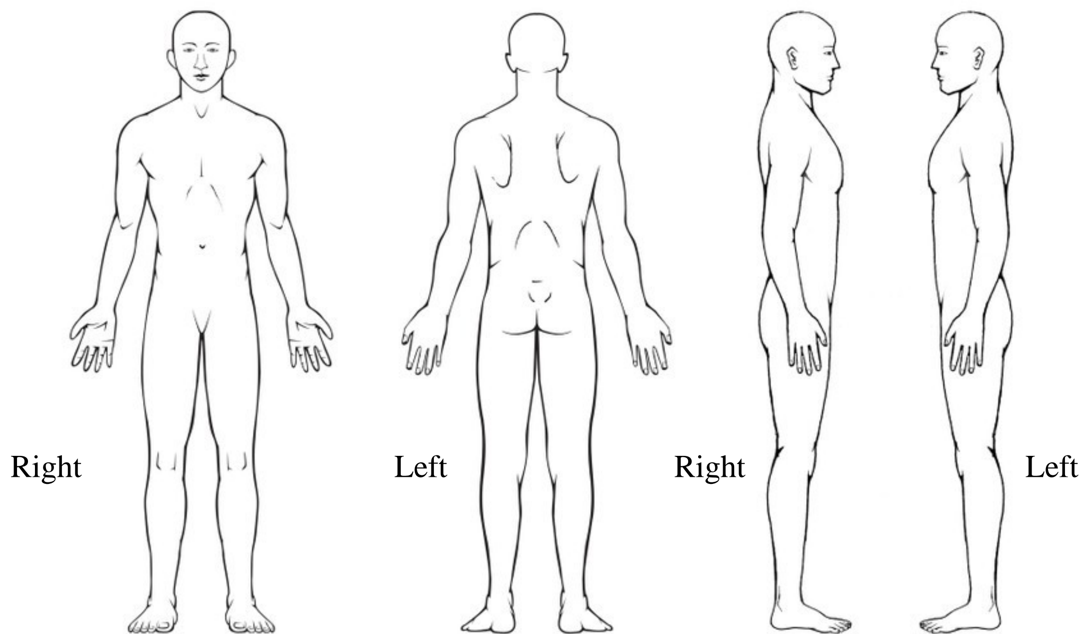
INTERVENTIONAL
SPINE & SURGERY
GROUP

Patient Name: ______________________________

Please shade the area where you feel or have felt pain, numbness, tingling, burning, or aching in relation to your current complaints.



Patient Signature: X ___________________________________

Date: ____

PATIENT INFORMATION

Name:____DOB: _____ ____ ______ Age: _________

Address: ______________________________________ City:_____________State: _____ Zip__________

Phone:____________________________ Cell:_________________ Social Security #:_____-_____-_______

E-Mail:____________________________________Height: ___________ Weight:_____________

Marital Status: S M W D Sex: M F Occupation:___________________________

Employer:______________________ Work Phone: ___________________________

Nearest Relative: _____________________________ Phone: _______________________________

Primary Care Physician:_____________________Address:_____________________Phone______________

Referring Physician: _______________________Address:_____________________Phone ______________

IS YOUR INJURY IS RELATED TO: ☐ WORK ☐ SCHOOL ☐ MOTOR VEHICLE ☐ OTHER Date: _________

INSURANCE INFORMATION

PRIMARY		SECONDARY	
Insurance Co:	_____________________________	Insurance Co:	_____________________________
Member ID #:	_____________________________	Member ID #:	_____________________________
Group/Plan#:	_____________________________	Group/Plan#:	_____________________________

MOTOR VEHICLE OR WORKERS COMPENSATION

Insurance Co: _________________________________

Claim Number: ________________________________

Phone: ________________________________

MEDICAL RELEASE – PLEASE SIGN

I HEREBY AUTHORIZE INTERVENTIONAL SPINE AND SURGERY GROUP THE FILING OF INSURANCE AND RELEASE OF INFORMATION NECESSARY TO PROCESS MY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO INTERVENTIONAL SPINE AND SURGERY GROUP FOR SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLES, AND CHARGES NOT PAID BY THE INSURANCE COMPANY. I ALSO AUTHORIZE INTERVENTIONAL SPINE AND SURGERY GROUP TO RELEASE ANY INFORMATION, INCLUDING DIAGNOSIS AND RECORDS OF TREATMENT OR EXAMINATION RENEDERED TO ME BY ANY PHYSICIAN THAT MAY BE ACTIVELY PARTICIPATING IN MY CARE.

Patient Signature: X_________________________ Date:___________________________

CERTIFICATION OF HEALTH INSURANCE

If you have private health insurance, please list the information below:

Insurance Company: _________________________

Policy Holder: ____________________________

Member ID: __________________________

Group/Plan #: _________________________

If you do not have private health insurance, please check the box below:

☐ I hereby certify that I do not have private health insurance.

Please be advised that if you have health insurance and do not provide the information at this time, you will be held responsible for any outstanding bills relating to your treatment.

____ ______________________
Patient Name (Print) Date

X____ ______________________
Patient Signature Date

INTERVENTIONAL SPINE & SURGERY GROUP

PATIENT: ______________________ DOB:_____________________

PHARMACY: ____

ALLERGIES: ____

MEDICATION & DOSAGE	PRESCRIBED BY

Interventional Spine and Surgery Group
8901 Kennedy Blvd Suite 1W
North Bergen, NJ 07047
Tel: (201) 430-2022 Fax: (201) 243-7261

IME/PIP Limit/Declaration Page Authorization Release

Patient Name: ___________________________________ Date of Birth: _____________________

I, _______________________________ authorize release of all medical records including my IME report and/or my personal injury protection (PIP) limit to Interventional Spine and Surgery Group at the above address. I understand all medical information including Reference to IME report / Results will be given to this office. I agree to this release.

Date:_______________________________________

Signature of Patient: X____

PATIENT CONSENT FOR TELEMEDICINE CONSULTATION

03/31/2020

PATIENT NAME: ____

I consent to participate in a telemedicine consultation with Interventional Spine and Surgery group.

During the telemedicine consult:

1. Details of your medical history, examination, and tests results will be discussed through the use of interactive video, audio, and telecommunication technology.
2. A physical examination of you may take place
3. A non-medical technician may be present
4. Video, audio, and/or photo recordings may be taken of you during the service.

All existing laws regarding your access to medical information and copies of your records apply to telemedicine consultations. Please note, not all telecommunications are recorded and stored. There is some risk to the confidentiality to your personal health information that is transmitted via telecommunication means. However, reasonable and appropriate efforts have been made to significantly reduce confidentiality risks associated with the telemedicine consultation and all existing confidentiality protections under federal and New Jersey law apply to information disclosed during the telemedicine consultation. You may withhold or withdraw consent to telemedicine consultations at any time without affecting your right to future care or treatment.

You have been advised of all the potential risks, consequences, and benefits of telemedicine. All your questions have been answered and you understand the written information provided above.

By signing this form, you agree to participate in telemedicine consultations.

If you cannot print and sign this form, you may send an email to lkelleher@spine-nj.com that states your name, date of birth, and that you "Grant consent to participate in telemedicine consultations with Interventional Spine and Surgery Group in accordance with the Patient Consent for Telemedicine Consultation dated March 31, 2020."

PATIENT SIGNATURE: X________________________ DATE_____________________

ASSIGNMENT OF BENEFITS

PATIENT NAME:____

I IRREVOCABLY ASSIGN TO INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. (STEVEN P. WALDMAN, M.D.) ALL OF MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIM BY INTERVENTIONAL SPINE AND SURGERY GROUP, LLC TO BE RELEASED TO INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. I IRREVOCABLY AUTHORIZE INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. I IRREVOCABLY AUTHORIZE INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

I IRREVOCABLY AUTHORIZE INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. TO OBTAIN COUNSEL AND ENTER LEGAL OR OTHER ACTION ON MY BEHALF AND/OR IN MY NAME, INCLUDING THE ARBITRATION/DISPUTE RESOLUTION PROCESS, TO COLLECT SUCH SUMS DUE IT SHOULD SUMS NOT BE PAID WITHIN THE LEGALLY PRESCRIBED TIME FRAME. IN THE EVENT THAT INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. ELECT TO BRING A LAWSUIT OR PETITION FOR ARBITRATION/DISPUTE RESOLUTION AGAINST THE INSURANCE CARRIER, I IRREVOCABLY ASSIGN MY RIGHTS TITLE, AND INTEREST UNDER THE MEDICAL EXPENSE BENEFITS AND/OR PIP SECTION OF ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS. THIS ASSIGNMENT SHALL ALLOW AN ATTORNEY OF INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. CHOOSING TO BRING SUIT OR SUBMIT TO ARBITRATION/DISPUTE RESOLUTION THEIR CLAIM FOR ANY UNPAID BILLS FOR SERVICES RENDERED FOR INJURIES THAT I SUSTAINED IN THIS OR ANY ACCIDENT.

IN THE EVENT THAT THIS ASSIGNMENT IS HELD INVALID FOR ANY REASON, I HEREBY AUTHORIZE INTERVENTIONAL SPINE AND SURGERY GROUP, LLC. TO APPOINT AN ATTORNEY OF ITS CHOICE TO REPRESENT ME DIRECTLY AGAINST AN INSURER FROM WHICH I MAY COLLECT PIP BENEFITS AND TO BRING A CLAIM IN A FORUM OF ITS CHOICE. THIS APPOINTMENT IS INTENDED ON ENABLING THE ATTORNEY TO COLLECT THE BILLS OF PATIENT.

THE UNDERSIGNED PATIENT DOES HEREBY AGREE AND ACKNOWLEDGE THAT HE/SHE MAY RECEIVE BENEFIT CHECKS DIRECTLY FROM THE INSURANCE CARRIER FOR SERVICES RENDERED BY THE PROVIDER. THE UNDERSIGNED PATIENT HEREBY AGREES TO IMMEDIATELY FORWARD SAID CHECKS TO INTERVENTIONAL SPINE AND SURGERY GROUP, LLC.UPON RECEIPT OF THE SAME.

FURTHERMORE, A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE VALID AS THE ORIGINAL. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT.

Patient Name______________________________ Date__________________________

Patient Signature X__________________________ Date of Accident__________________

NOTICE OF DOCTOR'S LIEN

Patient's Name:_______________________________

Date of Accident:______________________________

I do hereby authorize INTERVENTIONAL SPINE AND SURGERY GROUP (hereinafter referred to as "Doctor") to furnish you, my attorney, with a full report of the examination and diagnosis of myself in regard to the accident in which I was recently involved.

I do hereby authorize and direct you, my attorney, to pay directly to Doctor such sums as may be due and owing it for services rendered to me both by reason of this accident and by reason of other bills that are due to Doctor's office, and to withhold such sums for any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said Doctor. Furthermore, I hereby give a lien on my case to said Doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith. I fully understand that I am directly and fully responsible to said Doctor for all medical bills incurred for services rendered to me and that this agreement is made solely for Doctor's additional protection and is consideration of his awaiting payment. I further understand that such payment is not contingent on settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said Doctor of any change or addition of attorney used by me in connection with this accident, and I instruct my attorney to do the same and promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the Doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the Doctor's interest the Doctor will not await payment and can declare the entire balance due and payable.

____

Date

Signature of Patient

Health Insurance Appeal Form

Patient Name: ____

I hereby authorize Interventional Spine and Surgery Group to appeal on my behalf for all past and future claims.

Patient Signature: _________________________________ Date: __________________

Out of Network Disclosure

Please take notice that Interventional Spine and Surgery Group is non-participating or contracted with any insurance provider. As such, part or all of your upcoming procedure may be considered "out-of-network". You may be personally responsible for the co- payment, co-insurance, deductible, or other charges associated with such "out-of-network" services that are not covered by your insurance carrier.

Advance Directives

You have the right to enter into an advance directive. An advance directive means a written statement of your instructions and directions for health care in the event of your future decision-making incapacity. An advance directive may include a proxy directive or an instruction directive, or both (N.J.A.C. 8:43 A-1-3). **Interventional Spine and Surgery Group does not honor advance directives.** However, you may provide Interventional Spine and Surgery Group a copy of your advance directive in the event that you require additional treatment at another health care facility. Interventional Spine and Surgery Group will ensure your advance directive is forwarded to that facility.

By signing this disclosure, you or your legal representative, acknowledge that: (1) you have been informed that part or all of your procedure will be considered "out-of-network", if applicable; (2) you have the right to enter into an advance directive.

Understood and agreed:

Patient Signature: **X**____

Printed Name: ____

Date:_____________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:____ **Date of Birth:** ___________________________

Person Authorized to Receive Information:
By signing this authorization, I authorize INTERVENTIONAL SPINE AND SURGERY GROUP to use and/or disclose certain health information (HI) it has about me as needed to provide the proper care:

I hereby authorize the release of the following to the person/entity(s) listed above: *(check all that apply)*

□ **My Complete health record** (which includes info of ALL HI check boxes below)

□ History and Physical Exams
□ Lab Report
□ Consultation Report
□ Communicable Disease
□ Occupation/ Employer Information
□ Hospital notes
□ IME Records/Results
□ Appointment and Visit Notes
□ X-Ray Report
□ Prescription/ Pharmacy Records
□ My Personal Contact Information
□ My Spouse's Contact Information
□ Other (please specify): ______________________________
□ Personal Injury Protection (PIP) Limits

Include (*indicate by initialing*): Alcohol/ Drug Abuse Treatment ______HIV/ AIDS (inc. testing and related info) Mental Health Records ______Psychotherapy Notes

The information will be used or disclosed for the following purpose: *(check all that apply)*

□ Continuing Care
□ Legal
□ School
□ Research
□ Marketing
□ Second Opinion
□ Workers Compensation
□ Insurance Company
□ Other: ____________________________

Expiration Date of Authorization:

This authorization will expire on__________________(date or defined event). If no expiration is provided, this authorization will remain in effect for one year, unless earlier revoked or terminated by the patient or patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to the Privacy Officer or other authorized representative in our office. However, no revocation or termination will be effective to the extent we have already acted in reliance on the authorization.

By signing below, I acknowledge that I have read and understand:

- That when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by applicable federal and state privacy laws.
- Interventional Spine and Surgery Group may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the HI.
- I do not have to sign this authorization in order to receive treatment.
- By signing below, a photocopy of this authorization will be considered as valid as the original (copy to be provided upon request).

Signed by: X____ ______________________________
Signature of Patient or Legal Guardian Date

____ ______________________________
Print Name of Patient or Legal Guardian Relationship to Patient

PATIENT PRIVACY NOTICE

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR **HEALTH INFORMATION** (HI).

Under Federal and State law, we are legally required to protect the privacy of your health information ("HI"), which includes all health information received or maintained by us, including medical records, billing records and insurance information. We are providing you with this notice of privacy practices to explain how, when, and why we use and disclose your HI. With some exceptions, we may not use or disclose any more of your HI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the HI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the main reception area. You can also request a copy of this notice at any time from the contact person listed in Section VI below.

III. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION. We use and disclose health information for many different reasons. For some of these uses and disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your HI without your authorization for the following reasons:

1. **For treatment.** We may disclose your HI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the HI is related to HIV/AIDS, genetic testing, or federally- funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, if you're being treated for a knee injury, we may disclose your HI to an x-ray technician to coordinate your care.

2. **To obtain payment for treatment.** We may use and disclose your HI to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your HI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

3. **For health care operations.** We may disclose your HI, as necessary, to operate this organization. For example, we may use your HI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your HI to our accountants, attorneys, consultants, and others to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we may disclose HI when a law requires that we report information to government agencies and Jaw enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we may disclose HI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by Jaw.

6. **For health oversight activities.** For example, we may disclose HI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners and funeral directors.** We may provide coroners, medical examiners, and funeral directors necessary HI relating to an individual's death.

8. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide HI to law enforcement personnel or persons able to prevent or lessen such harm.

9. **For specific government functions.** We may disclose HI of military personnel and veterans in certain situations We may also disclose HI for national security and intelligence activities.

10. **For workers' compensation purposes.** We may provide HI in order to comply with workers' compensation laws.

11. **Appointment reminders and health-related benefits or services.** We may use HI to provide appointment reminders or give you information about treatment alternatives. or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather, we contact you at a different telephone number or address.

B. Disclosures to Family, Friends or Others.

We may provide your HI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written Authorization.** Other than as stated herein. we will not disclose your HI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your HI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

E. Business Vendors. We may engage certain persons to perform certain of our functions on our behalf and we may disclose certain health information to these persons. For example, we may share certain HI with our billing company or computer consultant to facilitate our health care operations or payment for services provided in connection with your care. We will require our business vendors to enter into an agreement to keep your HI confidential and to abide by certain terms and conditions.

IV. THE RIGHT TO SEE AND GET COPIES OF YOUR HI.

In most cases. you have the right to look at or get copies of your HI that we have, but you must make the request in writing. If we don't have your HI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request a copy of your information, we will charge reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request, in accordance with applicable law. Instead of providing the HI you requested, we may provide you with a summary or explanation of the HI as long as you agree to that and to the cost in advance. We may charge for the labor costs to transfer the information; and charge for the costs of electronic media if you request that we provide you with such media. Please note, if you are the parent or legal guardian of a minor, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent himself/herself (without your consent) may be restricted unless the minor patient provides an authorization for such disclosure.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your HI, you may file a complaint with the person listed in Section VI below. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, please contact the Privacy Officer at 201-430- 2022.
Written correspondence to the Privacy Officer should be sent to Interventional Spine and Surgery Group, 8901 Kennedy Blvd., Suite 1W, North Bergen, New Jersey 07047.

VII. EFFECTIVE DATE OF THIS NOTICE

REVISED NOTICE - EFFECTIVE AUGUST 2015

PATIENT BILL OF RIGHTS

As a patient at Interventional Spine and Surgery Group, LLC, a New Jersey healthcare facility, you have the following rights under state law and regulations.

1. **To be informed** of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights. Also given a written and verbal explanation of these rights, in terms the patient could understand. Interventional Spine and Surgery Group shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in thefacility;
2. **To be informed** of services available in the facility, of the names and Professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. **To be informed** if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment;
4. **To receive** from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health; or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medicalrecord;
5. **To give** inform, written consent prior to the start of specified, non-emergency medical procedures or treatments. Your physician should explain to you-in words you understand-specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives;
6. **To refuse** medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life-threatening or the procedure is required by law. Such refusal shall be documented in the patient's medical record.

7. **To expect** and receive appropriate assessment, management and treatment of pain and reasonable continuity of care.
8. **To be included** in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, role and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
9. **To a copy of your medical record**, at a reasonable fee, within 30 days after a written request to Interventional Spine and Surgery Group.
10. **To be advised in writing** of Interventional Spine and Surgery Group's rules regarding the conduct of patients, family members and visitors.
11. **To be free** from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others. Drugs and other medication shall not be used for discipline of patients or for convenience of facility personnel.
12. **To confidential treatment** of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health facility to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked.
13. **To be treated** with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient. Also, to have physical privacy during medical treatment and personal hygiene functions, unless you need assistance.
14. **To not be required** to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, state, and federal laws and rules:
    To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs, or practices or any attendance at religious services, shall be imposed upon anypatient;
    To not be discriminated against because of race, age, religion, sex, national origin, sexual preferences, handicap, diagnosis, ability to pay, source of payment or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.
    To present questions or grievances to Diana Sanchez, Compliance Officer at (201) 430-2022 and receive a response in a reasonable time. Interventional Spine and Surgery Group must provide you or your guardian with the names, addresses, and telephone numbers of the government agencies to which you can make a complaint and ask questions. Such as the New Jersey Department of Health & Senior Services. You may call the complaint hotline at (800) 792-9770.

Below is the patient and family responsibility as a patient at Interventional Spine and Surgery Group:

1. To provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations and other issues related to his/her health.
2. To make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
3. To follow the treatment plan established by the provider, including the instructions of health professionals as they carry out the physician's order.
4. To keep appointments and/or notify the clinic when he/she is unable to do so.
5. To assure that the financial obligations of his/her medical care are fulfilled as promptly as possible.
6. To follow Interventional Spine and Surgery Group policies and procedures.
7. To be considerate of the rights of other patients and personnel.

This Patient Bill of Rights is an abbreviated summary of the current New Jersey law and regulations governing the rights of Interventional Spine and Surgery Group patients. For more complete information, consult the NJ Department of Health regulations at www.state.nj.us/health regarding NJAC 8:43 G-4, or Public Law 1989 Chapter 170.

CONSENTS, DISCLOSURES, AND AUTHORIZATIONS

General Consent for Examination and Treatment

I hereby consent and authorize Interventional Spine and Surgery Group ("Interventional Spine & Surgery Group") and all physicians and ancillary medical personnel of Interventional Spine & Surgery Group, to perform medical examinations and provide routine medical care for all my visits to Interventional Spine & Surgery Group. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment and healthcare operations of Interventional Spine & Surgery Group. Any photographs or other images taken will become part of my medical record. Interventional Spine & Surgery Group will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that Interventional Spine & Surgery Group will provide me with information and forms prior to such procedures.

Consent To Use and Disclose Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize Interventional Spine & Surgery Group to use and disclose my health information, which includes all or any part of my medical records, including drug or alcohol treatment information, genetic, genetic counseling and genetic testing information, HIV/AIDS information, and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of Interventional Spine & Surgery Group. I understand that, for example, my health information may be used or disclosed by Interventional Spine & Surgery Group to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by Interventional Spine & Surgery Group; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand Interventional Spine & Surgery Group may release my health information as required by law or court order.

Disclosures to Authorized Individuals

I understand that Interventional Spine & Surgery Group may release my HI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name:____ Relationship:________________________________

Address/Phone:____

Health Info: Yes / No [circleas applicable]   Payment Info: Yes / No [circle as applicable]

Name:____ Relationship:________________________________

Address/Phone:____

Health Info: Yes / No [circleas applicable]   Payment Info: Yes / No [circle as applicable]

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

❑ Home Telephone (h)___________________   ❑ Detailed Message   ❑ Call Back Message Only

❑ Work Telephone (w)___________________   ❑ Detailed Message   ❑ Call Back Message Only

❑ Cell Telephone (C)___________________   ❑ Detailed Message   ❑ Call Back Message Only

❑ Text Message

I understand that if I do not select any option, I agree that Interventional Spine & Surgery Group may leave any of the following detailed messages and/or texts at the indicated telephone number: appointment reminders, insurance/financial issues, test results, and any other information regarding care/treatment.

Disclosure of Financial Interest

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest in a health care service. You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be obtained by calling your insurance company.

Consent and Authorization

I have read and understand the terms of this entire document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form.

I acknowledge receipt and understanding of Interventional Spine & Surgery Group's Patient Privacy Notice, Patient Bill of Rights, and Consent and Authorization.

Patient signature: X____ Date: _________________________

- Office Use Only -

INABILITY TO OBTAIN ACKOWLEDGMENT OF RECEIPT OF PATIENT PRIVACY NOTICE, PATIENT BILL OF RIGHTS, AND/OR CONSENT AND AUTHORIZATION

To be completed only if no signature is obtained. If it is not possible the obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained.

Reason: ____

Signature of Interventional Spine and Surgery Group Representative: ____

Printed Name: ____ Date: _______________________