

MITCHELL F. REITER, M.D. PC
Orthopaedic Spine Surgeon
33 Overlook Rd., Suite 305, Summit, NJ 07901
T: (908) 608-9620 / F: (908) 608-9622

1. Patient Information

please print clearly and complete ALL fields

Name: _____ Social Security No: _____ - ____ - ____
Date of Birth: _____ Sex: Male Female Marital Status: _____
Address: _____ City, State, Zip: _____
Home phone: (____) _____ Cell: (____) _____ Work: (____) _____ Ext. _____
Email: _____ Personal info. may may not be sent to this e-mail
Family Physician: _____ Phone: (____) _____
Address: _____ City, State, Zip: _____
Referred by: _____ Address: _____
City, State, Zip: _____
Patient Employer: _____ Occupation: _____ Phone: (____) _____
Employer Address: _____ City, State, Zip: _____
Spouse's Name: _____ Spouse's Employer: _____
Employer Address: _____ City, State, Zip: _____
Spouse's Work Phone: Work: (____) _____ Ext. _____ Spouse's Date of Birth: _____
Party response for Payment (if minor): _____ Relationship to patient: _____
Address: _____ City, State, Zip: _____
Reason for Visit: Major Complaint: _____
Injury/accident: yes no (If yes check one and complete #3 below): motor vehicle work-injury other
Date of Injury or Onset of Problem: _____ Injury Location: _____
Injury details: _____

2. Work/Auto Related Injuries

For Work or Auto Related Injuries Only

Insurance Company: _____ Claim Number: _____
Address: _____ City, State, Zip: _____
Insurance Phone #: (____) _____ Insurance Contact person: _____
Was work injury reported to employer? yes no If so, to whom? _____

4. In Case of Emergency

Name of Friend or Relative not living with you (other than spouse): _____
Address: _____ City, State, Zip: _____
Home phone#: (____) _____ Work#: (____) _____ Ext. _____ Cell#: (____) _____

5. Medication Allergies

I do not have any allergies that I know of.
Please list all allergies: _____

6. Pharmacy Information

Name: _____
Address: _____
City, State: _____
Phone #: _____

Please complete the reverse side of this form

Treatment Authorization

Personal information may be may not be left on my home phone cell phone

I authorize the release of my personal information to the following individual(s): _____

I hereby authorize **Mitchell Reiter, M.D. PC** to furnish any designated insurance company all information necessary to file an insurance claim.

Legal Assignment of Benefits and Release of Medical and Plan Documents

I have provided complete and accurate demographic and insurance information, allowing **Mitchell F. Reiter MD, PC** to act as my billing agent for services rendered. In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Mitchell F. Reiter MD, PC** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments which I am entitled to, including: Medicare, other government sponsored programs, private insurance, personal injury protection, workman's compensation, and any other insurance plans to **Mitchell F. Reiter MD, PC**.

I hereby authorize the doctor to release all medical information necessary to process this claim and all claims associated with his care whether or not billed directly by him. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic 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 above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Arbitration

I authorize **Mitchell Reiter, M.D. PC** to arbitrate any Personal Injury protection (PIP) insurance based denials of coverage/claims on my behalf and to release all pertinent medical records required to pursue such arbitration.

I certify that I have read the foregoing information and understand the above contents.

I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Signature of Insured or Guardian: _____

Date: _____



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CLINICAL HISTORY FORM

DATE OF VISIT: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

AGE: _____ **GENDER:** _____ **HEIGHT:** _____ **WEIGHT:** _____

ALLERGIES: _____

MEDICAL HISTORY:

- | | | | |
|------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CANCER | <input type="checkbox"/> DIFFICULTY WITH ANESTHESIA |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> BLEEDING / CLOTS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> HIGH / LOW BLOOD PRESSURE |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> EASY BRUISING | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> OSTEOPOROSIS / OSTEOPENIA |
| <input type="checkbox"/> GERD | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> SCOLIOSIS | <input type="checkbox"/> MENTAL HEALTH |

OTHERS CONDITIONS: _____

SURGICAL HISTORY / YEAR

CURRENT MEDICATIONS (Name / Dose / How often)

_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

EMPLOYMENT: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED **# OF CHILDREN:** _____

ALCOHOL CONSUMPTION: NONE SOCIAL DAILY WEEKLY QUIT

TOBACCO CONSUMPTION: NEVER DAILY WEEKLY QUIT

FAMILY HISTORY

MOTHER: _____

GRANDPARENTS: _____

FATHER: _____

BROTHERS / SISTERS: _____



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ACKNOWLEDGEMENT & AGREEMENT

I _____ acknowledge that I have been advised that Mitchell F. Reiter, M.D., PC does not participate with my insurance carrier and I have been advised that I will be utilizing my out-of-network benefits. I understand that as a courtesy, his office will bill my insurance company directly for services rendered.

I acknowledge that I have been advised that my insurance carrier may issue payment for services rendered directly to me. I will immediately forward all insurance checks and copies of correspondence enclosed with the check directly to Mitchell Reiter MD, PC without delay.

**Failure to promptly forward the payment may result in:
Late Payment Penalties, Interest, Collection and Legal Action**

Signature

Date



**New Jersey Department of Banking and Insurance
 CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION
 MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF
 MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF
 CLAIMS**

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

**CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF
 INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS**

I, , by marking (or) and signing below, agree to:

- representation by in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.
- release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#: _____ Date: _____
 Relationship to Patient: I am the Patient I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

**New Patient Consent to the Use and Disclosure of Health Information for Treatment,
Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, Mitchell F. Reiter, M.D., PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Mitchell F. Reiter, M.D., PC is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Mitchell F. Reiter, M.D., PC reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Mitchell F. Reiter, M.D., PC change their notice, they will send a copy of and revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health insurance:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I understand that Mitchell F. Reiter, M.D., PC may provide my PHI to a family member, friend or other person that I indicate is involved in my care or the payment for my health care, unless I object in whole or in part.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____.

[] Consent refused by patient, and treatment refused as permitted.

[] Consent added to the patient's medical record on _____.