

REGISTRATION FORM - MAJOR MEDICAL

Date: _____

Last Name: _____ First and Middle: _____ S #: _____

Birthdate: _____ Age: _____ Sex: F M Marital Status: M S D W

Home Address: _____ City: _____ State: _____ Zip: _____

*Does the above address, match the address on your State Identification Card? Y N

Home/Work Phone: _____ Mobile Phone: _____

Email Address: _____ Employer/Occupation: _____

PRIMARY INSURANCE

Insurance Name: _____ Type: PPO POS EPO HMO Note Sure

Policy Holder's Name: _____ Relation: _____ Policy Holder's DOB: _____

Policy # _____ Group # _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Insurance Name: _____ Type: PPO POS EPO HMO Note Sure

Policy Holder's Name: _____ Relation: _____ Policy Holder's DOB: _____

Policy # _____ Group # _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

NO FAULT INFORMATION

No Fault Carrier: _____ Date of Accident: _____

Adjuster Name: _____ Adjuster Phone: _____ WCB #: _____

Address: _____ City: _____ State: _____ Zip: _____

WORKER'S COMPENSATION INFORMATION

Worker's Compensation Carrier: _____ Date of Accident: _____ WCB# _____

Carrier Case #: _____ Adjuster Name: _____ Adjuster Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

The given information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that in the event that insurance benefits are paid directly to me, I will forward payment to SAM

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Any questions? Please call 833-4-

CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER with the understanding that if to do so within 90 days, it may be determined that the services of a collection fees and/ costs associated with the collection of said past due balance(s) is mine. I understand that FAILURE TO FORWARD A CHECK constitutes third degree THEFT OF SERVICES, a felony under NJSA 2c:20-8. I also authorize SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER or insurance company to release any information required to process my claims.

Patient / Guardian Signature Date

Release of Information:

I hereby authorize the physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company (ies).

Patient/ Guardian Signature Date

EMERGENCY CONTACT: Name: _____ Relation: _____ Phone: _____

REFERRING PHYSICIAN: Doctor's Name: _____ City, State: _____

PRIMARY/FAMILY PHYSICIAN: Doctor's Name: _____ City, State: _____

PREFERRED PHARMACY: SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER e-prescribes non-narcotic medications as mandated by Federal Laws. In order to comply, we need accurate pharmacy information. All controlled substances must be obtained at the same pharmacy, where possible, and must be filled in The State of NJ. Should you need to change pharmacies arise, our office must be informed ahead of time. Please provide your pharmacy's information where you expect to fill any prescriptions written by the practitioners at SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER

Pharmacy Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Patients Rights and Responsibilities:

I hereby acknowledge that I have read the Patient Rights and Responsibilities. I have read the Patient Rights as posted during my check-in. A printed copy is included in the Practice Policies form and is available to me should I request it.

Patient/ Guardian Signature Date

Assignment of Benefits As a courtesy to the patient and their families, SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER does submit claims to many third party payers. I request that payment of authorized Medicare or private benefits be made to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER for any covered services furnished by SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER. If my insurance carrier pays me directly, I agree to forward all funds to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER within 10 business days.

Disclosure of Information I understand that my medical records and billing information are made and retained by SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER and are accessible to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER personnel, who may use disclosed medical information for SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER operations and functions and to any other health care personnel involved in my continuum of care for this admission.

Release of Records I authorize SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER to release to any governmental health care program and its agents, or to any private insurance company or its agents any information needed to determine my benefits payable for SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER. I hereby authorize my attending physicians to release all medical records pertaining to my healthcare information to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER.

Acknowledgement of Notice of Private Practice A complete description of how my medical information will be used and disclosed by SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER has been given to me and I have had a chance to review SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER's NOTICE OF PRIVATE PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this consent form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Private Practices.

Consent for Care Treatment I, the undersigned, do hereby agree and give consent to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

Patient Name: _____ Date of Birth _____

Patient/ Guardian Signature _____ Date _____

Witness Signature _____ Date _____

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

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I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. Payment and Explanation of Benefits for services rendered to me should be sent directly to the above healthcare provider directly or if my policy prohibits payment to said health care provider then the check should be made out to me care of the above health care provider and send to the address shown on the medical claim form. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

This Conditional Assignment of Rights and Guarantee to Cooperate is made between Monocacy Anesthesia Company d/b/a North Jersey Interventional Pain Centers having an office at 408 Main Street #101, Boonton, NJ 07005, herein referred to as the "Provider" and the following individual, hereinafter referred to as "patient":

Name of Patient: _____

Address: _____

In consideration of services rendered, the Patient authorizes this **Conditional Assignment of Rights and Guarantee to Cooperate** to the benefit of the Provider. The Patient agrees to these terms and conditions:

1. The Patient assigns directly to the Provider the payment of, and the rights to collect payment of, any no-fault automobile insurance benefits to which the Patient may ben entitled for services rendered by the Provider.

2. Pre-certification: The Patient and the Provider agree to comply with any policy terms concerning pre-certification of treatment, which may include a decision point review. The provider agrees to submit a proposed care plan to be approved by the carrier in accordance with N.J.A.C. 11:3-4. The Provider shall hold the patient harmless for any co-penalty imposed for the failure to precertify treatment.

3. The patient authorizes, assigns, and directs payment of no-fault insurance benefits to the Provider for medical invoices upon which payment is due for medical services rendered. Further, the Patient assigns to the Provider the right to prosecute claim(s) against the no-fault insurance carrier (the "Carrier") named in this paragraph No. 2, for the payment of no-fault medical benefits to which the Patient is entitled in accordance with the applicable provisions of the following insurance policy.

Name of Insurance Carrier: _____

Policy Number: _____

4. In the event that the Patient fails to file an application for benefits under the New Jersey State No-fault laws, and the Provider has not been paid by the carrier for medical services rendered to the Patient, the Provider is hereby authorized to file an application on the Patient's behalf in order that the Provider may realize payment.

5. Guarantee: Patient agrees to fully cooperate with Provider's efforts to prosecute claim against the no-fault insurance carrier in the event timely payment of medical benefits is not made to Provider for services rendered.

6. This Limited Assignment of Rights an Guarantee to Cooperate shall be deemed a "limited assignment" to the Provider solely for the purpose of collecting payment from the carrier for medical services rendered.

I agree to pay \$100 for each returned for each check and \$1000 per each day that the physician or his designees spend trying to collect fees from checks to me that I did not send within FIVE (5) business days to physician.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature _____ Print _____ Date _____

If unable to sign or a minor, Signature of Guardian/Representative _____ Print _____

DATE: _____ Relationship to Patient _____

Agreement to Pay for Physician Services

I, _____, agree to pay SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER for physician services he rendered on dates shown below.

Date(s) of Service: All dates where service was rendered or as specified below.

Total Amount Due or Past Date to be paid: 1st of each month

It is understood that I, agree to make payments in the amount of up to 25% to 100% per month of the outstanding balance, due on the 1st of each month for the period of months it may take to settle my past due balance, until payment of said past due balance is made in full. Payments will be made by cash or check. I may ask Dr. Johar to charge the credit card below for the monthly payment, but agree that if I do I will incur an additional credit card processing fee of 5% each time the credit card is used for payment. I further agree to accept responsibility to pay . Karan Johar, KARAN JOHAR, MD, PLLC, LENOX HILL PAIN MANAGEMENT AND SPINE, PLLC any and all fees incurred if my check bounces or my credit card is declined.

Credit Card Type: Visa / MasterCard / American Express / Discover

Credit Card Number: _____ Expiration Date: _____ CVV: _____

Name as appears on card: _____

It is understood that if I miss any payments SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER has my agreement, and the right, to charge the full balance of my debt to the credit card as shown above, transfer my debt to a collection agency, or seek restitution in court. If my account is transferred to a collection agency or legal proceeding are undertaken in court to recover the amount I owe to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER. I further agree to pay any and all additional costs associated with said collection agency fees or legal and court costs in addition to the balance of my debt.

Name of Patient (print or type)

STREET

City, State, Zip+4

Phone: _____

X _____ Patient Signature

TELECOMMUNICATIONS POLICY:

I, _____, hereby give SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER and all its affiliate entities permission to leave messages regarding:

- Medical Information
- Billing Information

On my answering machine at the following numbers:

I, _____, hereby voluntarily provide my email and cell telephone number to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER and their authorized representative to communicate with me by email and text message with respect to confirming my follow up/procedure appointments, medical claims submitted to my insurance company as well as any balances not covered by insurance, coinsurance, deductibles or any other balance deemed patient responsibility.

To be clear, I am consenting to communication by email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify the practice in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER. There are no hardware or software requirements needed to receive email communication from SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER or their authorized representatives other than an active email account obtained from a vendor that provides such email accounts.

SAM CARUTHERS, MD OR MONOCACY ANESTHESIA COMPANY OR NORTH JERSEY INTERVENTIONAL PAIN CENTER will not sell, share, or rent your email address or any other personal information collected on this consent.

Email address: _____

Cell phone #: _____

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Signature _____ Print _____ Date _____

If unable to sign, or are a minor _____ Print _____

Signature of Guardian/Representative

Date: _____ Relationship to Patient _____

HISTORY

Chief Complaint: What is the main problem that brings you in today?

History of Present Illness:

Please describe your symptoms, including any numbness, pain or weakness.

When did your symptoms begin and how have they progressed?

Are they the result of an acute injury or accident?

Which doctors have you seen for this problem?

Which diagnostic studies have you had (MRI, X-ray, CT Scan)?

What has been your diagnosis?

Which treatments have helped?

What makes your symptoms better or worse?

Are you seeing an attorney for this problem?

Past Medical History:

Please list any current and past medical conditions or problems (i.e. Diabetes, High BP,)

Have you had any surgeries or fractures?

Please list all food and drug allergies:

Medications (may attach separate list):

Social and Family History:

Are you married, single, widowed or divorced?

Which activities are impaired by your symptoms?

HISTORY

Alcohol/Drugs: What is your approximate weekly use of alcoholic beverages?

_____ I don't drink alcohol.

_____ Less than 1-2 drinks a week.

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3-6 drinks a week.
 Drink some alcohol on a daily basis.

Have you or a parent ever had a problem with:

- Alcoholism: Yes No Drug Abuse: Yes No

- Tobacco: What is your approximate daily use of tobacco?

I don't smoke ½ pack/day 1 pack/day 1-2 packs/day More than 2 packs/day

Review of Systems:

Please circle or place an "x" next to any of the following conditions you might have now or before.

<input type="checkbox"/> Taking blood thinners	<input type="checkbox"/> Family dysfunction	<input type="checkbox"/> Trouble breathing lying flat
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Nausea	<input type="checkbox"/> Swollen ankles
<input type="checkbox"/> Infections	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Joint pain or swelling
<input type="checkbox"/> Chemical exposures	<input type="checkbox"/> Chills	<input type="checkbox"/> List joints: _____
<input type="checkbox"/> Thyroid disorders	<input type="checkbox"/> Problems with sexual function	<input type="checkbox"/> Muscle tenderness
<input type="checkbox"/> Lupus	<input type="checkbox"/> Loss of sensation around groin or buttocks	<input type="checkbox"/> Generalized morning stiffness
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Unexplained fevers	<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Depression	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Pain or burning when urinating
<input type="checkbox"/> Anger	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Excessive fatigue	<input type="checkbox"/> Need to urinate more at night
<input type="checkbox"/> Eye, ear, nose, throat, lung, heart, stomach, kidney or skin disorders (please circle)	<input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Persistent eye redness
<input type="checkbox"/> Stroke	<input type="checkbox"/> Memory difficulties	<input type="checkbox"/> Dry eyes or mouth
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Unusual stress in home life	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Headaches	<input type="checkbox"/> Unusual stress in work life	<input type="checkbox"/> Weight Gain
	<input type="checkbox"/> Trouble breathing with exercise	<input type="checkbox"/> Weight Loss

Gastrointestinal: Do you have ulcers? Yes No Has your ulcer bled? Yes No
Do you have reflux, hiatal hernia or GERD? Yes No

Check all of those that apply to you:

1. Bowel Function: Normal Loss of control or accidents Constipation
2. Bladder Function: Normal Loss of control or accidents Difficulty starting or stopping Urgency
3. Leg/Foot: Normal Weakness (Right/Left)
4. Arm/Hand: Normal Weakness (Right/Left)