PREMIER SPINE & SPORTS MEDICINE

Premier Spine & Sports
140 Sylvan Ave, Suite 108
Englewood Cliffs, NJ 07632

Jersey City Medical Center
377 Jersey Ave, Suite 280
Jersey City, NJ 07302

P 201-242-1600
F 201-455-6708

## PATIENT INFORMATION

Patient Name: _____ Date: _____ / _____ / _____
First 이름 Last 성

Social Security 소셜번호#: _____-_____-_____ DOB: _____ / _____ / _____ Age: _____ Sex: Male / Female

Home Address: _____
집 주소: Street Apt #

_____
City State Zip Code

Home 집전화번호: (_____) _____ - _____ Cell 핸드폰번호: (_____) _____ - _____ Preferred contact: cell, home, work, email

Work 직장번호: (_____) _____ - _____ Email 이메일: _____

Employer 고용주: _____ Occupation 직업: _____

Work Address 직장 주소: _____

_____

## INSURANCE INFORMATION

Primary Insurance 본인 의료보험: _____ Policy Holder's Name 보험 가입자: _____

ID 아이디#: _____ Group 그룹#: _____

Relation to Patient 환자의 관계: _____ Policy Holder's SS 소셜#: _____-____-_____ Policy Holder's DOB: ____ / ____ /_____

Secondary Insurance 이차 의료보험: _____ Policy Holder's Name 보험 가입자: _____

ID 아이디#: _____ Group 그룹#: _____

Relation to Patient 환자의 관계: _____ Policy Holder's SS 소셜#: _____-____-_____ Policy Holder's DOB: ____ / ____ /_____

Claim 청구번호#: _____ Policy #: _____

Date of Accident/Injury 차사고 날짜: _____ / _____ / _____ Other: _____

Attorney 변호사: _____ Phone 전화번호: (_____) _____ - _____

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Family Physician 담당일반내과: _____ Phone: (_____)_____-_____

Pharmacy 약국: _____ Location 위치: _____ Phone 전화번호: (_____)_____-_____

Emergency Contact 비상 연락처: _____ Relationship 환자의 관계: _____ Phone 전화번호: (___)____-_____

Referred by 추천해주신분: _____ Phone 전화번호: (_____) _____-_____

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By signing below, I acknowledge that the information I provided is correct to the best of my ability.

아래에 서명함으로써, 본인은 제공된 정보가 본인의 능력 중 가장 정확함을 인정합니다.

Patient Signature 환자서명: _____

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# RECEIPT OF NOTICE OF PRIVACY PRACTICES

## WRITTEN ACKNOWLEDGEMENT FORM

## PATIENT HIPPA AWARENESS

With my permission, Dr. Ruby E. Kim may use and disclose protected health information (PHI) about me to carry out the treatment, payment, and healthcare operations (TPO). Please refer to Dr. Ruby E. Kim's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have been made available a copy of the Notice of Privacy Practices prior to signing this consent. Dr. Ruby E. Kim reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by written request to the Privacy Officer.

With my permission, the office of Dr. Ruby E. Kim may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Ruby E. Kim may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as patient statements and bills.

I have the right to request that Dr. Ruby E. Kim restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am allowing Dr. Ruby E. Kim to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Patient's Name 환자이름 Date

_____

Patient's Signature 환자서명

_____ _____

Guardian's Name Relationship to Patient

_____

Guardian's Signature

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Primary Insurance: _____

Secondary Insurance: _____

_____ (Initials) I consent that I am responsible for (any and all) charges assigned to me by my insurance company including, but not limited to, yearly deductibles, co-insurance, co-pays, non-plan coverage, etc.

_____ (Initials) I consent that I do understand and will abide by the below listed administrative fees which will be enforced by Premier Spine and Sports Medicine / Ruby Kim, MD.
I agree to pay for the following administrative fees accordingly:

- Returned payments for in-sufficient funds $30.00
- Patient account placed with collection agency $45.00
- If a patient account is unpaid for greater than 90 days, a 6.5% interest charge will be applied to the unpaid total owed.

_____ (Initials) If I received a check from the insurance company for payments of date of service or procedures and I am not sending it to Premier Spine and Sports Medicine before 30 days,
**I AM RESPONSIBLE FOR THE FULL AMOUNT OF THE BILL,**
**PLUS 6.5% INTEREST AND THE FEES TO FILE A CLAIM IN COURT.**

_____ _____
Patient's Name 환자이름 Date

_____
Patient's Signature 환자서명

_____ _____
Guardian's Name Relationship to Patient

_____
Guardian's Signature

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**ASSIGNMENT OF BENEFITS**
**&**
**LIMITED POWER OF ATTORNEY**

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me, and this specifically includes filing arbitration/litigation in your name on my behalf against the personal injury protection carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is in challenge or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your names as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

_____ _____

Patient's Name 환자이름 Date

_____

Patient's Signature 환자서명

_____ _____

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Guardian's Name

Relationship to Patient

_____

Guardian's Signature

## PATIENT FINANCIAL POLICY

Thank you for choosing Premier Spine and Sports Medicine as your health care provider. While your health and well-being is our primary concern, we realize that the cost of healthcare is a concern for our patients. We offer the following information to help you understand our financial policies and aid you in planning for payment. Carefully review the information and please ask if you have any questions.

**Insurance**: It is your responsibility to provide Premier Spine and Sports Medicine with your current insurance information. We will ask for your insurance card at your first visit and keep a copy for our records. We may occasionally request a copy at a later date in order to update your records so please bring your current insurance card with you every time you visit our office. We will help you receive the maximum benefits your insurance allows. However, please remember that your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your claims for you, but we will not become involved in disputes between you and your insurance carrier. In order to properly bill your insurance company, you agree to provide us with all of your insurance information, including primary and secondary insurance, as well as any changes in your insurance information. Failure to provide complete insurance information may result in your being responsible for the entire bill. Not all services are a covered benefit in all insurance plans. Some health plans select certain services that they will not cover. Your insurance company makes the final determination of your eligibility and benefits. **In the event that your health plan determines a service to be "not covered," you may be responsible for the entire charge.** Also, please be aware that if we are out of network for your insurance carrier, your share of our charges is typically more than if we are in network. Once your insurance company has processed your claim, and you and Premier Spine and Sports Medicine have received an explanation of benefits, we will bill you for the remaining balance which is your responsibility. This balance is due upon your receipt of our statement. In the event that you are unable to pay the balance in full, we encourage you to contact our business office promptly for assistance in arranging reasonable installment payments.

**Coinsurance**: Payments may be required by your insurance plan. All payments must be paid when you check in at our front desk prior to your appointment. If you do not have your payment, your appointment may be rescheduled.

**Self-pay Accounts:** Self-pay accounts are for patients without insurance coverage. **It may also include patients covered by insurance plans in which Premier Spine and Sports Medicine does not participate or patients without an insurance card on file with us**. It is your responsibility to know if Premier Spine and Sports Medicine is participating with your plan. If there is a discrepancy with our information, you will be considered self-pay until you provide information proving otherwise. Self-pay patients are required to pay a deposit toward estimated charges prior to the first appointment (currently $500, subject to change), prior to each follow-up appointment (currently $300, subject to change), and prior to each injection appointment (approximately $300, depending on the injection, subject to change). If these deposits should result in a credit balance, we will refund the overpayment to you. If a procedure is recommended, we will work with you to determine reasonable payment arrangements prior to the procedure date.

**Past Due Accounts**: If your account is referred to a collection agency or an attorney, you agree to pay all of the collection costs, including attorneys' fees and court costs. Accounts referred to a collection agency or attorney may be reported to the Credit Bureau. If your account becomes past due, any upcoming appointments may need to be postponed until your

account is made current. If your account has been referred to a collection agency or attorney, you must pay the balance in full, including any collection fees, before an appointment will be scheduled, and you may be required to make the same up-front payments as required of self-pay patients (as detailed above), regardless of any insurance coverage. It may also be possible that our physicians and other health care providers will no longer be able to provide your care. In this case, you will be notified by certified mail and given adequate time to find a new medical provider.

**Preauthorization:** Your insurance company may require a referral from another physician and/or a pre-authorization/pre-notification/pre-certification. While it is your responsibility to obtain these, we will assist you. Please be aware that while a referral and/or a pre-authorization/pre-notification/precertification may be required by your insurance company, having a referral and/or pre-authorization/pre-notification/pre-certification does not guarantee payment by your insurance company. However, failure to obtain these may result in a lower payment or no payment from your insurance company and the balance will be your responsibility.

**Workers' Compensation and Automobile Accident Accounts:** In the case of an on the job or automobile accident injury, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If you do not provide this information, your appointment may be re-scheduled to another time when you will have the information or your account may be assigned self-pay status, requiring up-front payments. We do not accept attorney letters or contingency payments and we do not bill any third parties.

**PATIENT AUTHORIZATION, ACKNOWLEDGEMENT, AND AGREEMENT**

I hereby authorize payment of health insurance benefits (and, if applicable, government benefits) directly to Premier Spine and Sports Medicine for services furnished to me. I authorize the release of any of my healthcare information necessary to process my claims. I further authorize the release of my healthcare information to other health care providers, hospitals, and facilities involved in my treatment. I understand, acknowledge, and agree that I am financially responsible for my deductible, co-pay, co-insurance, and any amount exceeding what my insurance company pays, except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, and preauthorizations.

I HAVE READ THE ABOVE PATIENT FINANCIAL POLICY AND/OR IT HAS BEEN FULLY EXPLAINED TO ME. I CERTIFY THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Patient's Name: _____ Date: _____

Patient's or Legal Representative's Signature 환자서명: _____

If Legal Representative, provide relationship to Patient: _____

Witness' Name: _____

Witness' Signature: _____