Name:
Chart:
Date:

Michael A. Meese MD 17 Elm Avenue Hackensack, New Jersey 07601
201-968-0508 F201-968-0509

Personal Information

Name:

Address:

City, State, Zip

Phone #:

Cell #:

#

Social Security #:

Sex: Marital Status:

DOB: **Age:**

Date of Injury:

Primary Care Physician:

Employer:

Address:

City, State, Zip:

Phone #:

Occupation/Position:

Referred by:

Attorney / Physician / Other

Attorney:

Address:

City, State, Zip:

Phone #:

Fax #:

Signature:

Date:

Health Insurance:

Primary Ins:

Policy Holder:

Policy #:

Group#:

Secondary Ins:

Policy Holder:

Policy #:

Group #:

Motor Vehicle - No Fault Insurance

Auto Insurance:

Claim #:

Date of Accident:

Adjuster:

Phone #:

Fax #:

Workers Compensation Claim

Insurance Company:

Address:

City, State, Zip:

Date of Injury:

Claim #:

Adjuster/NCM:

Phone #

Fax #:

Name:

Chart:

Date:

Patient History

Today's Date: _____

Patient Name: _____ Age: _____
Last First Middle

What is the reason for today's visit? _____

Date symptoms first started: _____ Was this work related? YES _____ NO _____

Was this due to an auto accident? YES _____ NO _____ Date of Accident: _____

Who sent you to our office? _____

Have ☐MRI's ☐x-rays been made? Where and When? _____

Please list any medical problems you have: _____

_____

_____

Past Hospitalizations and/or Surgeries: _____

_____

Family History: _____

Drug allergies: (Please circle one) YES NO If Yes, please list: _____

Current Medications	Dose	Current Medications	Dose

Do you smoke? (circle one) Yes No If Yes, how much? _____

Do you drink alcohol? (circle one) Yes No If Yes, how much? _____

Do you now or have you ever had any of the following

Condition	Yes	No		Condition	Yes	No
Asthma, Bronchitis, Emphysema				Severe or Frequent Headaches		
Shortness of Breath or Chest Pain				Vision or Hearing Difficulties		
Heart Disease or Angina				Numbness or Tingling		
Do you have pacemaker?				Dizziness or Fainting		
High Blood Pressure				Weakness		
Heart Attack or Related Surgery				Weight or Energy Loss		
Stroke/TIA				Hernia		
Blood Clot/Emboli				Varicose Veins		
Epilepsy or Seizures				Allergies		
Thyroid Problems				Pins or Metal Implants		
Anemia				Joint Replacement		
Infectious Disease				Cervical Injury or Surgery		
Diabetes				Lumbar-Thoracic Injury or Surgery		
Cancer				Shoulder Injury or Surgery		
Arthritis				Elbow-Hand Injury or Surgery		
Osteoporosis				Knee Injury or Surgery		
Gout				Leg-Ankle Injury or Surgery		
Emotional or Psychological Concerns				Do you smoke?		
Bowel or Bladder Problems				ARE YOU PREGNANT?		

Patient/Guardian Signature _____ Date _____

Reviewed By _____ Date _____

Name:
Chart:
Date:

MAM Orthopaedics

Our Financial Policy

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy or your financial responsibility.

New patients or patients with a change of address or Insurance policy must fill out patient information forms prior to seeing the doctor. As the member you are responsible for keeping our office up to date with all insurance plan changes. It is your responsibility to know what benefits are specifically covered by your insurance policy.

We will need to photocopy your insurance card(s) and your driver's license or comparative legal ID for your file.

Please be aware that that your specific plan may or may not cover all services rendered. All services not paid for by your insurance company are considered "non-covered benefits" and they are solely your responsibility. If your insurance company requires referrals from your primary care physician or other specific requirements, it is your responsibility to know these rules and obtain all proper referrals and documentation necessary for payment. If you do not adhere to your insurance plan's requirements you understand that you are responsible to pay the full amount of the bill.

Copayments: By law we must collect your carrier designated co-pay at the time of service. Please be prepared to pay that co-pay at each visit.

Non Co-pay plans: If your plan does not require a co-pay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

Patients Without Insurance: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to our insurance forms and sent to your carrier who will reimburse you directly.

Medicare: We will submit a bill for rendered services to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to secondary insurance if you have one. Please understand Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. As a Medicare member you must provide the office with a valid name, address, and phone number for your Primary Care Physician.

I hereby authorize my insurance company to pay benefits directly to the doctor and for our office to release information to your insurance company, which they may require in order to process your bill.

I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty dollars ($50.00).

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us any special concerns.

No Fault/Motor Vehicle Accident: If you have been involved in a Motor Vehicle Accident you are responsible for providing us with a correct claim number, date of accident, and benefit information for YOUR policy. It is your responsibility to file an application for benefits before seeking treatment. Failure to do so will result in unpaid claims becoming due from you.

I have read and understood all of the above information and agree to the provisions.

Print Name	Signature	Date

Name:
Chart:
Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS INTENDED TO EXPLAIN HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

USES AND DISCLOSURES

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan and from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of treatment, the type of service provided and your medical diagnosis.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day to day activities and management of MAM ORTHOPAEDICS, P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be given to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORT: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

AUTHORIZATION: Other uses and disclosures require your authorization. Disclosure of your health information and/or its use for any purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation. This will not affect any use or disclosure of information that occurred before you notified us. I agree that MAM ORTHOPAEDICS, P.A. may request and use my prescription medication history from other healthcare providers or third- party pharmacy benefit payors for treatment purposes.

INDIVIDUAL RIGHTS:

The right to request restriction on the use and disclosure of your protected health information.

The right to receive confidential communications concerning your medical condition and treatment.

The right to inspect and copy your protected health information.

The right to amend or submit correction to protected health information.

The right to receive an accounting of how and to whom your protected health information has been disclosed.

The right to receive a printed copy of this notice.

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FROM MAM ORTHOPAEDICS, P.A.

SIGNATURE _____

DATE _____

Name:
Chart:
Date:

Michael A. Meese, M.D.
17 Elm Avenue
Hackensack, NJ 07601
201-968-0508

Dear Patient,

Please take a moment and describe below, the where, when and how of the injury that you are being treated for today. This is a requirement of your insurance carrier and must accompany the claim we submit on your behalf.

Thank you.

Patient's Name: _____

Date _____ Date of Injury: _____

Name:
Chart:
Date:

MAM Orthopaedics
17 Elm Avenue
Hackensack, NJ 07601

ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, *(MAM Orthopaedics PA dba Sports Medicine and Orthopaedic Center of New Jersey LLC dba Michael A. Meese, M.D.)* 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 appeals process" as set forth in the NJ 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 to 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.

Dated: _____

Patient's Signature _____

Patient's Name (Print) _____

SPORTS MEDICINE AND ORTHOPAEDIC CENTER
17 ELM AVENUE HACKENSACK, NJ.
201-968-0508

DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Section One: Health Plans Surgeon Participates With:

Your surgeon, Dr.Meese, presently participates with the following health insurance plans:

1) Empire Blue Cross, Medicare, Qualcare and Magnacare

If your health plan is not listed above in this Section One, your surgeon does not participate with your health plan. In order to proceed with any health care services, you, the patient, must complete, sign and date this form.

Section Two: Hospitals Surgeon Is Associated With:

Your surgeon, Dr.Meese presently has privileges at the following hospitals to perform surgical procedures:

1) Hackensack Meridian Health 30 Prospect Ave. Hackensack, N.J

2) Holy Name Medical Center 718 Teaneck Rd. Teaneck, N.J

Please contact your health plan or the hospital at which you are to receive surgical services to determine the participation status of the hospital, other providers and services the hospital is affiliated with, and associated cost obligations for you, the patient, prior to booking your procedure.

Section Three: Ambulatory Surgical Centers Surgeon Is Associated With:

Your surgeon, Dr. Meese, presently has privileges at the following ambulatory surgical centers to perform surgical procedures:

1.Patient Care Associates Grand Ave. Englewood, N.J.

Please contact your health plan or the Ambulatory Surgical Center at which you are to receive surgical services to determine the participation status of the hospital and associated cost obligations for you, the patient, prior to booking your procedure.

Section Four: Licensed Assistant Healthcare Staff:

The following licensed healthcare professionals may perform assistant services on you, the patient, based upon the treatment plan and needs of the patient:

1) Dr. Charles Dutkowsky
2) Laurie Krum Nurse Practitioner/RN First Assistant

Section Five: Anesthesia, Radiology, Laboratory, Pathology Services:

The following outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient:

Hackensack Radiology Group, Paramus Medical Imaging, University Radiology, Affinity Radiology Center, N.J. Imaging Network, Bergen Anesthesia, Hackensack Meridian Health, Holy Name Medical Center. Dr. Meese provides a list of facilities. Please verify their participation in your network.

The patient is hereby notified and understands that these assistants, anesthesia, radiology, laboratory and/or pathology services may not participate with any health insurance plans and may be "out-of-network" providers subject to the following disclosures. Patient should

inquire with each provider to determine their participation status and/or contact patient's health plan or administrator for further consultation on costs associated with these services.

Section Six: Mandatory Disclosures & Patient Acknowledgment:

1) I understand that the surgeon that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan;

   Patient initials: _____

2) I understand that the amount or estimated amount the surgeon will bill me, the covered person, or my health plan, for the services is available upon request;

   Patient initials: _____

3) I may request from the surgeon an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the surgeon shall disclose to me, the patient, in writing, the amount or estimated amount that the surgeon will bill me, the covered person, or my health plan, for the service and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

   Patient initials: _____

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, that may be in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan; and

   Patient initials: _____

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

   Patient initials: _____

The surgeon and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient, under the law.

The surgeon further acknowledges and agrees that, if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of the surgeon or any of the health care professionals listed in this disclosure change as it relates to the patient's health benefits plan, the surgeon shall notify the patient promptly.

Section Seven: Acknowledgement of Receipt of Disclosures

I, the undersigned patient, acknowledge receipt of this disclosure form from my surgeon, and have read it and understand the contents. I have discussed my option to obtain treatment with other surgeons, health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment with this surgeon with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do so upon my own free will.

By: _____ Date: _____

Print Name: _____