KAYAL ORTHOPAEDIC CENTER, P.C.

Orthopaedic Surgeons
Robert A. Kayal, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Founder, President & CEO
Edward C. Friedland, MD, FAAOS
Board-Certified Orthopaedic Surgeon
E. Jeffrey Pope, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Joseph M. Bellapianta, MD, FAAOS
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Daphne E. Pinkas, MD
Board-Eligible Orthopaedic Surgeon

Foot & Ankle Surgeon
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Board-Certified Foot & Ankle Surgeon

Podiatrist
Theresa Ronna, DPM
Board-Certified Podiatrist

Physician Assistants
Michael G. Kayal, PA-C
Chief Physician Assistant
Dean P. Mellas, PA-C
Jillian M. Dilonno, PA-C
James J. Verardi, PA-C
Roya Salimi, PA-C, CNMT

WELCOME TO KAYAL ORTHOPAEDIC CENTER, P.C.

PATIENT'S NAME:		TODAY'S DATE:	

E-MAIL ADDRESS:	
PATIENT'S DATE OF BIRTH:	

BRIEFLY DESCRIBE THE REASON FOR TODAY'S VISIT	

DATE OF ONSET OR INJURY:	
IS TODAY'S VISIT RELATED TO A WORK OR OCCUPATION INJURY?	YES NO AUTHORIZATION #:
IS TODAY'S VISIT RELATED TO A MOTOR VEHICLE ACCIDENT?	YES NO AUTHORIZATION #:
IF SO, HAS THIS INJURY ALREADY BEEN REPORTED?	YES NO

AN IMPORTANT MESSAGE TO OUR PATIENTS ABOUT YOUR INSURANCE COVERAGE

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with different benefits and requirements. There is absolutely NO WAY that we can possibly know or keep up to date with each program's provisions. Some programs require that you utilize a specific facility. Some require pre-authorization for services, while others do not. Some require a signed referral from your primary care physician prior to any consultations with a specialist. Finally, some programs may require a second opinion. It is your responsibility to know and advise us of your program's requirements in advance each and every time that we provide a service. We will do our best to comply with any requirements that you may have. Please understand that if we provide a service that is outside of your program, you will be responsible for the appropriate fees. These are NOT our regulations. They are your insurance company's rules, and unless you follow them carefully, your insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to be used if you have any questions concerning your coverage. With respect to bill collections, please understand that unless other written arrangements are made with Kayal Orthopaedic Center, P.C., I agree to pay your final bill within 30 days of receipt. If I do not pay what I owe, I understand that I will be in default and the Kayal Orthopaedic Center, P.C. may retain an attorney to collect the balance due to it. If the Kayal Orthopaedic Center, P.C. retains an attorney who is not a salaried employee, I agree to pay the Kayal Orthopaedic Center, P.C.'s reasonable attorney fees upon placement of the claim with the law firm.

SIGNATURE OF PATIENT OR GUARANTOR OF PAYMENT:

x _____

PLEASE NOTIFY THE STAFF OF ANY CHANGES IN YOUR ADDRESS OR INSURANCE INFORMATION

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PATIENT HISTORY

NAME:		TODAY'S DATE:	

AGE:		HEIGHT:		WEIGHT:	

PAST MEDICAL HISTORY:	

PRIMARY CARE PHYSICIAN:		PHONE:	

CURRENT MEDICATIONS

DRUG	DOSAGE	FREQUENCY

ALLERGIES (DRUG, FOOD, METALS, ETC.)

E.g. Ibuprofen, Penicillin, Shell Fish, Peanuts, Milk, Eggs, Wheat, Soy, Silver, Nickle, Latex, Chemicals in Shampoo or Cosmetics, Sun, Seasonal, Pets

ALLERGY TYPE	SIDE EFFECT / ADVERSE REACTION

☐ ***Check here if you have ever had a skin reaction while wearing jewelry including body piercings. What type of metal jewelry: _____***

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SURGICAL HISTORY

SURGERY	DATE	DOCTOR & HOSPITAL

SOCIAL HISTORY

MARITAL STATUS (CIRCLE)	SEX & AGES OF CHILDREN (IF ANY)	TOBACCO USAGE IF ANY & FREQUENCY	ALCOHOL USAGE IF ANY & FREQUENCY	ILLICIT DRUG USAGE IF ANY & FREQUENCY	SEXUALLY TRANSMITTED DISEASES (CIRCLE)
SINGLE MARRIED DIVORCED WIDOWED					HEPATITIS C? HIV?

PERTINENT FAMILY MEDICAL HISTORY
(i.e. CANCER, HEART DISEASE, DIABETES, ARTHRITIS, ETC.)

MOTHER	FATHER	SIBLINGS	CHILDREN	OTHER

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF KAYAL ORTHOPAEDIC CENTER, P.C.'S NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, acknowledge receipt of KAYAL ORTHOPAEDIC CENTER, P.C.'S (the "Provider") Notice of Privacy Practices dated February 16, 2006 and I consent to the Provider's use and disclosure of my health information and insurance/payment information which specifically identifies me or which can reasonably be used to identify me for treatment, payment and healthy care operations of the Provider and in accordance with the Notice of the Provider's Privacy Practices. I understand that while this consent is voluntary, if I refuse to sign this consent, the Provider can refuse to treat me.

I also consent to the restrictions contained in the Notice of Privacy Practices regarding all worker's compensation information. I understand that such information will not be disclosed to me without the written authorization of the applicable worker's compensation carrier/payor. In the event that such worker's compensation carrier/payor refuses to release any or all of such records, I hold the Practice and all of its shareholders, physicians, employees and agents harmless in connection with such refusal.

I understand that I have the right to request that the Provider restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent at any time by notifying the Provider in writing, but if I revoke my consent, such revocation will not affect any actions that the Provider took before receiving my revocation.

_____

Signature of patient or patient's representative Date

_____

Printed name of patient or patient's representative

_____

Relationship to patient

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ASSIGNMENT OF BENEFITS FORM

Name of Insured (print): _____

Social Security Number: _____

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by the organization. I expressly assign all my rights in and to such insurance benefits directly to KAYAL ORTHOPAEDIC CENTER, P.C., and authorize KAYAL ORTHOPAEDIC CENTER, P.C. to endorse any and all drafts on my behalf, issued pursuant to this assignment, for the benefit of KAYAL ORTHOPAEDIC CENTER, P.C.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for product received.

In certain circumstances, insurance company may send check for services provided directly to the patient or the guarantor. In such cases, the patient and the guarantor agrees to endorse and forward such a check to KAYAL ORTHOPAEDIC CENTER, P.C. If the patient deposits such a check into a personal account, the patient and guarantor agrees to immediately send a check for the equivalent amount to KAYAL ORTHOPAEDIC CENTER, P.C.

KAYAL ORTHOPAEDIC CENTER, P.C.
784 Franklin Avenue, Suite 250
Franklin Lakes, NJ 07417

Name of person signing below (print): _____

Relationship to insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____

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IMPORTANT MESSAGE TO OUR PATIENTS

Recently some insurance companies decided to institute a policy that reimburses patients for services rendered by their physicians. In turn, the physician provider is then expected to bill and pursue the patient for the provided service. As such, in effort to avoid confusion and improper patient billing, if your insurance company reimburses you for services provided by the KAYAL ORTHOPAEDIC CENTER, PC, we ask that you simply:

- BRING IN ALL PAGES OF THE EXPLANATION OF BENEFITS MAILED TO YOU, ALONG WITH THE ATTACHED CHECK.
- ENDORSE THE CHECK AND BRING IT INTO OUR OFFICE. PLEASE DO NOT CASH THE CHECK AND THEN REIMBURSE THE KAYAL ORTHOPAEDIC CENTER, PC WITH A PERSONAL CHECK.
- CALL OUR BILLING DEPARTMENT IF YOU HAVE ANY QUESTIONS CONCERNING CHECKS THAT YOU MAY RECEIVE FROM YOUR INSURANCE COMPANY!

Failure to comply with this request will make you responsible for the full amount billed.

We are working in earnest to make this an easy process for both you and our billing staff. We truly appreciate your assistance in this important matter. Should you have any questions of concerns, please do not hesitate to contact me at the office.

Thank you for your cooperation in this matter.

Sincerely yours,

Billing Department

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IMPORTANT MESSAGE TO OUR PATIENTS

NON-INVASIVE PAIN RELIEF

Biologics, or the use of specialized cells to stimulate the patient healing process, is fast becoming the future of orthopaedics. At Kayal Orthopaedic Center, our surgical team uses advanced biomaterials to relieve pain, reduce inflammation and restore joint mobility in a variety of orthopedic conditions.

Dr. Robert A. Kayal, MD has been using these non-operative injection treatments for over 14 years with great success. During your appointment, a Kayal Orthopaedic Center provider injects medication directly into the painful joint region. Unlike medications that are distributed throughout the body, injections provide localized, directed joint relief.

Viscoelastic supplementation, steroid supplementation and corticosteroid injections are advanced treatment options often used in conjunction with physical therapy and oral medication. There are two common injection types:

- **Corticosteroid injections** provide a fast-acting anti-inflammatory result, and injections may include a local anesthetic to numb the area until the steroid begins to work.
- **Viscoelastic supplementation injections** are made of a natural lubricant found in joint fluid. When injected it helps to absorb shock and allows joints to glide better. These medications may be used to manage osteoarthritis, accelerate soft-tissue healing and encourage tissue regeneration.

Please be advised that if you receive any of the above injections they will be performed under Ultrasound guidance, which is a new cutting edge technology. Ultrasound guidance has become extremely popular for not just diagnostic imaging, but now is being routinely used for needle guidance to ensure accurate needle placement.

Please be aware that this is a billable charge to your insurance company.

Print name:_____

Signature:_____ Date:_____-_____-_____

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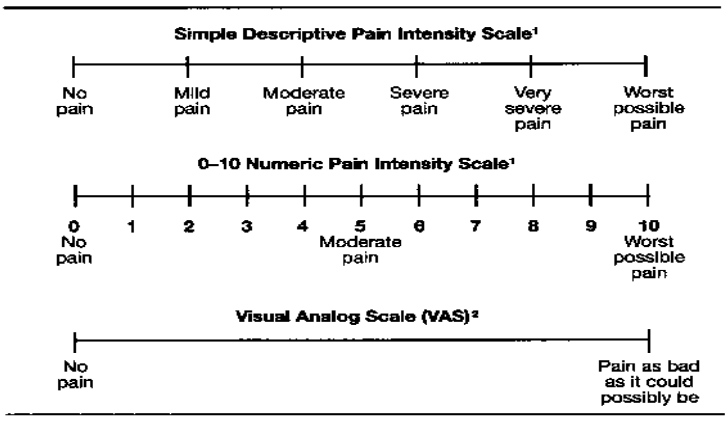
1. DESCRIBE PAIN:

   -How long have you been in pain? _____



[1] If used as a graphic rating scale, a 10 cm baseline is recommended.
[2] A 10-cm baseline is recommended for VAS scales.

   -What is pain level (from 1-10) _____

   -What are your symptoms? Please circle all that apply:

   - difficulties walking
   - going up and down stairs
   - getting in/out of bed
   - standing/sitting/bending over
   - Other_____

2. WHAT CONSERVATIVE CARE WAS PERFORMED? Please circle all that apply:

   - ice
   - rest
   - activity modification
   - chiropractic
   - physical therapy (with timing and duration),
   - acupuncture
   - pain and non-steroidal anti-inflammatory medication
   - if so, which one & for how long and how often ?
   - Advil/ibuprofen_____
   - Tylenol/acetaminophen _____
   - Aleve/naproxen sodium_____

_____ _____ _____

Patient's Name (Please print) Signature Date

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PATIENT DEMOGRAPHICS QUESTIONNAIRE

Please note that we are requesting this *optional* information in an attempt to comply with Federal "Meaningful Use" guidelines, as released by The Office of the National Coordinator for Health Information Technology. More information regarding these guidelines is available at http://healthit.hhs.gov.

You are **NOT** obligated to respond in order to be treated.

If you do not wish to provide this information, please simply fill in your name and today's date and check the "Declining to Respond" choice.

NAME _____ **TODAY'S DATE** ____-____-_____

Please check below as appropriate:

ETHNICITY	LANGUAGE(S) SPOKEN		
Caucasian	English	Sign Language	Declining to Respond
Black	Italian	Laotian	
Black Non-Hispanic	Spanish	Hindustani	
White Non-Hispanic	French	Hmong	
Hispanic	German	Punjabi	
Asian	Russian	Tagalog	
Asian Pacific Islander	Armenian	Vietnamese	
Pacific Islander	Chinese		
Subcontinent Asian American	Japanese		
Native American	Korean		
Native Hawaiian	Cambodian (Khmer)		
American Indian/Alaskan	Portuguese		
Other	Other		

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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.[1] 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

[1] 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.

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New Jersey Department of Banking and Insurance
NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

I, PRINT NAME , by marking √ and signing below, agree to:
__ representation by KAYAL ORTHOPAEDIC CENTER, PC 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.
The 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)

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:
New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807
You may also want to send a copy of your notice of revocation to the health care provider.

KAYAL ORTHOPAEDIC CENTER, P.C.

Orthopaedic Surgeons
Robert A. Kayal, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Founder, President & CEO
Edward C. Friedland, MD, FAAOS
Board-Certified Orthopaedic Surgeon
E. Jeffrey Pope, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Joseph M. Bellapianta, MD, FAAOS
Board-Certified Orthopaedic Surgeon
Daphne E. Pinkas, MD
Board-Eligible Orthopaedic Surgeon

Foot & Ankle Surgeon
Chad W. Rappaport, DPM, FACFAS
Board-Certified Foot & Ankle Surgeon

Podiatrist
Theresa Ronna, DPM
Board-Certified Podiatrist

Physician Assistants
Michael G. Kayal, PA-C
Chief Physician Assistant
Dean P. Mellas, PA-C
Jillian M. Dilonno, PA-C
James J. Verardi, PA-C
Roya Salimi, PA-C, CNMT

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

I hereby revoke my consent to representation by and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#_____ Date:_____-_____-_____

Relationship to Patient:
_____ I am the Patient
_____ I am the Personal Representative

Contact Information of Personal Representative
Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____FAX:_____EMAIL:_____

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CONSENT FOR RADIOGRAPHIC EXAMS FOR WOMEN OF REPRODUCTIVE AGE

PATIENT'S NAME:_____

DATE OF BIRTH:_____ - _____ - _____ AGE:_____

X-Ray exams of the abdomen and pelvis exposing the uterus to radiation are:

*Abdomen
*Lumbar Spine
*Sacrum
*Hip(s)
*Pelvis
*Coccyx (Tail Bone)

Onset of last menstrual period:_____ Today's Date:_____ - _____ - _____

I am Pregnant: YES_____ NO_____ I DON'T KNOW_____

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I do wish to this X-Ray examination completed today. I will not hold Kayal Orthopaedic Center, P.C. responsible for any potential harm to myself or my unborn child, By signing below I consent to the necessary X-Ray procedure(s).

PATIENT NAME:_____ SIGNATURE:_____

Consent to X-Ray a Minor

I am a parent or legal guardian of _____, who is a minor, _____years of age. I hereby authorize the performance of diagnostic X-Rays of said minor. Kayal Orthopaedic Center, P.C. has requested the X-Rays for further diagnostic purposes. At this time I know of no other condition which the taking of X-Rays would further complicate.

Signed:_____ Date:_____ - _____ - _____

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HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name:_____DOB:_____ - _____ - _____

Address:_____

I hereby authorize: KAYAL ORTHOPAEDIC CENTER, P.C. to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to:

_____

Please indicate the information or types of information to be disclosed (including dates if necessary):

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to KAYAL ORTHOPAEDIC CENTER, P.C.

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS).** This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

_____ - _____ - _____

Patient or Legal Representative Date

_____

Representative's authority to act on behalf of individual Witness

784 Franklin Avenue, Suite 250
Franklin Lakes, NJ 07417
P: 201.560.0711 • F: 201.560.0712

266 Harristown Road, Suite 107
Glen Rock, NJ 07452
P: 201.447.3880 • F: 201.447.9326

email@kayalortho.com

www.kayalortho.com

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E-Mail Authorization

Patient's Name:_____

Date of Birth:_____

E-Mail Address:_____

By providing us with your email address, you are authorizing us to send you emails to update you on announcements and/or new technologies and services we offer here at Kayal Orthopaedic Center, PC.

In addition, the staff at Kayal Orthopaedic Center, PC would also like to invite you to "Follow Us" on Facebook and Twitter. This will allow you to receive the latest updates, posts and announcements from our Facebook and Twitter accounts.

Follow us on Facebook at: Kayal Orthopaedic Center, PC
Follow us on Twitter at: kayalortho

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