

Woodbury Spine

Evan O'Brien, MD

*American Board of Spine Surgery
American Board of Orthopaedic Surgery*

Nick Kaffl, PA-C
Matthew Abad, PA-C
Chris Hennessey, PA-C

Linqiu Zhou, MD

*American Board of Pain Management
American Board of Physical Medicine & Rehabilitation*

Millennium Surgical Center
Underwood Memorial Hospital

Patient Registration Form

Patient Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Date of Birth: _____

Social Sec Number: _____ Female: _____ Male: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Telephone: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Insurance Information – Please give cards to the receptionist for copying

Primary Insurance: _____

Phone _____ Fax _____

Insured's Name _____ Date of Birth: _____

ID Number _____ Group Number _____

Secondary Insurance: _____

Phone _____ Fax _____

Insured's Name _____ Date of Birth: _____

ID Number _____ Group Number _____

Woodbury Spine

Patient Name: _____ Date: _____

If you had an accident please complete this section

Date of Accident: _____ How did it happen? ___Auto ___Work ___Other

Involvement in accident if auto: ___Driver ___Passenger ___Pedestrian ___Cyclist

Attorney's Name: _____

Address: _____

Phone: _____

Insurance Company (Worker's Comp or Auto): _____

Address: _____

Phone: _____

Claim Number: _____

Adjuster: _____

Woodbury Spine

Treating Physician Information

Patient Name: _____ Date: _____

Referring Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Primary Care Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Cardiologist

Name: _____

Address: _____

Phone: _____ Fax: _____

Other Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Other Physician

Name: _____

Address: _____

Phone: _____ Fax: _____

Woodbury Spine

Patient Name: _____ Date: _____

1. Consent for Medical and Surgical Treatment: I voluntarily consent to all medical care and services performed by my physician and all other health care providers at *Woodbury Spine*. I also consent to routine services, diagnostic procedures, medical treatment, and other services as deemed necessary by the health care providers treating me. I understand that I have a right to consent or to refuse to consent to any proposed treatment and to discuss it with my health care provider. _____Initials

2. Payment Agreement: I acknowledge full financial responsibility for services rendered by *Woodbury Spine*. I authorize direct payment of medical benefits to Evan D. O'Brien, M.D., P.C. (dba *Woodbury Spine*), for services rendered by *Woodbury Spine*. I agree to pay any balance due in full no later than 30 days of the statement, unless other arrangements have been made in advance. _____Initials

3. Medicare Authorization: I hereby authorize payment of Medicare benefits be made directly to Evan D. O'Brien, M.D., P.C., (*Woodbury Spine*) for any services rendered to me by my physician and health care providers employed by that corporation. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed for the purpose of determining these benefits. I understand that this authorization is in effect until revoked, in writing, by me. _____Initials

4. Insurance Authorization and Assignment: I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for payment, treatment, or health care operations. I authorize direct payment of medical benefits to Evan D. O'Brien, M.D., P.C. (*Woodbury Spine*), for services rendered. I further authorize the release and discharge of such protected health information to my insurance company or other health coverage plan as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. I understand that this authorization is in effect until revoked, in writing, by me. _____Initials

5. Right to Choose: Our practitioners may prescribe certain diagnostic tests necessary to help ensure the best diagnosis and treatment of your symptoms. He/She may suggest health care facilities and/or individuals regarded as qualified for the testing and treatment that is necessary. Please be aware that Dr. O'Brien and Dr. Zhou are part owners in Millennium Surgery Center. They are committed to providing the highest level of care in that facility. If you prefer to use the services of other health care providers and/or medical diagnostic facilities, you may do so. This will in no way affect the care that will be provided to you by our practitioners. _____Initials

6. A photocopy of these assignments shall be as valid as the original. _____Initials

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility, insurance authorization and right to choose.

Signature

Date

Woodbury Spine

Review of Systems

Name: _____ Date: _____

Have you been experiencing any of the following symptoms and/or conditions in the last 6 months?

	YES	NO		YES	NO
General			Cardiovascular		
Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Murmurs	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			Edema	<input type="checkbox"/>	<input type="checkbox"/>
Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Previous Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Spots	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Ent			Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Change in Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Black/Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>
Ringling in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Diarrrhea	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary		
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Increased Urination	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Skin/breast			Musculoskeletal		
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Color Change	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			Backache	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Neurological		
Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Coughing Blood	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
			Headaches	<input type="checkbox"/>	<input type="checkbox"/>

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Review of Systems

Name: _____ Date: _____

Psychiatric	YES	NO	Hematologic	YES	NO
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Memory Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Previous Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Allergic		
Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Please List All Allergies:		
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	1. _____		
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	2. _____		
Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	3. _____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>			

Family physician: _____ Tel: _____ Fax: _____

Cardiologist: _____ Tel: _____ Fax: _____

Other Physician: _____ Tel: _____ Fax: _____

Attorney: _____ Tel: _____ Fax: _____

BELOW IS FOR OFFICE USE ONLY

Initially Reviewed Date: _____ Comments on positive responses:

Physician/Practitioner Signature: _____

Woodbury Spine

HIPAA Privacy Notice

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

Woodbury Spine is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice from time to time to make the revised notice effective for all PHI we maintain. You may request a copy of our most current privacy notice from our staff.

Uses and Disclosures of PHI

Woodbury Spine may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.

- **Treatment** means the provision, coordination or management of your health care, including consultations with other health care providers regarding your care.
- **Payment** means any efforts necessary to obtain reimbursement for services provided to you. For example, your personal information may be included on bills submitted to your insurance carrier.
- **Health Care Operations** includes quality assurance activities, case management, licensing and training programs, as well as other management functions.

Disclosures Related to Communicating with You

The staff at Woodbury Spine may contact you to provide appointment reminders, and may leave this information on your answering machine or with whoever answers the phone at the number provided by you. We may disclose PHI to your family or an individual identified by you when they are involved in your care or the payment for your care.

Other Situations

Information about you may be disclosed without your written authorization in the following situations:

- To a public health authority, as required by law;
- For health oversight activities including audits or government investigations;
- For judicial and administrative proceedings as required by a court or administrative order;
- For law enforcement activities;
- For military, national defense and security and other special government functions;
- For workers' compensation purposes;
- To coroners, medical examiners, and funeral directors;
- If you are an organ donor, we may release information about you to organ procurement or organ donation organizations;

Woodbury Spine

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- For research projects, subject to strict oversight and approvals;
- In the event of a disaster, PHI may be disclosed as authorized by law.

Any other use or disclosure of your PHI may only be made with your written authorization. You may revoke your authorization at any time, in writing, except to the extent that your PHI has already been disclosed based on that authorization.

Patient Rights

Patients have certain rights with respect to their PHI, including:

- The right to access, copy or inspect PHI. This means that you may inspect and copy most of the medical information pertaining to you. You may be charged a reasonable fee for copying and mailing your records, as determined by state law. You may be denied access to your PHI in limited situations.
- The right to request restrictions on our use and disclosure of your PHI for treatment, payment or operations; however, we are not required to agree to your request.
- The right to reasonably request to receive communications of PHI by alternative means or at alternative locations.
- The right to amend or correct your PHI. We may deny this request if the information was not created by us, if we feel the information is correct, or for certain other reasons. If there are any corrections or amendments, this information will be included as an addition to already existing records. If your request is denied, you will be given a written explanation.
- The right to receive a list of all disclosures of your PHI made to individuals or entities other than you, except for disclosures related to treatment, payment operations or as otherwise required by law.
- The right to receive a copy of this notice.

Questions and Complaints

You have the right to complain to us or to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint in the office or to the government. Please contact our privacy officer if you have any questions, comments or complaints.

Privacy Officer Information

Woodbury Spine
1225 N. Broad Street, Suite 3
Woodbury, NJ 08096
ATTN: Privacy Officer
Tel 856-845-0707
Fax 856-845-0082

Woodbury Spine

ACKNOWLEDGMENT AND CONSENT

This acknowledgment of notice and consent authorizes Woodbury Spine to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices

Woodbury Spine has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments

We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to Contact Our Privacy Officer

Mail: Privacy Officer, Woodbury Spine
1225 N. Broad Street, Suite 3
Woodbury, NJ 08096
Telephone: 856-845-0707
Fax: 856-845-0082

Acknowledgment and Consent

I have received the Notice of Privacy Practices for Woodbury Spine, and authorize the use and disclosure of health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

Patient name (or patient's personal representative)

Date

Patient Signature

Name/relationship of personal representative, if applicable