DEMOGRAPHICS

Name (First, Middle Initial, Last):______________________________

Address: (No P.O. Box): ______________________________

____

____

Date of Birth (mm/dd/yyyy): ______/ ______/ _______

SSN: ________/ ________/ ________

Gender: M ☐ F ☐

Marital Status: S ☐ M ☐ D ☐ W ☐

Ethnicity (check one): Latino ☐ Non-Latino ☐ Prefer not to answer ☐

Race (check one): White ☐ African-American ☐ Asian ☐ Prefer not to answer ☐

Primary Language (check one): English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Prefer not to answer ☐

Home Phone: ______________________ Cell Phone: ______________________ Work Phone: ______________________

Email Address: ___________________________________ Occupation: ___________________________________

Employer: ___________________________________ Employer Address: ___________________________________

Referring MD: ___________________________________ Primary MD: ___________________________________

Emergency Contact: _______________________ Emergency Phone: _________________ Relationship: ______________

How did you hear about our office? ____

INSURANCE

Is your visit related to...? (check one) Worker's Comp ☐ Motor Vehicle Accident ☐ Other ☐

WC or MVA Insurance Name: ____

WC or MVA Address: ____

Adjuster/ Case Manager Name: ___________________________________ Claim Number: ________________________

Phone: ______________________________________ Date of Accident (mm/dd/yyyy): ______/ ______/ _______

Body Part(s) Injured: ____

Attorney Name: _____________________________________ Phone: __________________ Fax: __________________

Attorney Address: ____

Health Insurance: _____________________________________Effective Date (mm/dd/yyyy): ______/ ______/ ______

Health Insurance Address: ____

Member ID Number: ________________________________ Group Number: __________________________________

Policyholder's Name: ____ Referral Required: Yes ☐ No ☐

Policyholder's Date of Birth (mm/dd/yyyy): ____/ ____/ ____ SSN: _____-_____-_____ Relation to Insured:__________

Deductible: $_________ Co-pay: $_________ Policyholder's Employers: _____________________________________

We do not submit secondary insurance unless Medicare is your secondary. You are responsible for all balances not paid by your primary insurance.

Please bring driver's license and insurance card along with you to your appointment.

Appointment Date (mm/dd/yyyy): ______/ ______/ ______

Name: ________________________________ **Age:** _____ **Gender:** ____ **Weight:** ______ **Height:**______

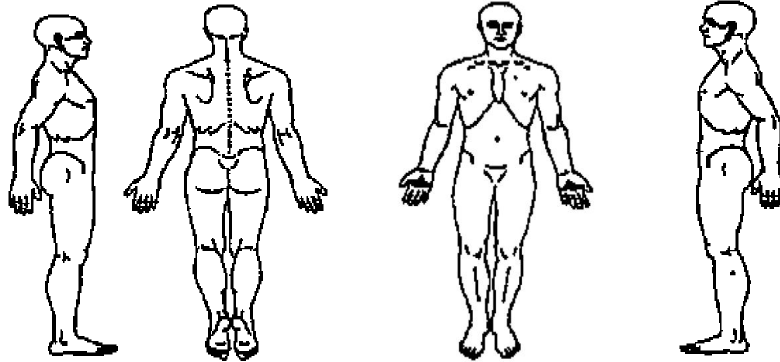
Where is your pain? ____

Pain Scale: Please circle the number that represents your current level of pain

1 2 3 4 5 6 7 8 9 10

Please indicate on the diagram the type of pain and where it is occurring:

P = Pain
B = Burning
T = Tingling
N = Numbness
W = Weakness
Is your pain...(check one)
☐ Constant (100% of the time)
☐ Frequent (75% of the time)
☐ Intermittent (50% of the time)
☐ Occasional (25% of the time)



When is your pain at its worst? _________________________ **When is your pain at its best?** ________________

How long have you been in pain? ____

How would you describe your pain? Sharp / Aching / Burning / Throbbing / Shooting / Electric / Indescribable

Other (please describe) ____

What worsen your pain? Standing / Walking / Sitting / Activity / Bending / Twisting / Lying Down

Other (please describe) ____

What eases your pain? Medication / Sitting / Lying Down / Standing / Physical Therapy / Heat / Ice / Chiropractic treatment

Other (please describe) ____

Does your pain affect any of the following? Concentration / Work / Daily Activities / Physical Activity / Appetite / Sleep

Other (please describe) ____

How many bowel movements do you have per week? _____________

Do you have harden stool? Yes / No **Do you have abdominal bloating?** Yes / No

Are you currently using any laxatives? Yes / No If so, what type? _____________

Have you ever had a back brace? Yes / No **Have you ever had a Tens Unit?** Yes / No

What treatment have you had for your pain (please be specific):

Physical Therapy (when, how long, where): ____

Chiropractor (when, how long, with whom): ____

Acupuncture (when, how long, with whom): ____

Injections (when, with whom): ____

Surgery (when, with whom): ____

Have you, or do you have any of the following:

- ☐ Muscle Pain
- ☐ Weakness
- ☐ Respiratory Distress
- ☐ Chills or Fever
- ☐ Throat Pain
- ☐ Colored or Thickened Mucus
- ☐ Cough
- ☐ Wheezing

Have you been prescribed medicine in the last 6 months? Yes / No

Does bladder cancer run in your family? Yes / No

Have you, or do you have burning, itching, and or discolored urination in the last 6 months? Yes / No

Do you have kidney problems? Yes / No

Have you ever had Urinary tract infection? Yes / No

PAST MEDICAL HISTORY

Cardiac (circle all that apply):
Hypertension Hypercholesterolemia Coronary heart disease/MI Irregular heart beat Atrial fibrillation/flutter
Internal cardia defibrillation/pacemaker Peripheral vascular disease Other:____________________

Pulmonary (circle all that apply):
Smoker Asthma COPD/Emphysema Sleep apnea Lung cancer Other:____________________

Gastrointestinal (circle all that apply):
GERD Gastritis Gastric ulcer Irritable bowel disease Hepatitis Liver cirrhosis Other:____________

Renal (circle all that apply):
Renal insufficiency Renal failure Kidney stones Other:__________

Endocrine (circle all that apply):
Diabetes Diabetic peripheral neuropathy Grave's Disease Hypothyroid Other:__________

Musculoskeletal (circle all that apply):
Osteoarthritis Rheumatoid arthritis Grave's Disease Sjogren's disease Degenerative join disease
Fibromyalgia Lyme's disease Other:______________________________

Neurological (circle all that apply):
Stoke TIA Migraines Seizure disorder Multiple sclerosis Alzheimer's disease Dementia Other:__________

Psychiatric (circle all that apply):
Depression Anxiety Bipolar Schizophrenia Panic disorder Post traumatic stress disorder
History of alcohol/drug abuse Other:______________________________

Hematological (circle all that apply):
Anemia Low platelets Bleeding disorder Blood clots Leukemia Lymphoma Other:______________

SURGICAL HISTORY

Please list past surgeries:

DATE	SURGERY

SOCIAL HISTORY

Do you currently smoke tobacco?

☐ Yes ☐ No ☐ Ex-Smoker

If yes, how many packs/day? _____ For how many years? ____

If ex-smoker, when did you stop? ____________________

Do you currently drink alcohol?

☐ Beer ☐ Wine ☐ Liquor

How much per day? _______ How much per week? _______

Do you currently use illicit drugs? ____________________

Are you currently working?

☐ Yes ☐ No ☐ Full-time ☐ Part-time

What is your occupation? ____________________

FAMILY HISTORY

Condition	Family Member
High blood pressure	
Lung disease	
Cancer (what type?)	
Diabetes	
Bleeding problems	

Problems with anesthesia ____________
Other: ____________

MEDICATION

Medication	Dose/Frequency

ALLERGIES

Allergy	Reaction

IMAGING STUDIES

Please indicate the date(s) of each procedure:

MRI____________ CT Scan____________ X-Ray ____________ EMG ____________

Other: ____________

OTHER SYMPTOMS

Have you recently had any of the following problems or symptoms?

Symptom	Response	Symptom	Response	Symptom	Response
Unexpected weight gain	☐ Yes ☐ No	Unexpected weight loss	☐ Yes ☐ No	Fever or chills	☐ Yes ☐ No
Chest pains	☐ Yes ☐ No	Fainted spells	☐ Yes ☐ No	Arm / leg swelling	☐ Yes ☐ No
Breathing difficulties	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Nausea or Vomiting	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Constipation	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No	Painful urination	☐ Yes ☐ No
Difficulty urinating	☐ Yes ☐ No	Loss of bowel control	☐ Yes ☐ No	Bloody stool	☐ Yes ☐ No
Loss of bladder control	☐ Yes ☐ No	Rashes or lesions	☐ Yes ☐ No	Bruising easily	☐ Yes ☐ No
Joint pain	☐ Yes ☐ No	Difficulty walking	☐ Yes ☐ No	Vision changes	☐ Yes ☐ No

Depression / Anxiety	☐ Yes ☐ No	Headaches / Migraines	☐ Yes ☐ No	Seizures / stroke	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No	Anemia	☐ Yes ☐ No

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: ____

Date of Birth (mm/dd/yyyy): _______/ _______/ _______ SSN: _______/ _______/ _______

I hereby authorize ____________________________________ ____________________
Name of physician/attorney/auto insurance *Physician's office phone number*

to disclose the following protected health information to **Progressive Pain Management.**

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates:______________________________
- ☐ All healthcare information
- ☐ Pip Ledger and Dec Page

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment

Signature:______________________________ Print name: ______________________________
Patient or Authorize Representative

Date (mm/dd/yyyy): ________/________/________

DESIGNATION OF DISCLOSURE

Designation of Certain Relatives, Close Friends and Other Caregivers
I agree that **Progressive Pain Management** may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care, in that case, **Progressive Pain Management** will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner (check all that apply):

You can disclose my health information as described below:

1.
- ☐ OK to leave message with detailed information at my home/cell number: (____) _____-_______
- ☐ On my answer machine
- ☐ With my spouse
- ☐ With anyone answering my phone
- ☐ Leave message with call back numbers only

2.
- ☐ OK to leave message with detailed information at my work number: (____) _____-_______
- ☐ OK to leave message with call back numbers only

3.
- ☐ OK to fax to my work fax number: (____) _____-_______
- ☐ OK to fax to my home fax number: (____) _____-_______

4.
- ☐ OK to email. Email address: _________________________
- ☐ OK to text to my cell phone number: (____) _____-_______

I designate the persons listed below as persons involved with my health care of payment relating to my health care for the purpose of **Progressive Pain Management** making the limited disclosure described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. I understand that **Progressive Pain Management** will not disclose health information to any person not designated except in case of an emergency.

Name: ________________________________ Last 4 digits of his/her SSN or DOB (required as identifier) _______
Name: ________________________________ Last 4 digits of his/her SSN or DOB (required as identifier) _______
Name: ________________________________ Last 4 digits of his/her SSN or DOB (required as identifier) _______

The following person(s) are NOT authorized to receive my Patient Health information:

Name: ______________________________ Name: ______________________________

Name: ______________________________ Name: ______________________________

Signature:______________________________ **Print name**: ______________________________
Patient or Authorized Representative

Date (mm/dd/yyyy): ________/________/________

PRACTICE POLICIES – PAGE 1 OF 2

Thank you for choosing **Progressive Pain Management**. We are committed to the treatment of your condition. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

We are happy to bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service as well as all required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company within ninety days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If you have HMO coverage, it is your responsibility to obtain the necessary referral for your visit or procedure and forward a copy of this referral to our office prior to your visit or procedure.

All patients are expected to pay at the time of service. We accept checks, money orders, MasterCard, Visa, American Express and Discover. Self-pay patients are required to pay in full at the time of service. If your insurance plan requires a copayment, it is payable at the time of service**. If you present without the copayment or do not remit copayment within 24 hours of your visit, we reserve the right to bill you a $15.00 administrative fee.** If for any reason a payment is dishonored by your bank, there will be a $40.00 service fee added to your bill and you will be required to pay by cash, certified check, money order or credit card for all future services.

We are participating providers for many plans. However, we encourage you to use your out-of-network benefits for all other carriers. You will be required to show your insurance card and driver's license at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement. In the event that your insurance carrier issues payment directly to you, it is your responsibility to forward that payment along with the explanation of benefits for appropriate posting of the payment to **Progressive Pain Management**.

There may be times when our physician is out of the office and you are required to see a physician who is not in your network. In these instances, we will work with your insurance plan to obtain in-network benefits to minimize your out-of-pocket payment.

Filing a secondary claim is a courtesy to the patient. We will only submit to your secondary carrier if they have electronic submission. If there is no response the balance will be your responsibility. If we receive payment from you and your secondary carrier, a refund of the overpayment will be made to you. We will not file tertiary insurance, but will provide a claim to you upon requires. You are responsible for all tertiary balances.

If you fail to meet your financial obligations in a timely manner, we reserve the right to discontinue care and refer your account to collections**. You are responsible for any interest, agency, and legal fees associated with collections, which could total up to 50% of the balance owed**.

We do accept **Workers Compensation and Personal Injury cases**. We will only file these claims with your regular insurance if a written denials from the workers compensation or personal injury carrier is received. **We accept liens only for services provided in our office**. All necessary legal contact information must be provided in advance of your service to allow us time to process the necessary lien paperwork.

Disability Forms, Reports, Etc.

Requests for completion of disability forms, reports, or other paperwork will require a minimum fee of $15.00, paid in advance, related to the amount of the preparation involved. Please allow 5 business days for completion.

Appointments

Please be sure to provide a telephone number where you may be reached. If you have voice mail on your contact telephone number, our staff will leave a message including the time, date and location of your appointment.

We require 24 hours notice if you intend to cancel your appointment. Should you cancel, reschedule or fail to appear for an appointment twice without 24-hour notices, we reserve the right to charge a no-show fee.

If you are scheduled for a procedure at any location and cancel without a 24-hour notice to our office, a cancellation fee of $50.00 will be billed to you directly. Missed appointments for procedures at surgery centers (including taking of medications and lack of transportation) will be billed in the amount of $100.00.

If you are late for your appointment, we reserve the right to reschedule your appointment or see you as the schedule permits. If you are a new patient and do not complete your forms in advance, you are required to be at the office at least 45 minutes in advance of your appointment to complete the necessary forms. **Failure to do so will result in the rescheduling of your new patient visit.**

HIPPA Privacy

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of the offices of Progressive Pain Management. This policy explains your rights including your right to see and copy your records, to limit disclosure of your protected health information and to request an amendment to your record. You may revoke in writing any consent for release of your health care information except to the extent that the office has already made disclosures with your prior consent. Because of the privacy regulations we are not a liberty to discuss your treatment with anyone unless you specifically designate your permission to do so. If you wish to allow access to your protected health information to any individual, ask our receptionist for an ***Access to Medical Records*** form. By signing this release, you allow us to discuss your care with the specified individual(s). If a family member has concerns about your care, we may not discuss these concerns without your written permission. Our ***Notice of Privacy Practices*** provides information on your rights and is available on our website. We encourage you to read it in full. If you have any questions regarding our notice and if we change our notice, you may obtain a copy of the revised notice by contacting us at 732-389-3500 or by visiting our website at ***www.progressivepain.com.***

Authorization to Release Information and Assignments of Benefits

I hereby assign all medical and/or surgical benefits to which I entitled, including Medicare, Blue Shield, HMO's and commercial insurance to **Progressive Plan Management**. **I understand that I am fully responsible for all charges whether or not they are covered by said insurance.** I hereby authorize assignee to release any information necessary to secure payment on my behalf.

Medication Policy

It is important to your health that you follow the directions carefully on all medications that we prescribe. In addition we must be informed of all other medications, prescriptions, over-the-counter and supplements that you are taking. **We will not refill controlled medications in advance of their refill date nor will we mail prescriptions. The must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make appointments, *we require a 3 day notice of a medication refill.***

Psychological Evaluations

Because of the nature of our treatment, there may be occasions when the physician determines that that a psychological evaluation is necessary. For example, many healthcare plans require evaluations prior to intrathecal pump or dorsal column stimulator placements. We reserve the right to discontinue care if you fail to obtain an evaluation as requested.

Staff

We require our staff to address our patients with professionalism and we ask that our patients do the same in return. If at any time our staff feels that your tone or language is offensive or abusive, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. **We will document your record and depending on the severity of the situation, you may be discharged from the practice.**

We are committed to providing the best possible treatment and ask your cooperation in following our policies.

I have read and understand the above policies and agree to abide by them. I further understand that failure to do so may result in my discharge from the practice.

(Please sign form in office)

Signature:____________________________________ Print name: ____

Patient or Authorized Representative

Date (mm/dd/yyyy): ________/________/________

CONSENT FOR MEDICATION MAINTENANCE THERAPY FOR INTRACTABLE PAIN – PAGE 1 OF 2

I wish to try pain management with **medication maintenance therapy**. This therapy consists of the chronic administration of opioid (narcotic) medications for pain control. The principal opioid medications are morphine, fentanyl, tapentadol, propoxyphene, pentazocine, butorphanol, butalbitol, oxycodone, hydrocodone, hydromorphone, methadone and codeine. These medications are controlled substances and are subject to a variety of legal constraints as to their prescription, use and distribution.

I understand **opioids** are likely to induce **physical dependence** and that abrupt withdrawal is likely to cause symptoms such as abdominal and muscle cramps, irritability, nausea, vomiting, sweats, chills and generalized aching. In some individuals severe withdrawal reaction may be life threatening. I understand that these medications may be safely discontinued when tapered slowly and that even graduation discontinuation may lead to increased sensitivity to pain. I understand that if I am pregnant or become pregnant while taking opioid medications, my child would be physically dependent on the opioids and withdrawal can be life threatening for a baby.

I understand that I am likely to become **tolerant** to these medications and that I will probably require increasing doses to achieve adequate pain relief. I understand the **physical dependence** and **tolerance** are difference from **addiction**, which refers to psychological dependence on medication for purposes other than pain relief.

I agree to receive prescriptions for these medications only from **Progressive Pain Management** while I remain under their care and to inform other treating physicians regarding the medications I receive for pain management.

I understand that it is **illegal to furnish controlled substances prescribe for my use to any person (family or non-family) for any reason. I further understand that furnishing these medications is equivalent to narcotic distribution which is a felony in this country.** I agree to take strict precautions to prevent unauthorized access to my medications.

I understand that these medications used to treat pain may impair alertness and coordination and **that it is illegal to operate a motor vehicle when ability to drive is impaired by such** and I agree to comply with such prohibition.

I understand that opioid medications may cause variety of side effects including, but not limited to, nausea, vomiting, constipation, dry mouth, fluid retention, weight gain, weight lost, suppression of the immune system, suppression of thyroid function, suppression of menstrual cycle, suppression of male hormone, itching and allergic reactions.

I understand that the effects of sedatives, muscle relaxants and mind-altering medications or chemical may dangerously increased when administered to a patient of opioid medications. I agree to inform other physicians as to which medications I am taking and to request that they consult with **Progressive Pain Management** regarding the co-administration of medications that may affect alertness or consciousness.

CONSENT FOR MEDICATION MAINTENANCE THERAPY FOR INTRACTABLE PAIN – PAGE 2 OF 2

I agree to adhere strictly to medical instructions and laws governing the use of these medications and **to refrain from the use of illegal drugs or alcohol.** While on these medications, I authorize **Progressive Pain Management** to test my blood or urine for the presence of illicit substances without prior notice and agree to submit to psychiatric or drug abuse evaluation should **Progress Pain Management** request it.

I am responsible for my pain medications. I agree to take medication only as prescribed and to contact my pain clinic physician before making any changes. I understand that the goals of my pain physician's treatment plan may include time-contingent use of opioids. If it appears to the physician that there **is no improvement to my daily function or quality of life** from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed and non-prescribed by the physician.

I understand that increasing my dose without the close supervision of my physician could lead a drug overdose, causing a severe sedation, respiratory depression and death.

Prescriptions can only be written for one-month supply and will be filled at the same pharmacy. Refill requests shall be made during regular office hours, and **can be picked up only in person.** Refills will not be made at night, on holidays or on weekends.

Refill prescriptions are not made if I "run out early" or "lose a prescription" or "spill" or "misplace my medication". I am responsible for taking the medication to the dose prescribed and for keeping track of the amount remaining. If my medication is stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the discretion of my physician. I will call at least one week in advance to schedule an evaluation or pickup for my prescriptions.

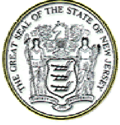
My signature below signifies that I have read each article in this document and agree to abide by its requirements. **I understand that failure to do so will lead to termination of this treatment.**

Signature:____ **Date (mm/dd/yyyy):** ________/________/________

Signature:____ **Date (mm/dd/yyyy):** ________/________/________

Physician Certification:
I have reviewed the above document with the patient whose signature appears above. I believe that this patient suffers from the condition(s) indicated in my evaluation note, that this condition causes severe pain and that this patient is a candidate for pain management with opioid medications.

Physician's Signature:____________________________________ **Date (mm/dd/yyyy):** ________/________/________



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 [ ] 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.

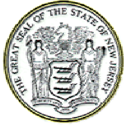
☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

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.

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.



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:______________________________

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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.