MARK DRZALA, M.D. PC
Orthopaedic Spine Surgeon
T: (908) 608-9610 / F: (908) 608-9622

MAC Building I – Suite 305
33 Overlook Rd, Summit, NJ 07901

Harries Pavilion – 2nd Floor
1 Bay Avenue, Montclair, NJ 07028

1. Patient Information

please print clearly and complete ALL fields

Name: _____ Social Security No: ___ - ___ - ____

Date of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Address: _____ City, State, Zip: _____

Home phone: (___) _____ Cell: (___) _____ Work: (___) _____ Ext. _____

Email: _____ Personal info. ☐ may ☐may not be sent to this e-mail

Family Physician: _____ Phone: (___) _____

Address: _____ City, State, Zip: _____

Referred by: _____ Address: _____

City, State, Zip: _____

Patient Employer: _____ Occupation: _____ Phone: (___) _____

Employer Address: _____ City, State, Zip: _____

Spouse's Name: _____ Spouse's Employer: _____

Employer Address: _____ City, State, Zip: _____

Spouse's Work Phone: Work: (___) _____ Ext. _____ Spouse's Date of Birth: _____

Party response for Payment (if minor): _____ Relationship to patient: _____

Address: _____ City, State, Zip: _____

Reason for Visit: Major Complaint: _____

Injury/accident: ☐ yes ☐ no (If yes check one and complete #3 below): ☐ motor vehicle ☐ work-injury ☐ other

Date of Injury or Onset of Problem: _____ Injury Location: _____

Injury details: _____

_____

2. Work/Auto Related Injuries

For Work or Auto Related Injuries Only

Insurance Company: _____ Claim Number: _____

Address: _____ City, State, Zip: _____

Insurance Phone #: (___) _____ Insurance Contact person: _____

Was work injury reported to employer? ☐ yes ☐ no If so, to whom? _____

4. In Case of Emergency

Name of Friend or Relative not living with you (other than spouse): _____

Address: _____ City, State, Zip: _____

Home phone#: (___) _____ Work#: (___) _____ Ext. _____ Cell#: (___) _____

5. Medication Allergies

☐ I do not have any allergies that I know of.

Please list all allergies: _____

_____

_____

_____

6. Pharmacy Information

Name: _____

Address: _____

City, State: _____

Phone #: _____

Please complete the reverse side of this form

Treatment Authorization

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

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

_____

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

Legal Assignment of Benefits and Release of Medical and Plan Documents

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

I hereby authorize the doctor to release all medical information necessary to process this claim and all claims associated with his care whether or not billed directly by him. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

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

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

Arbitration

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

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

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

Signature of Insured or Guardian: _____

Date: _____

Mark R. Drzala, MD, PC

Orthopaedic Spine Surgery

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CLINICAL HISTORY FORM

DATE OF VISIT: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

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

ALLERGIES: _____

MEDICAL HISTORY:

☐ DIABETES	☐ HEART DISEASE	☐ CANCER	☐ DIFFICULTY WITH ANESTHESIA
☐ ARTHRITIS	☐ BLEEDING / CLOTS	☐ HEPATITIS	☐ HIGH / LOW BLOOD PRESSURE
☐ ULCERS	☐ EASY BRUISING	☐ SEIZURES	☐ OSTEOPOROSIS / OSTEOPENIA
☐ GERD	☐ KIDNEY DISEASE	☐ SCOLIOSIS	☐ MENTAL HEALTH

OTHERS CONDITIONS: _____

SURGICAL HISTORY / YEAR

_____

_____

_____

CURRENT MEDICATIONS (Name / Dose / How often)

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

EMPLOYMENT: _____

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

ALCOHOL CONSUMPTION: ☐ NONE ☐ SOCIAL ☐ DAILY ☐ WEEKLY ☐ QUIT

TOBACCO CONSUMPTION: ☐ NEVER ☐ DAILY ☐ WEEKLY ☐ QUIT

FAMILY HISTORY

MOTHER: _____ GRANDPARENTS: _____

FATHER: _____ BROTHERS / SISTERS: _____

Mark R. Drzala, MD, PC

Orthopaedic Spine Surgery

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MONTCLAIR OFFICE
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Montclair, NJ 07028
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ACKNOWLEDGEMENT & AGREEMENT

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

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

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

_____ _____

Signature Date

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

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

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

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

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

INDEPENDENT ARBITRATION OF CLAIMS

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

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

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

☐ representation by [Mark Drzala M.D. PC and staff] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

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

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

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

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

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

I,_____, understand that as part of my health care, Mark R. Drzala MD, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

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

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

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

I understand that Mark R. Drzala MD, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Mark R. Drzala MD, P.C. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Mark R. Drzala MD, P.C. change their notice, they will send a copy of and revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

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

_____

_____

_____

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

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

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by_____on _____.

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

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