Metropolitan Orthopedics
Kent S. Lerner, M.D., FA.C.S.
Fellow American Academy of Orthopedic Surgeons
Phone: 201.991.9019 17 Jauncey Ave., North Arlington, NJ 07031

New Patient/Medicare Information Sheet

General Information

Patient Name: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Phone: (____)____-_____ Cell: (____)____-_____ Work: (____)____-_____
S.S. #: _____-____-_____ Date of Birth: ____/____/____ Age: ____ Sex: M ❑ F ❑
How did you hear about us? _____

Primary Care Physician

Primary Care Doctor: _____ Phone: (____)____-_____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Information

Subscriber's Name: _____
S.S. #: _____-____-_____ Date of Birth: ____/____/____ Phone: (____)____-_____
Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance Co. Phone: (____)____-_____ Policy No.: _____

Accident Information

Motor Vehicle Accident Y ❑ N ❑ Date of Accident: ____/____/____
Work-Related Accident Y ❑ N ❑ Date of Accident: ____/____/____
Auto Insurance Co.: _____ Phone: (____)____-_____
City: _____ State: _____ Zip: _____
Claim Number: _____

Medical Information

Why are you here to see the doctor? _____
_____
List Allergies: _____ Are you allergic to aspirin? Y ❑ N ❑
List all medications you are currently taking: _____
Incase of an emergency notify: _____

Assignment of Benefits: I hereby authorize payment directly to the physician. The benefits due me for his services as described above. I understand that I am financially responsible for any changes not covered by this authorization. Release of Information: I hereby authorize the physician/supplier to release any information needed or required to process this claim.

Signature_____ Date: ____/____/____

KENT S LERNER, M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A. PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone #_____Social Security #_____

SECTION B: To the patient PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may copy our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting

Contact Person:_____ Phone #_____

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received you revocation, and we may decline to treat you or to continue treating you if you revoke this consent.
Signature: I_____have fully had the opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representatives Name:_____
Relationship to Patient:_____
You are entitled to a copy of this consent after you sign it
Consent will be stored in Patient's chart.

REVOCATION OF CONSENT:
I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect my action you took in reliance on m, Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: Date:

Motor Vehicle Accident

Today's Date _____ Name _____
Age: _____ Height: _____ Weight: _____

Date of Accident: _____
Did you lose any time from work as a result of this accident? Circle Yes No Length of time_____

Explain briefly how this accident occurred: _____
_____
_____
_____

Circle what areas were injured: Neck Back Shoulder/Upper extremity Knee/Lower extremity
Arm Hand Knee

List your complaints in order of severity: _____
_____
_____
_____

Have you received any treatment for your injuries? If so, circle treatment and indicate for how long
Physical Therapy _____ Chiropractic treatment _____ Orthopaedic _____ Other – describe
_____

Did you have any previous diagnostic testing performed? Circle please X-rays EMG testing
CT scans MRI's Other: Please indicate _____

Please circle what pertains to your medical history: No medical problems Diabetes
Hypertension Heart disease Asthma COPD Thyroid

List the medications you are currently taking: _____
_____
Do you have any drug allergies? If so, to what: _____
_____

Indicate any surgical procedures you have undergone: _____
_____
_____

Were you involved in any previous accidents or have you sustained any previous injuries? Indicate
date of accident and list any injuries sustained: _____
_____
_____

DOCTOR'S LIEN

Attorney: _____

PATIENT/CLIENT:

Re: Medical Reports and Doctor's Lien

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical services rendered me both by reason of this accident and by reason of any other bills that are due their office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict by which may be paid to you, my attorney or myself as the 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 submitted to him/her for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of him/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

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, but will require me to make payments on a current basis.

DATED:

Patient's signature: _____

The undersigned being attorneys of record for the above patient does hereby agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said above named.

Dated: _____ **Attorney's Signature:** _____

Metropolitan Orthopaedics, LLC

17 Jauncey Avenue
North Arlington, New Jersey 07031
(201) 991-9019 Fax: (201) 991-0931
www.metro-orthopaedics.com

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Fellow American Academy of Orthopaedic Surgeons

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

Patient Name (Print) _____

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 PIP 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 appears process" as set forth in the N.J. 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 challenged 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 name 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 o 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 Signature: _____ Date: _____

This part to be filled out by patient

ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

TYPE OR PRINT LEGIBLY | CLAIM #: | DATE SUBMITTED: Month / Day / Year

PATIENT INFORMATION

1. PATIENT'S NAME: Last / First / Initial
2. PATIENT'S ADDRESS (No., Street)
3. CITY
4. STATE
5. ZIP CODE
6. TELEPHONE # (Include Area Code)
7. PATIENT BIRTHDATE
8. SEX ☐ M ☐ F
9. S.S. NUMBER
10. INSURANCE COMPANY
11. POLICY NUMBER
12. DATE OF ACCIDENT
13. IS PATIENT'S CONDITION RELATED TO:
   - A. EMPLOYMENT ☐ YES ☐ NO
   - B. AUTO ACCIDENT? ☐ YES ☐ NO
   - C. OTHER ACCIDENT? ☐ YES ☐ NO
14. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

15. POLICYHOLDER'S NAME: Last / First / Initial
16. POLICYHOLDER'S ADDRESS (No., Street)
17. CITY
18. ST/
19. TELEPHONE # (Include Area Code)
20. ZIP CODE
21. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

22. NAME OF TREATING PROVIDER Last	First	Initial	23. TAX I.D. NUMBER	24. SPECIALTY	25. FACILITY OR OFFICE NAM
Lerer	Kent	S	202008712	Orthopardics	Metropolitan

26. FACILITY/OFFICE ADDRESS (No., Street)	27. CITY	28. STATE	29. ZIP CODE
17 Jauncey avenue	North Arlington	NJ	07031

30. TELEPHONE # (Include Area Code)	31. EMAIL ADDRESS	32. FAX # (Include Area Code)	33. INITIAL DATE OF TX	34. DATE OF LAST VI
201-991-9019		201-991-0931		

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW.
(*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ ALL MEDICATION ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTICS TESTING ☐ OTHER

36. PRIMARY DIAGNOSIS (ICD-9)	37. SECONDARY DIAGNOSIS (ICD-9)	38. ADDITIONAL DIAGNOSIS (ICD-9)	39. ADDITIONAL DIAGNOSIS (ICD-9)

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

40. DATE(S) OF TREATMENT REQUESTED

FROM	TO

41. CHECK APPROPRIATE CARE PATH (if applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

42. REQUEST FOR SERVICES : CPT / HCPS / NDC CODES
(Use left box for single codes or left and right box for a range of codes)

		FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (Number of weeks)	TOTAL UNITS

42. CHECKMARK ATTACHMENTS BELOW. (*NOTE-ALL SUPPORTING DOCUMENTS CHECKED **MUST** BE PROVIDED ON SEPARATE ATTACHMENT)

☐ SOAP NOTES ☐ PROGRESS NOTES ☐ TEST RESULTS ☐ MEDICAL HISTORY ☐ PRESCRIPTIONS ☐ OTHER

FRAUD PREVENTION-NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND REVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

43. _____

SIGNATURE OF PROVIDER DATE