PATIENT REGISTRATION

DATE__________________________FAMILY/REFERRING DR.____________________________________

PATIENT NAME____BIRTH DATE_____/_____/_____

ADDRESS_________________________________CITY____________________ STATE_______ ZIP________

EMAIL______________________________ DRIVERS LICENSE___________________________________

PATIENT S.S. #_______________________________PHONE__________________________AGE_________

SEX M ☐ F ☐ MARITAL STATUS S ☐ M ☐ W ☐ D☐ Cell Phone______________________

PATIENT EMPLOYER &ADDRESS____

EMPLOYER PHONE____

REASON FOR VISIT_______________________________ IS VISIT DUE TO AN INJURY ☐YES ☐NO

REFERRED BY WHOM____

SPOUSE OR NEAREST RELATIVE_____________________________________PHONE_________________

ADDRESS____RELATIONSHIP___________________

RESPONSIBLE PERSON NAME_______________________________________S.S. #__________________

ADDRESS____

PHONE (H)_________________________(W)___________________RELATIONSHIP___________________

EMPLOYER & ADDRESS____

INSURANCE INFORMATION

PRIMARY CARRIER_________________________________ Card Holder Name______________________________

ADDRESS____ Card Holder Date of Birth______________

I D #__________________________________GROUP # _________________________PLAN________________________

SECONDARY CARRIER_______________________________ Card Holder Name______________________________

ADDRESS____ Card Holder Date of Birth_____________

I D #__________________________________GROUP #________________________PLAN________________________

I HEREBY AUTHORIZE ESSEX SURGICAL, LLC, AND /OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY.
WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME____DATE_________________________________

PATIENT SIGNATURE/RESPONSIBLE PERSON

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

YOUR NAME____DATE_________________

	YES	NO	EFFECT		YES	NO	EFFECT
PENICILLIN	☐	☐	____________	TAPE	☐	☐	______________
OTHER MEDICATION	☐	☐	____________	HAY FEVER	☐	☐	______________
________________	☐	☐	____________	FOOD	☐	☐	______________
IODINE	☐	☐	____________	SHELL FOOD	☐	☐	______________
CONTACT ALLERGY	☐	☐	____________	LATEX	☐	☐	______________

EXPLAIN ALLERGIC EFFECTS: ____

ILLNESS & MEDICAL PROBLEMS:

YES	NO		YES	NO	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	BRONCHITIS
☐	☐	HEART ATTACK	☐	☐	EMPHYSEMA
☐	☐	HEART MURMUR	☐	☐	PNEUMONIA
☐	☐	OTHER HEART PROBLEMS	☐	☐	TUBERCULOSIS
☐	☐	DIABETES	☐	☐	ANESTHESIA PROBLEMS
☐	☐	DIZZY SPELLS	☐	☐	STOMACH ULCER
☐	☐	GLAUCOMA	☐	☐	COLITIS
☐	☐	OTHER EYE TROUBLE	☐	☐	DIVERTICULOSIS
☐	☐	EAR TROUBLE	☐	☐	HEPATITIS
☐	☐	SINUS TROUBLE	☐	☐	MONONUCLEOSIS
☐	☐	DEAF OR HEARING IMP.	☐	☐	GALL BLADDER TROUBLE
☐	☐	NOSE BLEEDS	☐	☐	STROKE
☐	☐	NOSE OBSTRUCTION	☐	☐	SLEEP APNEA/DISORDERS
☐	☐	SWELLING IN NECK	☐	☐	CONVULSIONS/SEIZURES
☐	☐	ASTHMA	☐	☐	THYROID PROBLEMS
☐	☐	HEALING PROBLEMS	☐	☐	KIDNEY / BLADDER PROBLEMS
☐	☐	HERNIAS	☐	☐	VARICOSE VEINS
☐	☐	LOW BLOOD PRESSURE	☐	☐	BLEED EASILY
☐	☐	ARTHRITIS	☐	☐	EYE PROBLEMS
☐	☐	BRUISE EASILY	☐	☐	PARALYSIS
☐	☐	BLEEDING DISORDER	☐	☐	LUNG PROBLEMS
☐	☐	ANKLE SWELL			

☐ ☐ MENTAL / NEUROLOGICAL CONDITION:

EXPLAIN: ____

☐ ☐ CANCER:

YEAR / TYPE: ____

MEDICAL HISTORY

YOUR NAME ___________________________WEIGHT________HEIGHT ____________

SURGERY (OPERATIONS):

1. ____
2. ____
3. ____
4. ____

ADMISSIONS TO HOSPITALS:

1. ____
2.
3. ____
4.
5. ____

CONSUMPTION OF THE FOLLOWING:

Aspirin_______________ Amount Daily ____________ Amount Weekly_______________
Alcohol _______________ Amount Daily ____________ Amount Weekly _______________
Tobacco ______________ Amount Daily ____________ Amount Weekly _______________

BLEEDING PROBLEMS: (WITH CUTS? TOOTH EXTRACTIONS? PREGNANCY? SURGERY?)
EXPLAIN:

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:
EXPLAIN:

FAMILY HISTORY OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:
EXPLAIN:

FAMILY HISTORY: ANY FAMILY HISTORY OF MEDICAL PROBLEMS OR ILLNESS?
Mother__________________________ **Father** ______________________________
__________________________ ______________________________
Sister __________________________ **Brother** ______________________________
__________________________ ______________________________

ESSEX SURGICAL, LLC
776 Northfield Ave, West Orange NJ 07052
Tel: 973-324-2300 Fax: 973-324-2113

Patient Label

Facility Consent Form

Patient's Name: ______________________________ Date: ______________

Physician's Name: ______________________________

Consent for Treatment

I, the above-named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff of the above surgical center, which may include routine diagnostic procedures and such medical treatment as my doctor or his/her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatments or procedures I may receive while at the Center.

Release of Medical Records

I authorize the Center to release all or any part of my medical record to (a) hospitals or medical service companies, insurance companies, workers' compensation carriers, welfare funds or other organizations or agencies that may be concerned with the payment of costs related to my treatment (b) any other organization or agency to which the Center is permitted to release such information under applicable laws and (C) facility billing company/representative and/or attorney(s) retained by the center. In the event I am transferred or admitted to a hospital post-operatively, I authorize the Center to obtain a copy of the hospital discharge summary.

Financial Arrangements

I authorize, assign, and direct my insurer or payor to pay directly to the above Center any or all benefits, up to the amount of my bill, accruing to me in connection with my treatment. I agree that, in consideration of the services that were provided to me. I individually obligate myself to pay the account promptly in accordance with the regular rates and terms of the facility. I am financially responsible to the Center. Furthermore, I understand that my insurer or payor may require certain health care services to be authorized before they are furnished to me. I individually obligate myself to pay the account of the Center with respect to services that I choose to receive notwithstanding that my health insurer or payor has refused to give preauthorization for all or any portion of my services.

Precertification: Your insurance company will be called to pre-certify your procedure. Please make sure that we have the correct insurance information. It is important to notify us if you have different plans for physician and hospital services. I understand that pre-certification is not a guarantee of payment and I am responsible for fees for services.

☐ I understand I am using my out of network benefits. This facility is not contracted with my insurance company to provide services. I understand that the reimbursement may be sent to me instead of the Center. Upon receipt of the insurance payment, I will forward the check and the explanation of benefits to the Center. In addition, I understand that my insurance plan may still hold me responsible for any deductibles and/or coinsurance.

☐ I understand I am using my in network benefits. I understand that although the surgical center is contracted with the insurance company, my insurance plan will hold me responsible for a deductible and/or coinsurance.

☐ I understand I am paying for services out of pocket (self-pay) and have decided not to use insurance to cover the cost of my procedures/services. I am fully responsible for all expenses related to my procedure.

Facility Charge: When your procedure is performed at the above surgical center, there will be a facility fee. There is a charge for the use of the surgical suite for your procedure. Fees will vary according to the type of procedure(s) that is/are being performed. Patient responsibility is dependent upon individual insurance plans.

______________________________ ______________________________

Patient's or parent/guardian's signature Date Witness

If you have any questions regarding the above information, please speak with the Administrator.

Collection Expenses

Should my account with the surgery center be referred to an attorney or outside agency for collection, I will pay all reasonable collection expenses (including attorney's fees) associated with the collection effort. I acknowledge that all delinquent accounts will bear interest at the legal rate.

ESSEX SURGICAL, LLC

Patient Label

Additional Charges

Professional Fees: These are the fees that are billed by your physician and/or his/her assistant for his/her services in performing your procedure. These fees are within the range considered usual and customary for this area. Patient responsibility will vary according to each insurance plan. **For questions pertaining to your physician's and/or assistant bill, please call the number on the bill.**

Anesthesia: A board-certified anesthesiologist will be participating in your procedure in order to provide comfort and safety. This service will be billed to your insurance company unless other arrangements have been made. This service is provided to you by physicians who are not acting as an agent of Essex Surgical, LLC.

For questions pertaining to your anesthesiology bill, please call: Ambulatory Anesthesia Associates or Optimum Anesthesia, LLC 908-653-9399 ext 132.

Biopsies/Tissue: If a biopsy or tissue removal is required during the course of your procedure, a tissue sample may be sent to a laboratory to be analyzed by a pathologist. You may receive a separate bill from the pathologist.

For questions pertaining to your pathology bill, please call the Pathology Office Listed on the Bill.

Radiology: You may receive a separate bill for any radiographic services related to your procedure.

For questions pertaining to your radiology bill, please call the number on the bill.

Patient Rights

I acknowledge that I have received a copy of the Patient's Rights and HIPAA Privacy Regulations, which includes, but is not limited to my health information being disclosed to Essex Surgical Billing Company/Representative, Collection Agency and/or Attorney (s) retained for the purpose of obtaining information from insurance company (s) that may be involved with the payment of cost related to my treatment and for obtaining fees for medical services rendered.

Clothing and Valuables

I fully understand that the Center is NOT responsible for any personal property (clothing, eyeglasses, dentures, etc.) brought in or retained in the lockers at any time. I fully understand that any valuables (money, jewelry, and keys) should be given to a family member or other responsible party for safekeeping.

Acknowledgement of Driving Risks

I understand that the procedure I will receive today may cause conditions that render driving unsafe. I have been informed by the surgery center that I should not drive for at least 24 hours after receiving the procedure and that I should not attempt to drive until my symptoms have resolved. I understand that the Center will assist me in making alternative transportation arrangements if necessary and I so request.

Patient Signature

The undersigned certifies that this form has been fully explained to him/her, and the undersigned is satisfied that he/she understands its content and significance.

Signature of Patient ____________ Date ______ Time ______ Witness ____________

Representative/Guardian Signature

Patient is a Minor or unable to sign because: ____________

The undersigned certifies that this form has been fully explained, and the undersigned is satisfied that the contents are understood. The undersigned certifies that he/she has been duly authorized by the patient as the patient's legal representative or guardian to execute the above and accept on behalf of the patient.

Signature of Representative/Legal Guardian ____________ Date ______ Time ______ Witness ____________

Rev 10/10/12 LN

Essex Surgical, LLC
776 Northfield Avenue West orange New Jersey 07052
Tel: (973) 324-2300 Fax: (973) 324-1421

Physician /Facility Notice

Please be advised that the following notice will apply to all future office visits and/or procedures performed by George C. Peck, Jr., MD, Richard E. Peck, MD, Robert Marini, MD, Frank Femino, MD, Stephen Ducey, MD, Seth Queler, MD, Mark Drzala, MD, Mitchell Reiter, MD, Kevin McCracken, MD, Prashant Patel, MD, Michael Kelly, DO, Heidi Hullinger, MD, Praveen Kadimcherla, MD and Shailendra Hajela, MD for services performed at Essex Surgical, LLC.

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (e) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for service. We believe, that in your case, Medicare will likely deny payment for Cosmetic Surgery and /or Surgical Procedures not covered in an Ambulatory Care Facility for the following reasons: Your procedure may not be authorized by Medicare as it may not be a covered procedure in an ambulatory care facility and/or may be deemed cosmetic in nature.

Beneficiary Agreement

I have been notified by my physician that, in my case, Medicare is likely to deny that he or she believes that, in my case, Medicare is likely to deny payment for the service(s) identified above, for the reason(s) stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed___________________________________ Date__________________________

Essex Surgical, LLC
776 Northfield Avenue West Orange, New Jersey 07052
Tel: (973) 324-2300 Fax: (973) 324-2113

Revocable Assignment of Benefits & Authorization

I, ____(Name of Patient), assign to my medical provider Essex Surgical LLC , any and all of my rights and benefits under my insurance contract and/or my employee welfare benefit plan(s) as well as all of my rights and benefits under the Employee Retirement Income Security Act of 1974 ("**ERISA**") and any other applicable state or federal law(s), regulation(s), statute(s), or rule(s), which are in any way related to the medical services provided to me by **Essex Surgical LLC** at any time. I assign to **Essex Surgical LLC** any and all of my rights and benefits under my plan or policy as well as state and/or federal law(s), regulation(s), statute(s), or rule(s), to seek plan or policy documents, file appeals, seek statutory and other penalties, seek equitable relief, commence legal action, and directly receive payment of benefits insofar as they in any way relate to the treatment and/or services provided to me by **Essex Surgical LLC** at any time. I assign to **Essex Surgical LLC** any recovery, settlement, penalty, and/or other relief obtained. I authorize **Essex Surgical LLC to** file insurance claims on my behalf for services rendered to me at any time by **Essex Surgical LLC**. I direct that all reimbursable payments for treatment and/or services rendered to me by **Essex Surgical LLC** go directly to the **Essex Surgical LLC** or any individual or entity they deem appropriate, I authorize **Essex Surgical LLC** to file arbitration and/or litigation in my name and on my behalf against my PIP carrier, Healthcare Carrier, Employee Welfare Benefit Plan, Workers' Compensation Plan, or any similar entity, which is in any way related to the treatment and/or services provided to me by **Essex Surgical LLC** at any time. I authorize **Essex Surgical LLC** to retain an attorney of **Essex Surgical LLC** choice on my behalf for collection of Essex **Surgical LLC** bills and/or to file insurance claims on my behalf for services rendered to me. I authorize and consent to **Essex Surgical LLC** acting on my behalf in this regard and regarding my general health insurance coverage, and I specifically authorize **Essex Surgical LLC** to pursue any administrative appeals conducted pursuant to any contract, plan, law or statute, including, but not limited to, **ERISA**. **Essex Surgical LLC** may affirmatively disclaim any part of this assignment and authorization at any time and for any and/or no reason(s) through writing. There is no reciprocal right on the part of the **Patient** once this document is executed. **Patient** does not retain any power, right, or ability, to revoke or withdraw any authorization or assignment. Should **Essex Surgical LLC** disclaim any part of this assignment or authorization it shall result in the right(s) and/or benefit(s) explicitly disclaimed returning to **Patient**.

____
NAME OF PATIENT

____
SIGNATURE OF PATIENT/GUARDIAN

____
DATE

ESSEX SURGICAL, LLC
ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

Patient Name______________________________________ **Claim #** _________________________________

I hereby authorize **Essex Surgical, LLC** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to **Essex Surgical, LLC** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

____

Patient/Guardian Name (Print) Patient/Guardian Name (Signature) Date

____

Patient Address

Provider: Essex Surgical, LLC
776 Northfield Avenue
West Orange, New Jersey 07052

****

No FAULT AND/OR WORKERS COMPENSATION PATIENTS

I, _____________, (Assignor) hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney:_____________________. I further authorize **Essex Surgical, LLC** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will ***only*** be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

ATTORNEY INFORMATION

Attorney Name:___________________________________ Attorney Phone#:______________________________

Addresss:___________________________________City_________________________State_____Zip_________

I, ____________________, (Assignor) hereby assign to Essex Surgical, LLC, (Assignee) all rights and privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _________________, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits, or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a Law Enforcement Agency, The Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a Civil Penalty not to exceed five thousand dollars and the value of the subject Motor Vehicle stated claim for each Violation.

____

Patient/Guardian (Print) Patient/Guardian (Signature) Date

____

Patient Address

Provider: Essex Surgical, LLC
776 Northfield Avenue
West Orange, New Jersey 07052

ANESTHESIA
ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

Patient Name_______________________________________ **Claim #** __________________________________

I hereby authorize **Ambulatory Anesthesia Associates, LLC** (AAA) or **Optimum Anesthesia, LLC** to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments, for medical services rendered to myself or my dependants, to the facility/ physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to **Ambulatory Anesthesia Associates, LLC** (AAA) or **Optimum Anesthesia, LLC** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

____

Patient/Guardian Name (Print) Patient/Guardian Name (Signature) Date

____

Patient Address

Provider: Ambulatory Anesthesia Associates, LLC or Optimum Anesthesia, LLC
312 Courtyard Drive
Hillsborough, New Jersey 08844

****

No FAULT AND/OR WORKERS COMPENSATION PATIENTS

I, _____________, (Assignor) hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney:_____________________. I further authorize **Ambulatory Anesthesia Associates, LLC** (AAA) or **Optimum Anesthesia, LLC** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will ***only***
be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, for which I am responsible.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependants and that this agreement is made solely for your additional protection and in consideration of your awaiting payment. I further understand that your attorney, if needed, will arbitrate my bills for payment.

ATTORNEY INFORMATION

Attorney Name:___________________________________ Attorney Phone#:______________________________

Addresss:___________________________________City________________________State______Zip_________

I, ____________________, (Assignor) hereby assign to **Ambulatory Anesthesia Associates, LLC** , (Assignee) or **Optimum Anesthesia, LLC** (Assignee) all rights and privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _________________, notwithstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits, or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a Law Enforcement Agency, The Department of Motor Vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a Civil Penalty not to exceed five thousand dollars and the value of the subject Motor Vehicle stated claim for each Violation.

____

Patient/Guardian (Print) Patient/Guardian (Signature) Date

____

Patient Address

Provider: Ambulatory Anesthesia Associates, LLC or Optimum Anesthesia, LLC
312 Courtyard Drive
Hillsborough, New Jersey 08844

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 [Essex Surgical, LLC] 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.

* 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.

☐ 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)

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by Essex Surgical, LLC and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: ______________________ Ins. ID#____________ Date:____________
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

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.

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: ____

ADDRESS:____

____

PHONE: ________________ FAX: ________________ EMAIL: ____________________________________

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.

Essex Surgical, LLC
776 Northfield Avenue West Orange New Jersey 07052
Tel: (973) 324-2300 Fax: (973) 324-2113

As I am over 18 years of age, I authorize Essex Surgical, LLC (includes the physicians and office or clinical staff) to share my medical information regarding the procedure (s) that will be performed on ____________________ with my parent, guardian or the following named person (s):

_________________________________ _________________________relationship
Print Name

_________________________________ _________________________relationship
Print Name

_________________________________ _________________________relationship
Print Name

For the purpose of medical care and/or billing (including fees billed to insurance and/or billed directly to the patient.

Date:__________________________ Date:________________________________

______________________________ ______________________________
Patient Signature Witness Signature

______________________________ ______________________________
Print Name Print Witness Name

ESSEX SURGICAL, LLC
776 NORTHFIELD AVENUE
WEST ORANGE NEW JERSEY 07052

I have received the following documents prior to my scheduled procedure date.

□ Advanced Medical Directive Policy

□ Notice of Ownership/Financial Policy

□ Patient Rights

□ Notice of Privacy Practice

By signing this form, I agree to review the documents that I have received prior to my surgery date. By proceeding with my scheduled procedure, I understand and agree with the policies stated on the forms that I have reviewed.

____
Print Patient Name

_____________________________ ____________________
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because,

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (please specify) ______________________________________.

Acknowledgment of Advance Directive Policy

All patients have the right to participate and make decisions regarding their own healthcare treatment and to make an advanced directive or execute powers of attorney that authorize others to make decision on their behalf based on the patient's expressed wishes when the patient is unable to make or communicate their own decisions. Essex Surgical, LLC respects and upholds these rights.

However, unlike acute long-term hospital settings, the surgery center does not routinely perform 'high risk' procedures. While every surgical procedure carries a risk, the procedures performed at Essex Surgical, LLC are minimal risk. Your doctor will discuss the specific risks of your procedure and give you to opportunity to ask any questions.

It is the policy of Essex Surgical, LLC regardless of the contents of any Advanced Directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measure and transfer you to an acute care hospital for further evaluation. The acute care hospital to continue with further treatment or withdrawal of treatment measures already begun according to your wishes, advance directive, or health care power of attorney. Your agreement with this policy, by your signature below, does not revoke or invalidate any current health care directive or health care power of attorney.

If you do not agree with this policy, we are pleased to assist you in rescheduling the procedure.

Please complete the following questions and sign.	**Please Circle.**	
Have you executed an advance directive, living will or health care power of attorney that authorizes someone to make health care decisions for you?	**Yes**	**No**
If you answered 'yes' above, have you provided us a copy for your medical record?	**Yes**	**No**
By signing this document, I acknowledge that I have read and understand its contents and agree to the policy as described. If I have indicated I would like additional information, I acknowledge receipt of that information.		

Patient's Signature	Patient's Representative Signature
Date	Date Relationship to Patient: □ Court Appointed Guardian □ Health Care Surrogate □ Attorney in Fact □ Other: