ORTHOPAEDIC & SPORTS MEDICINE SPECIALISTS INC.

David V. Lopez, M.D. FAAOS

Patient Information

Office: □ Little Silver □ Freehold □ Edison

PATIENT NAME (First, M., Last)	PATIENT ID (Office Use Only)	TODAY'S DATE	DOB	AGE

SEX □ M □ F	MARITAL STATUS ☐ Married; ☐ Single; ☐ Other	HOME	CELL	SS #

ADDRESS	EMAIL

CITY, STATE, ZIP

PRIMARY CARE PROVIDER (PCP) NAME	EMERGENCY CONTACT NAME

PCP PHONE	EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE

RACE	ETHNICITY	LANGUAGE

NAME OF AUTHORIZED PARTIES THAT MAY DISCUSS MEDICAL CARE	RELATIONSHIP	PHONE
	RELATIONSHIP	PHONE

IS IT OKAY TO LEAVE TEST RESULTS ON VOICEMAIL? **HOME**: □ YES □ NO **CELL**: □ YES □ NO

Employer Information (Patient Only)

COMPANY / EMPLOYER NAME AND ADDRESS	
OCCUPATION	**EMPLOYER PHONE #**

EMPLOYMENT STATUS: □ Full Time □ Part Time □ Self Employed □ Work at Home □ Retired □ Student

Referring Physician

NAME		
ADDRESS		
CITY	**STATE**	**ZIP**

Responsible Party (Billing) □ Same as patient □ Different from patient (fill out below, if different)

RESPONSIBLE PARTY NAME (First, M., Last)	HOME	CELL

ADDRESS	DATE OF BIRTH	SS #
CITY, STATE, ZIP	**SEX** □ M □ F	**PATIENT'S RELATION TO RESP**
EMPLOYER	**OCCUPATION**	**RESP PARTY ID (Office Use Only)**

Primary Insurance

Who is the primary insured party / subscriber (check one):
□ Patient □Responsible Party □Other (complete below)

INSURANCE COMPANY NAME **CO-PAY AMOUNT**		**INSURED'S NAME (If "other," complete this column in addition to left column)**		
INSURANCE COMPANY ADDRESS		**INSURED'S ADDRESS, CITY, STATE, ZIP**		
INSURANCE COMPANY CITY, STATE, ZIP		**INSURED'S DATE OF BIRTH**		
INSURANCE COMPANY PHONE NUMBES		**INSURED'S SS #**	**SEX** □ M □ F	**PATIENT'S RELATION TO INSURED**
INSURED'S POLICY NUMBES **INSURED'S GROUP #**		**INSURED'S EMPLOYER**		**INSURED'S OCCUPATION**

Secondary Insurance

Who is the secondary insured party / subscriber (check one):
□ Patient □Responsible Party □Other (complete below)

INSURANCE COMPANY NAME **CO-PAY AMOUNT**		**INSURED'S NAME**		
INSURANCE COMPANY ADDRESS		**INSURED'S ADDRESS, CITY, STATE, ZIP**		
INSURANCE COMPANY CITY, STATE, ZIP		**INSURED'S DATE OF BIRTH**		
INSURANCE COMPANY PHONE NUMBES		**INSURED'S SS #**	**SEX** □ M □ F	**PATIENT'S RELATION TO INSURED**
INSURED'S POLICY NUMBES **INSURED'S GROUP #**		**INSURED'S EMPLOYER**		**INSURED'S OCCUPATION**

Tertiary Insurance

Who is the tertiary insured party / subscriber (check one):
□ Patient □Responsible Party □Other (complete below)

INSURANCE COMPANY NAME **CO-PAY AMOUNT**		**INSURED'S NAME**		
INSURANCE COMPANY ADDRESS		**INSURED'S ADDRESS, CITY, STATE, ZIP**		
INSURANCE COMPANY CITY, STATE, ZIP		**INSURED'S DATE OF BIRTH**		
INSURANCE COMPANY PHONE NUMBES		**INSURED'S SS #**	**SEX** □ M □ F	**PATIENT'S RELATION TO INSURED**
INSURED'S POLICY NUMBES **INSURED'S GROUP #**		**INSURED'S EMPLOYER**		**INSURED'S OCCUPATION**

Responsible Party

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC, to release any information acquired in the course of my treatment to my insurance company, employer, physicians, institutions, or third party payers, as required for certain claims filed.

Signature of Patient / Parent / Guardian **Printed Name** **Date**

I / We authorize direct payment to ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC for any and all medical surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian **Printed Name** **Date**

ORTHOPAEDIC & SPORTS MEDICINE SPECIALISTS INC.

David V. Lopez, M.D. FAAOS

Patient Information

PATIENT NAME					TODAY'S DATE
DOB	AGE	HEIGHT	WEIGHT	BP /	BP TAKEN BY
PHARMACY NAME			PHARMACY TOWN		PHARMACY PHONE

Description of Symptoms/Injury

DATE OF Symptoms/Injury	SIDE INVOLVED: ☐ R ☐ L ☐ BOTH

TYPE OF INJURY / ILLNESS

THE COMPLAINT IS A RESULT OF: ☐ FALLING ☐ TWISTING ☐ SQUATTING ☐ LIFTING ☐ PUSHING ☐ PULLING

☐ OTHER (PLEASE EXPLAIN):

HAVE ANY TEST(S) OR TREATMENT(S) BEEN PERFORMED FOR THIS PROBLEM? ☐ YES (PLEASE LIST) ☐ NO

Surgical and Medical History

Do you have or have you previously had:

☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Emphysema / COPD	☐ HIV / AIDS
☐ Elevated Cholesterol	☐ Blood Clots	☐ Stomach Problems	☐ Osteoporosis	☐ Liver / Kidney Disease
☐ Diabetes (Type: ___)	☐ Bleeding Disorder	☐ Thyroid	☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Cancer **Type**:		☐ Other:	

Any Allergies to Medications? ☐ YES **(PLEASE LIST. NOTE ANY SERIOUS EFFECTS)** ☐ NO

Current Medications (include dosage and strength; include supplements / vitamins):

_____ _____

_____ _____

Surgical History (include date and, if applicable, which side):

_____ _____

_____ _____

For Women Only: Are you on birth control pills? ☐ YES ☐ NO; Are you pregnant? ☐ YES (# of weeks: _____) ☐ NO

Do you have a family history of:

☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Emphysema / COPD	☐ HIV / AIDS
☐ Elevated Cholesterol	☐ Blood Clots	☐ Stomach Problems	☐ Osteoporosis	☐ Liver / Kidney Disease
☐ Diabetes (Type: ___)	☐ Bleeding Disorder	☐ Thyroid	☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Cancer **Type**:		☐ Other:	

Social History (Patient Only)

Do you drink alcohol? Yes No If yes, how often? _____

Do you smoke? Yes No Formerly If yes, how often? _____ If formerly, how long ago did you quit? _____

Do you take any illicit drugs? Yes No

Orthopaedic and Sports Medicine Specialists, Inc – Financial Policy

WELCOME, and thank you for choosing Orthopaedic and Sports Medicine Associates, Inc, for your medical care. We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration and we believe are reasonable and in line with other area physician charges.

INSURANCE: The patient or their guarantor is responsible for payment for services provided by Dr. Lopez at the time of service. Orthopaedic and Sports Medicine Specialists, Inc, will file claims directly with your insurance carrier for services verified under your plan. Verification does not guarantee your insurance will pay for services. Payments of co-pays, co-insurance, deductibles, or fees for non-covered services are required at the time of service.

HMO / PPO OR CONTRACTED INSURANCE PLANS: Each time you make an appointment with Dr. Lopez, it is your responsibility to make sure that he is currently contracted with your plan and that you have obtained the necessary referrals. We will bill your plan and allow 45 days for payment. If the services are not paid the balance will become your responsibility. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, pre-existing conditions, or "reasonable and customary" charges.

IF YOU DO NOT HAVE MEDICAL INSURANCE: We request payment at the time of service or satisfactory payment arrangements made prior to service. If you are unable to pay for non-emergent services and do not have insurance, the service or treatment may be delayed until acceptable payment arrangements can be made. If you have any questions about your account balance, please call Maureen at our billing office at 732-888-2100, Ext. 612, between 8:30 a.m. and 4:00 p.m., Monday – Friday.

MEDICARE: If you are a Medicare patient, we ask that you pay the Medicare deductible at the time of service only if you have not met the deductible and your 20% co-insurance. If you have a supplemental policy, then you will only be required to pay the Medicare deductible. As a courtesy to you, Orthopaedic and Sports Medicine Specialists, Inc., will file Medicare and any supplemental insurance claims to your insurance carrier(s).

INSURANCE ASSIGNMENT & AUTHORIZATION TO RELEASE INFORMATION. I hereby authorize ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC, to release any information acquired in the course of my treatment that may be necessary to process my claim. I permit a copy of this authorization to be used in place of the original. In consideration of services rendered, I authorize payment to be made directly to ORTHOPAEDIC AND SPORTS MEDICINE SPECIALISTS, INC. Please be aware that we will not forgive patient deductibles, co-payments, or co-insurance payments, as it is against the law to do so.

COLLECTION. In the event that this account is placed with an attorney or collection agency because of an unpaid balance remaining on my account, I agree & promise to pay a collection fee of $50.00 or 20% of the total balance due, whichever is greater**.** I agree if my account balance is over 90 days old, I will be responsible for a late fee $50.00.

NO SHOW POLICY I understand that a charge of $50.00 will be made for broken and/or no show appointments unless 24 hour notice given, which I agree to pay.

MEDICARE PATIENTS. I hereby acknowledge that I am not a member of any Medicare HMO plan.

REFFERALS / AUTHORIZATIONS. It is the patient's responsibility to make sure that a referral has been obtained from their Primary Care Physician and to bring a copy of that referral to our office. If you do not have the referral you may be asked to reschedule your appointment or you may choose to pay in full for services that day.

CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE. Co-pays are the fixed amount that your insurance plan has designated as your responsibility for each office visit. This amount will be collected prior to your office visit. If a coinsurance or deductible is applied to your responsibility instead, you will be billed for the additional amount once your insurance processes the claim.

WORKERS COMP AND MOTOR VEHICLE ACCIDENT. We will bill the insurance carrier directly. You are responsible for providing the complete claim information, claim address, and adjuster's contact information. If your worker's comp or PIP insurance denies your claim, we will then bill your medical insurance if the appropriate information and referrals needed were provided in a timely manner. We will **NOT** await the results of any litigation to receive payment. We do **NOT** accept "Letters of Protection." You will be billed for any patient co-insurance and deductible or if the claims are denied. You will be responsible for payment in **FULL**.

SELF PAY. If you do not have medical insurance coverage, payment in full is required at the time of service.

RETURNED CHECKS. If a check you issued as payment is returned by your bank (for any reason), you will be charged the bank fee. Any future payments to our office must be made by cash or credit / debit card ONLY.

I have read all of the information above and agree that, regardless of my insurance status, I understand I am responsible for the balance on my account for any professional services rendered.

Patient Signature: _____ DOB: _____ Date: _____

ORTHOPAEDIC & SPORTS MEDICINE SPECIALISTS, INC.

David V. Lopez, M.D. FAAOS
BOARD CERTIFIED ORTHOPAEDIC SURGEON
BOARD CERTIFICATION IN ORTHOPAEDIC SPORTS MEDICINE
DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
ASSISTANT PROFESSOR IN THE DEPARTMENT OF ORTHOPAEDIC SURGERY
AT THE SETON HALL - HACKENSACK MERIDIAN SCHOOL OF MEDICINE

PHONE: 732-888-2100 www.lopezortho.com

Contract for Opioid Therapy

My policy regarding the prescription of opioids for nonmalignant pain is strict and non-negotiable. Narcotics should only be used as an adjunct to other therapies and as a last resort after other treatment modalities have failed.

My objectives when prescribing narcotics are:

- To provide adequate analgesia with the least dose possible.
- To minimize side effects.
- To allow you to become more functional.
- To avoid abuse and addiction.

Please read the following 20 statements listed below

1. The goal of my medication plan is to discontinue the use of short action opioids (Vicodin, Lortab, Lorcet, Norco, and Percocet) for chronic pain conditions.
2. Prescription refills will be done on an as needed basis, but no sooner than 10 (ten) days.
3. No refills will be made after clinic hours and on weekends or holidays.
4. I will use my medication only as prescribed. I will not take more than the amount indicated. Any evidence of such may result in termination of patient-physician relationship with Dr. Lopez.
5. I will not share my medications with anyone.
6. If I lose my medication, my prescription will not be replaced. Only in the event of extraordinary circumstances will an exception be made (ie. Your house burns down or you have a police report).
7. If my prescription is not refilled, I might experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, irritability, aches throughout my body, and a flu-like feeling. I am aware the opioid withdrawal is uncomfortable but not life threatening. I may choose to seek medical attention at an emergency room.
8. While being a patient of Dr. Lopez, I will not receive prescriptions for opioids or other sedatives from any other licensed prescriber, unless it is authorized by Dr. Lopez. Any evidence of such will result in termination of the patient-physician relationship with Dr. Lopez.
9. I will not alter nor forge my prescriptions. Any evidence of such will result in termination of patient-physician relationship with Dr. Lopez.
10. I will use only **1 (one)** pharmacy to fill my medication.
11. I agree to provide a sample of my urine, and in some cases blood, for drug screening at my physician's request. Failure to do so will result in termination of the patient-physician relationship with Dr. Lopez.

ORTHOPAEDIC & SPORTS MEDICINE SPECIALISTS, INC.

David V. Lopez, M.D. FAAOS
BOARD CERTIFIED ORTHOPAEDIC SURGEON
BOARD CERTIFICATION IN ORTHOPAEDIC SPORTS MEDICINE
DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGERY
FELLOW OF THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
ASSISTANT PROFESSOR IN THE DEPARTMENT OF ORTHOPAEDIC SURGERY
AT THE SETON HALL - HACKENSACK MERIDIAN SCHOOL OF MEDICINE

PHONE: 732-888-2100 www.lopezortho.com

12. Findings of other non-prescribed drugs in my urine or blood will result in termination of the patient-physician relationship with Dr. Lopez.
13. I am aware that **addiction** is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medication is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest drug history and that of my family to the best of my knowledge.
14. I understand that physical **dependence** is a normal and expected result of using medicines for a long time. Dependence is not the same as addiction. I am aware that physical dependence means that if pain medicine use is markedly decreased, stopped, or reversed by some agents (nalpuphine, buprenorphine, or stadol) I will experience withdrawal symptoms.
15. I am aware that **tolerance** to analgesia means that I may require more medicine to get the same amount of pain relief. Tolerance does not seem to be a big problem for most patients. If it occurs, increasing doses may not always help and may cause unacceptable side effects. This may cause my doctor to switch to another opioid or choose another form of treatment.
16. I am aware that the use of opioids has been associated with the following side effects:
    - Sleepiness and drowsiness
    - Nausea and/or Vomiting
    - Constipation
    - Urinary retention
    - Dizziness
    - Itching
    - Allergic reaction
    - Slow breathing / Slow reflexes and reaction times
    - Low testosterone levels in males
17. If the medications cause dizziness, sedation, or drowsiness, I understand I must not drive a motor vehicle or operate machinery that could put my life or someone else's in jeopardy.
18. Overdose of this medication may cause **death** by stopping my breathing.
19. I have read this contract or had it read to me. I understand all of it. I have had the chance to have all of my questions regarding this statement answered to my satisfaction. By signing this form voluntarily, I give Orthopaedics and Sports Medicine Specialists, Inc, my consent for the treatment of pain with opioid medications.
20. If I violate this agreement, my doctor will discontinue this form of treatment.

Patients Name: _____

Patient's Signature: _____ Date signed: _____

Pharmacy: _____ Phone #: _____

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 **Orthopaedic & Sports Medicine Specialists, INC.** 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 or the Chapter 32 Independent Arbitration System, 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.

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 ☐ 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

---

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: _____