RUTGERS
New Jersey Medical School

Department of Anesthesiology
Division of Pain Management
Doctor's Office Center
90 Bergen Street, Suite #3400
Newark, NJ 07103

Phone: 973-972-2085
Fax: 973-972-2130

Dear New Patient:

Please complete the enclosed forms and bring with you on the day of your scheduled appointment. The following information will be needed for the appointment:

- Medical records- office notes, operative reports, etc
- Copies of MRI/CT SCANS
- List of medications
- Copy of current insurance card(s)
- Proof of Identification- Driver's License or Passport
- Birth Certificate (if patient is minor)
- If you're covered by MVA or Worker's Compensation Insurance we require:
    - Name and address of the company
    - Phone#, Claim#, Date of Injury/Loss
    - Name adjuster/case manager

It's important for you to have this information the day of your appointment so that the Pain Management doctors can best treat you. Please contact the office if you have any questions (973) 972-2085.

Sincerely,
Pain Management

New Jersey Medical School

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Patient____
Last Name First Name

Responsible Party (if a minor)____
Last Name First Name

Address____

____
City State Zip

Home Number______________________________CellNumber__________________________

Email ___________________________________

Birthdate: ______________ SS#:____________________Sex:□ Male □Female

Race______________Religon__________________□Single□Married□Widowed□Divorced

Employer:______________________________________ Fulltime□ Part Time□

Business Address____

Occupation________________________Business/CellPhone____________________________

Spouse's Name____
Last First

Employer___________________________________ Fulltime□ Part Time□

Business Address____

Occupation______________________Business/CellPhone_________________________________

Emergency Contact Name___________________________________Relationship To You___________

Address___________________________City___________________State______

PhoneNumber________________________Business/Cell#____________________________________

Referring Physician Information

Last/FirstName____

Address____________________________________City______________________________

State_________________________Zip____

Telephone__________________________________Fax_______________________________

Primary Care Physician Information

Last/First Name____

Address_________________________________City___________________________________

State_______________________ Zip Code____

Telephone______________________________Fax____________________________________

Insurance Information

Person Responsible for Account____
Last/ First Name

Relationship to Patient_________________SS#___________________Birthdate______________

Insurance Company____

ID#___________________________________Group#_______________________________

Claims Address____

Phone #_______________________________Adjuster Name_________________________

Employer Name____

Employer Address____

City_______________________________State_____________________Zipcode__________

Phone______________________________Fax______________________________________

Secondary Insurance Information

Person Responsible for Account____
Last/ First Name

Relationship to Patient_________________SS#___________________Birthdate___________

Insurance Company____

ID#___________________________________Group#_______________________________

Claims Address____

Phone #_________________________________Adjuster Name_________________________

Employer Name____

Employer Address____

City_______________________________State_____________________Zipcode__________

Phone______________________________Fax______________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We keep record of the health care services we provide to you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal you records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office's Practice Administrator/Manager.

Our Notice of Privacy Practices describes more in detail/ how your health information may be used and revealed, and how you can obtain your information.

***YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT**

I, ___________________________________, have received a copy of this Office's Notice of Privacy Practices.

____

Print Name

____

Signature Date

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

□Individual refused to sign

□An emergency situation prevented us from obtaining acknowledgement □ Other (Specify)

____

____

Employee Signature/Date____

PATIENT RECORD OF DISCLOSURES

HIPPA privacy rule gives you the right to request confidential communications or that communication of Protected Health Information (PHI) be made by alternative means.

Please indicate the manner in which you wish to be contacted (check all that apply):

□ Home Telephone____________________□ Other ___________________

□ O.K. to leave message w/ detailed information

□ Leave message w/ call back number only

□ Work Telephone___________________
□ O.K. to leave message w/ detailed information
□ Leave message w/ call back number only

□ Written communication:
□ O.K. to mail to home address
□ O.K. to mail to work/ business address
□ O.K. to fax to this number__________________________

____
Patient Signature Date

____
Print Name Birth date

Disclosures of Protected Health Information
Office Use Only

Date	Disclosed to whom address or fax number	Purpose of Disclosure	By Whom Disclosed

DISCLOSURE OF FINANCIAL INTEREST IN SURGICAL CENTER

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service. Accordingly, please take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred:

- Surgical Center at Millburn
- Specialty Surgical Center of Secaucus

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Additionally, please be advised that the procedure(s) you are scheduled to undergo at Surgical Center at Millburn or Specialty Surgical Center of Secaucus, will be considered to be "out-of-network services, and reimbursed at an "out-of-network" level by your insurance carrier.

The Centers for Medicare & Medicaid Services Conditions of Coverage regarding ambulatory surgical centers mandate that ambulatory surgical centers disclose to patients a physician's financial interest in an ambulatory surgical center to which the physician refers his or her patients. Accordingly, please take notice of the following information:

The following physician has ownership in Surgical Center at Millburn, and Specialty Surgical Center of Secaucus to which patients are referred:

Andrew G. Kaufman, MD

Please sign below to acknowledge that you have been informed of ownership interest in the above entities prior to or at the time you were referred to the above entities.

____

Patient Name (please Print) Date

____

Patient Signature