I agree to send such payment to Collegiate Sports Care LLC within one week after I receive same. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ACCOUNT EVEN THOUGH INSURANCE MAY BE PENDING ON ALL OR A PORTION OF THE CHARGES.

X_____ Date: ____/____/_____

Patient/Guardian Signature

COLLEGIATE ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE

Purpose of Your Consult/Visit

Was injury/pain a result of an accident? ☐ Yes ☐ No If Yes, ☐ Job Related ☐ Auto ☐ Other:_____

What is the condition for which you are seeking medical attention?_____

Site of injury (which body part): _____ Side: ☐ Right ☐ Left

Date of injury or onset:____/____/_____ Having pain since:____/____/_____

Attorney Information (if applicable)

Name:_____ Phone: (_____) _____-_____ Fax: (_____) _____-_____

Describe the events of the injury/accident/pain: _____

_____

_____

_____

Have you previously been treated for this or a similar condition? ☐ Yes ☐ No

If yes, what was the treatment?_____

_____

_____

_____

What were the results of the treatment?_____

_____

_____

_____

List any previous major injuries/surgeries: _____

_____

_____

_____

Have you had any diagnostic tests related to condition (i.e., x-ray, MRI, CT, EMG)? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

PLEASE GIVE ANY REPORTS/RESULTS OF TESTING TO RECEPTIONIST

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

X_____ Date: ____/____/_____

Patient/Guardian Signature

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Personal History PLEASE PRINT

Have You Had?	✓ YES	Family History (list family member)	Please list any surgeries related to disorder/injury
Recurrent Headaches			
Bone Injuries/Fractures			Body Part(s):
Joint Injuries (i.e., Arthritis, Carpal Tunnel)			Body Part(s):
Epilepsy/Seizures			
Cancer			Type of Cancer(s):
Thyroid Disorder			
Heart Murmur			
Angina			
Congestive Heart Failure			
Heart Disease			
Heart Arrhythmia			
Heart Stents			
Diabetes			☐ Type I ☐ Type II
High Blood Pressure			
High Cholesterol			
Anemia			
Sickle Cell			
Bleeding Disorders			
Hepatitis			☐ Type A ☐ Type B
Kidney/Liver Disorders			Type of Disorder:
Lupus			
Alcohol/Drug Abuse			How Often? How Long?
Lyme Disease			
Tuberculosis			
Gout			
Asthma/Emphysema			
Other:			

Do you smoke? ☐ Yes ☐ No If Yes, how many packs per day?____ For how many years have you been a smoker?_____

Are you allergic to Latex? ☐ Yes ☐ No

If Yes, what is the reaction? ☐ Redness ☐ Swelling ☐ Rash ☐ Hives ☐ Other: _____

List any medications that you are allergic to: _____

If Yes, what is the reaction? ☐ Redness ☐ Swelling ☐ Rash ☐ Hives ☐ Other: _____

List any medication(s) you are currently taking: _____

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HIPAA Compliant Authorization for the Release of Patient Information

PURSUANT TO 45 CFR 164.508

TO: _____

Name of Healthcare Provider/Physician/Facility/Medicare Contractor

Street Address:_____ Apt./Floor:_____

City:_____ State:_____ ZIP Code:_____

RE: Patient Name:_____

Date of Birth:____/____/_____ Social Security #:_____-____-_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurses' notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/ histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
- All physical, occupational and rehab requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All employment, personnel or wage records.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period ____/____/_____ to ____/____/_____.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

Name of Representative: _____

Representative Capacity (e.g. attorney, records requestor, agent, etc.): _____

Street Address:_____ Apt./Floor:_____

City: _____ State:_____ ZIP Code:_____

I understand the following: See CFR §164.508(c) (2) (i-iii)

X _____ Date:____/____/_____

Patient/Guardian Signature

X _____ Date:____/____/_____

Signature of Legal Representative

COLLEGIATE ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE

Acknowledgement of Receipt of Notice of Privacy Practices

We keep record of the healthcare services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your records to others unless you direct us to do so or unless the law authorizes or tells us to do so. You may see your record or get more information about it by contacting our office's Practice Administrator/Manager.

Our notice of Privacy Practices describes in more detail how your health information may be used and revealed, and how you can obtain your information.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I, _____, received a copy of the Office's Notice of Privacy Practice.

X _____ Date:____/____/_____
Patient/Guardian Signature

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other _____

X _____ Date:____/____/_____

COLLEGIATE ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE

Legal Assignment of Benefits & Designation of Authorized Representative

I, _____, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Collegiate Sports Care LLC (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws.

A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X _____ Date:____/____/_____

Signature of Insured/Guardian

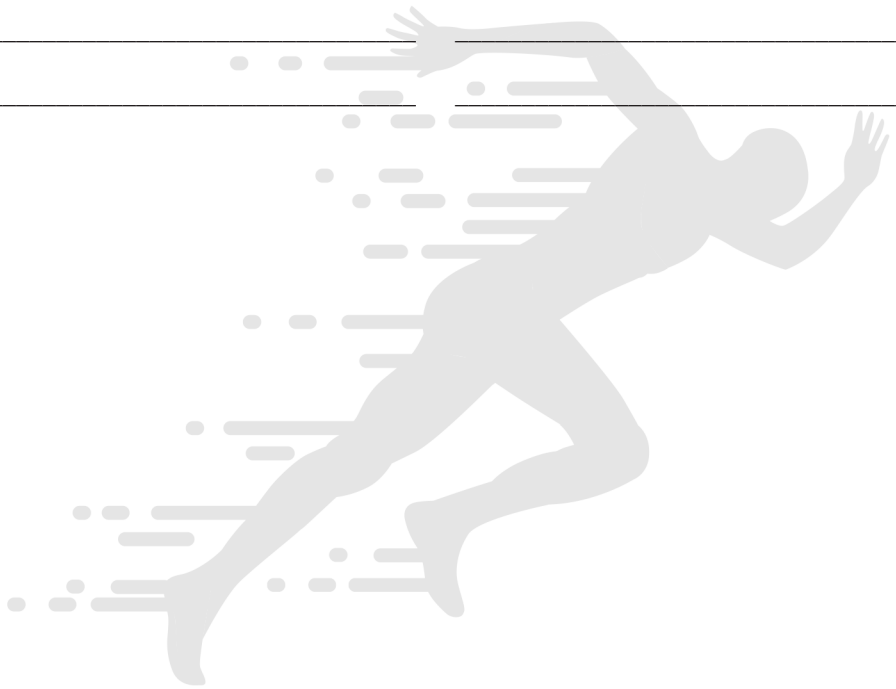
Name of Insured/Guardian (print): _____

COLLEGIATE ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE

Permission to Speak With Relative/Acquaintance

I, _____, give Dr. Gehrmann and/or his representative's permission to disclose any information pertaining to my care/treatment to the following person (s) listed below. Due to HIPAA laws/regulation you may not disclose any of my information to anyone other than the names listed below._____ Date:____/____/_____
Signature of Insured/Guardian

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____



Provider's General Disclosure Form

New Jersey Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act ("Act") Disclosure and Acknowledgement Form

Each provider in this office ("Provider") hereby notifies you of the following:

I. Provider is in-network with respect to the following health benefits plans: Medicare.

II. Provider is out-of-network with respect to all health benefits plans not listed in I. above

III. Provider is affiliated with the following facilities: Harrison Endo Surgical Center, Overlook Medical Center, St Barnabas, St Joseph's Medical Center (Paterson & Wayne), EliteSurgical Center.

IV. You should be aware that, with respect to a Provider who is out-of-network with your health benefits plan:

a. You will have a financial responsibility applicable to the health care services provided by the Provider in excess of your copayment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your health benefits plan; and

b. You should contact your carrier for further additional information those costs.

V. Other Providers: Provider may refer you to, coordinate your care with or engage, or has referred you to, coordinated your care with or engaged, certain other providers, who are not employed by Provider's practice, to render anesthesiology, laboratory, pathology, radiology or assistant surgeon services. A list of these providers and their contact information is enclosed herewith. You can determine the health plans in which the foregoing healthcare provider(s) participate by contacting them at their respective phone number. You should contact your carrier for further consultation on costs associated with this/these provider's/providers' services.

VI. The receipt an acknowledgment of this disclosure shall not waive or otherwise affect any protection you may have under existing statutes or regulations regarding in-network health benefits plan coverage available to you or created under the Act.

VII. If between the time of you were notified of Provider's network status and the time of your procedure, the network status of Provider changes, then Provider shall promptly notify you of the same.

COLLEGIATE ORTHOPAEDICS & SPORTS MEDICINE INSTITUTE

Dear Patient:

I acknowledge that I am being made aware that the practice is out of network with my healthcare plan. As an out of network physician depending on your specific plan, you may have a financial responsibility for services related to your out of network deductible-copay and/or coinsurance. Additionally, you may be responsible for the portion of our charges that are not covered by your insurance, and we recommend that you contact your insurance carrier for further information regarding the costs under your specific plan.

As a courtesy to our patients, we will bill your insurance company directly for reimbursement for our services. Occasionally the insurance company will either mail the check directly to you along with you explanation of benefits, we kindly request that you sign the check and submit with a copy of that explanation of benefits, you can also send a personal check in the exact amount stated on the statement received by your carrier made payable to Collegiate Orthopaedics & Sports Medicine Institute. It can be mailed to 345 Main St. Ste 201, Madison, NJ, 07940. We thank you for cooperating in this matter and we are happy to assist you in any way we can.

I acknowledge the Dr. Robin Gehrmann is an out of network provider and I elect to obtain services from Collegiate Orthopaedics & Sports Medicine Institute and I also acknowledge that I have read the attached information regarding fee disclosures.

Effective immediately, there will be a $50 fee for a no-show or cancellation, if our office is not notified within 24 hours of the scheduled appointment.

If you have any questions, feel free to ask one of our staff members.

PATIENT NAME_____ DATE_____
(Please print)

Patient Signature_____ Parent's Signature_____(if required)