JERSEY JSR
JOINT | SPINE | REGEN

Gerald M Vernon, DO, CAQPM
Board Certified Interventional Spine & Joint Interventional Regenerative Orthopedics
Office: 479 Newman Springs Rd, Bldg. A, Ste. 203, Marlboro, NJ 07746 Mailing Address: P.O. Box 100 Brielle, NJ 08730
Phone: 732-858-6638 | Fax: 732-399-5463 | Email: info@jerseyjsr.com

Patient Information

Name: _____ DOB: _____ Age: _____
Address: _____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone: _____
Email: _____

Gender at Birth (optional): _____
Gender Identity (optional): _____
Marital Status _____
Last 4 Digits of SSN : XXX-XX-_____
Smoker: ☐ Yes ☐ No

Insurance & Pharmacy Information

Primary
Insurance Company: _____
Member ID# _____
Group# _____
Policy Holder _____
Relationship to Policy Holder: _____
Policy Holder DOB _____
Plan type (PPO / HMO / POS / Medicare Advantage)
_____

Secondary
Insurance Company: _____
Member ID# _____
Group# _____
Policy Holder _____
Relationship to Policy Holder: _____
Policy Holder DOB _____
Plan type (PPO / HMO / POS / Medicare Advantage)
_____

Pharmacy Information

Primary
Pharmacy Name: _____
Address: _____
City:_____ State:_____ Zip:_____
Phone: _____ Fax: _____

Secondary
Pharmacy Name: _____
Address: _____
City:_____ State:_____ Zip:_____
Phone: _____ Fax: _____

Primary Care Physician Information

Physician Name: _____
Practice Name: _____
Phone Number: _____
Fax Number: _____

Have you seen your PCP regarding this condition?
☐ Yes ☐ No

Do you authorize us to share relevant medical records with your Primary Care Physician for coordination of care?
☐ Yes ☐ No

Emergency Contact

Name _____ **Relationship** _____ **Phone:** _____

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Medical History

Current medications _____

_____

_____

Allergies/Reaction _____

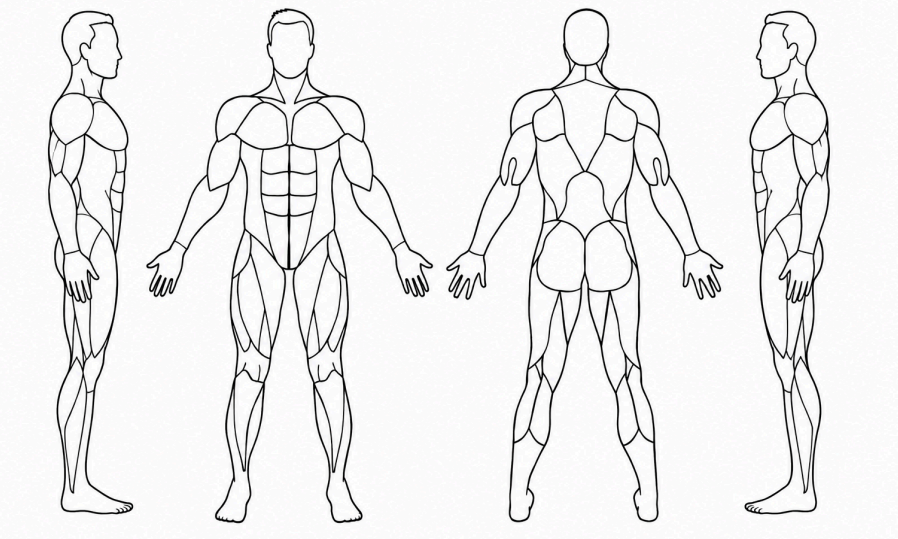
_____

Past surgical history _____

_____

Pain Information

Mark any pain location with an "X" on diagram



All Pain location(s) from worst pain to least _____

How did it start? _____

Duration _____ Constant or spontaneous? _____

Intensity 1 2 3 4 5 6 7 8 9 10 Numbness or tingling: If yes, where? _____

Radiation/travel of pain? _____

Quality of Pain: Dull Ache Cramping Burning Shooting Sharp

What activities make your pain worse? (circle)
Standing Sitting Walking Bending forward or backward bathroom use Other: _____

What makes your pain better: _____

Other associated symptoms: _____

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What Imaging studies have you had (circle all) X-Ray CT Scan MRI EMG Other: _____

Date	Body Part	Facility	Phone

Conservative Treatments Received (Circle) PT OT Chiropractic Massage Acupuncture

Other: _____

Interventional Treatments Received: _____

Name and Phone # of other doctors and/or surgeons you have seen for this issue:

_____

_____

_____

MEDICATION HISTORY AUTHORIZATION
I authorize Jersey JSR | Joint | Spine | Regen, its physicians, providers, and authorized staff to obtain and review my prescription medication history from pharmacies, pharmacy benefit managers, electronic prescribing networks, insurance databases, and other healthcare sources for purposes of medical treatment, medication management, patient safety, and coordination of care. This review may include past and current prescription medications obtained from outside healthcare providers.

Information obtained will be used solely for treatment, medication management, patient safety, and healthcare operations as permitted under applicable privacy laws.

PAIN MANAGEMENT MEDICATION & TESTING AUTHORIZATION
As part of pain management treatment and patient safety protocols, Jersey JSR | Joint | Spine | Regen may require urine drug screening and/or other toxicology testing during the initial evaluation and periodically throughout treatment when medically appropriate. Testing may be used to assist in clinical decision-making, medication monitoring, patient safety, and compliance with treatment protocols.
By signing below, I acknowledge that I have reviewed the information above and voluntarily consent to prescription medication history review, medication monitoring, and medically necessary testing as part of my treatment and ongoing care.

☐ I Understand & Consent ☐ I Do Not Consent

_____ _____ _____
Patient Name Signature Date

If the patient is not the person executing this authorization, please complete the information below:

_____ _____ _____ _____
Legal Relationship Patient Name Signature Date

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Patient Name _____ **DOB** _____

Past psychiatric history: _____

_____

Any Implants/Devices (pacemaker, SCS, defibrillator, etc) _____

_____

Past Medical History (Check all that apply) ☐ No Known Medical Problems

Cardiovascular
- ☐ High Blood Pressure (Hypertension)
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Heart Attack (MI)
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Irregular Heartbeat / Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Pacemaker
- ☐ Stroke / TIA
- ☐ Peripheral Vascular Disease
- ☐ High Cholesterol

Endocrine / Metabolic
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Vitamin D Deficiency
- ☐ Gout

Gastrointestinal
- ☐ GERD / Acid Reflux
- ☐ Ulcers
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ IBS
- ☐ Chronic Constipation
- ☐ Liver Disease
- ☐ Hepatitis

Infectious Disease
- ☐ Lyme Disease
- ☐ HIV/AIDS
- ☐ MRSA History
- ☐ Chronic Infection
- ☐ COVID-19 Complications

Neurologic
- ☐ Migraines
- ☐ Chronic Headaches
- ☐ Neuropathy
- ☐ Seizure Disorder
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Tremors
- ☐ Vertigo
- ☐ Dizziness
- ☐ Sciatica
- ☐ Radiculopathy
- ☐ Spinal Stenosis

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea
- ☐ Tuberculosis History

Renal / Urologic
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Frequent UTIs
- ☐ Bladder Dysfunction
- ☐ Incontinence

Autoimmune / Inflammatory
- ☐ Lupus
- ☐ Psoriatic Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Sjogren's Syndrome
- ☐ Autoimmune Disorder (Other)

Hematologic / Cancer
- ☐ Bleeding Disorder
- ☐ Blood Clots / DVT
- ☐ Pulmonary Embolism
- ☐ Anemia
- ☐ Cancer History
- ☐ Chemotherapy History
- ☐ Radiation Therapy History

Musculoskeletal / Orthopedic
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Degenerative Disc Disease
- ☐ Herniated Disc
- ☐ Scoliosis
- ☐ Sacroiliac Joint Dysfunction
- ☐ Bursitis
- ☐ Tendonitis
- ☐ Plantar Fasciitis
- ☐ Carpal Tunnel Syndrome
- ☐ TMJ Disorder
- ☐ Frozen Shoulder
- ☐ Rotator Cuff Injury
- ☐ Meniscus Tear
- ☐ ACL Injury
- ☐ Hip Labral Tear

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Bipolar Disorder
- ☐ Panic Disorder
- ☐ ADHD
- ☐ Insomnia
- ☐ Substance Abuse History

Other Important For Procedures
- ☐ Easy Bruising
- ☐ Poor Wound Healing
- ☐ Latex Allergy
- ☐ Contrast Dye Allergy
- ☐ Metal Implant History
- ☐ Prior Steroid Reactions
- ☐ Current Blood Thinner Use
- ☐ Pregnancy
- ☐ None of the Above

Other: _____

_____

_____

_____

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Patient Name _____ **DOB** _____

Past Surgical History

□ No Prior Surgical Procedures

Spine Procedures / Surgery
☐ Cervical Fusion
☐ Cervical Disc Replacement
☐ Lumbar Fusion
☐ Lumbar Laminectomy
☐ Lumbar Discectomy
☐ Artificial Disc Replacement
☐ Kyphoplasty
☐ Vertebroplasty
☐ Spinal Cord Stimulator Implant
☐ Intrathecal Pain Pump
☐ Epidural Steroid Injection History
☐ Facet Injection History
☐ Radiofrequency Ablation (RFA)
☐ SI Joint Injection
☐ Trigger Point Injections

Abdominal / General Surgery
☐ Appendectomy
☐ Gallbladder Removal
☐ Hernia Repair
☐ Colon Surgery
☐ Gastric Bypass
☐ Abdominal Surgery (Other)

Gynecologic / Urologic
☐ Hysterectomy
☐ C-Section
☐ Prostate Surgery
☐ Bladder Surgery
☐ Kidney Surgery

Shoulder / Upper Extremity
☐ Rotator Cuff Repair
☐ Shoulder Replacement
☐ Shoulder Arthroscopy
☐ Labrum Repair
☐ Biceps Tendon Repair
☐ Carpal Tunnel Release
☐ Cubital Tunnel Surgery
☐ Wrist Surgery
☐ Elbow Surgery
☐ Hand Surgery
☐ Finger Surgery

Hip / Pelvis
☐ Hip Replacement
☐ Hip Arthroscopy
☐ Hip Labral Repair
☐ Pelvic Surgery
☐ SI Joint Fusion

Cardiovascular Surgery
☐ Cardiac Stent
☐ Open Heart Surgery
☐ Pacemaker Placement
☐ Vascular Surgery

Cancer Related Surgery
☐ Tumor Removal
☐ Mastectomy
☐ Cancer Surgery

Knee
☐ Knee Arthroscopy
☐ ACL Reconstruction
☐ Meniscus Repair
☐ Partial Knee Replacement
☐ Total Knee Replacement
☐ Patellar Surgery

Foot / Ankle
☐ Ankle Surgery
☐ Achilles Tendon Repair
☐ Plantar Fascia Surgery
☐ Bunion Surgery
☐ Foot Reconstruction
☐ Fracture Repair

General Orthopedic Surgery
☐ Fracture Repair
☐ Hardware Placement (plates/screws)
☐ Hardware Removal
☐ Joint Replacement
☐ Tendon Repair
☐ Ligament Repair

Neurologic Surgery
☐ Brain Surgery
☐ Shunt Placement
☐ Peripheral Nerve Surgery

Other Procedures
☐ PRP Injection History
☐ Stem Cell Injection History
☐ Bone Marrow Aspiration Procedure
☐ Prolotherapy History
☐ Chiropractic Treatment History
☐ Physical Therapy History
☐ Acupuncture History

Social History

Marital Status
☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Separated
☐ Domestic Partner
☐ Other: _____

Employment / Work Status
☐ Employed Full Time
☐ Employed Part Time
☐ Self-Employed
☐ Retired
☐ Unemployed
☐ Disabled
☐ Student
☐ Homemaker
☐ Workers Compensation Leave
☐ Medical Leave / FMLA
☐ Other: _____

Living Situation
☐ Live Alone
☐ Live With Spouse/Partner
☐ Live With Family
☐ Assisted Living Facility
☐ Nursing Home
☐ Group Home
☐ Other: _____

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Consent to Treat

Patient Name (print) _____ DOB: _____

I hereby authorize Jersey Joint, Spine, and Regen, LLC through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my condition. This treatment will be rendered by a licensed medical doctor.

I understand that I have the right to refuse any procedure or treatment and that I have the right to ask questions about any treatment or examination I have received. I understand that no guarantees can be made or expected, but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon the facts known. Lastly, I understand that it is imperative that I communicate to my provider any aggravation or injury that may have occurred during my treatment, whether inside or outside the facility.

I have read the above and understand the risks and benefits of receiving medical care and treatment from the facility.

I further authorize Jersey Joint, Spine, and Regen, LLC to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Initials _____

Authorization to Release Medical Benefits

I authorize the holder of the following benefit information (e.g., Employer's Benefits Representative, Insurance Provider Service Representative, etc.) to release copies of the following documents to Jersey Joint, Spine, & Regen LLC, in detail:

[X] Summary Plan Description (SPD)
[X] Plan Claim Appeal Procedure
[X] Identification of the Fund, Plan Administrator, Claim Administrators
[X] Full explanation of Medical Benefits

Initials _____

I have read and understand the information above and agree to the terms stated herein.

_____	_____	_____
Patient Name	Signature	Date

If the patient is not the person executing this authorization, please complete the information below:

_____	_____	_____	_____
Legal Relationship	Patient Name	Signature	Date

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Authorization to obtain Health Information from another medical Provider

Authorization for Use/Disclosure of Information:
I voluntarily authorize and direct my health care provider, _____,
to use or disclose my health information during the term of this authorization to the receipt I have identified below.
Recipient: My health care provider may disclose my health information to:

Purpose: The information below is disclosed for the purpose of continued medical treatment. Disclose the following information for treatment dates from _____ to _____.

___ Complete Record
___ Diagnostics (X-Rays, MRIs, etc)
___ Therapy Notes
___ Billing
___ Consultation/Evaluations
___ Laboratory Reports
___ Discharge Summary
___ Narratives
___ Procedure Reports
___ Operating Reports
___ Prescriptions
___ Other, Please Specify: _____

Initials _____

Letter of Payment Authorization

I hereby instruct and direct _____ Insurance Company to pay all available insurance benefits directly to Jersey Joint, Spine, & Regen LLC for professional medical services rendered to me.

If my insurance carrier sends payment directly to me rather than to Jersey Joint, Spine, & Regen LLC, I agree to immediately forward such payment to Jersey Joint, Spine, & Regen LLC for services rendered. This authorization applies to all allowable medical benefits otherwise payable to me under my insurance policy. A copy of this authorization shall be considered as effective and valid as the original. I authorize Jersey Joint, Spine, & Regen LLC to communicate directly with my insurance carrier on my behalf regarding claims submitted for services rendered.

I further authorize Jersey Joint, Spine, & Regen LLC to verify benefits, obtain claim information, submit medical documentation, request claim reconsideration, initiate appeals, dispute denied or underpaid claims, and take actions reasonably necessary to secure payment of insurance benefits related to my medical treatment.

I understand that Jersey Joint, Spine, & Regen LLC is an out-of-network healthcare provider and is not a participating provider with my insurance plan or insurance carrier. I understand that out-of-network reimbursement, coverage determinations, and patient financial responsibility are determined solely by my insurance carrier according to the terms of my individual policy.

I understand that verification of benefits is not a guarantee of payment, reimbursement amount, coverage determination, or claim approval by my insurance carrier.

I understand that I remain financially responsible for all copayments, deductibles, coinsurance amounts, denied claims, non-covered services, and any remaining balance not paid by my insurance carrier.

I have read and understand the information above and agree to the terms stated herein.

_____ _____ _____
Patient Name | Signature | Date

If the patient is not the person executing this authorization, please complete the information below:

_____ _____ _____ _____
Legal Relationship | Patient Name | Signature | Date

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Patient Name _____ **DOB** _____

MARKETING AUTHORIZATION

1. Authorizing marketing communication from this practice means I may:

a. Receive treatment communications concerning treatment alternatives or other health related products or services.
b. Be contacted for appointment reminders or information about treatment alternatives or other related benefits and services that may interest me.
c. Communications regarding practice updates, educational information, available healthcare services, and appointment-related communications.

I understand that I have the right to "opt out" of receiving such communications.

2. Marketing Authorization Options:

- ☐ I wish to receive Marketing Communications from the Practice ONLY
- ☐ I wish to receive Marketing Communications from the Practice and this Practice's Business Associate(s)
- ☐ I do NOT wish to receive any Marketing Communications

Communications that encourage you to use our services is considered marketing. If we intend to use or sell PHI for personal gain or commercial advantage, we must first obtain written authorization from you.

I authorize the practice to communicate with me about my appointments through the following means:

- ☐ Telephone/leaving messages (home / cell / work)
- ☐ Text Message
- ☐ E-mail

I consent to receive emails, telephone calls, voicemail messages, and text messages from Jersey JSR | Joint | Spine | Regen regarding appointments, scheduling, billing matters, and healthcare-related communication at the phone number I have provided. I understand electronic communications, including text messages and email, may not always be encrypted and may carry some privacy risk. I understand standard messages and data rates may apply.

Other communications for such purposes that do not involve financial remuneration are adequately captured in this practice's notice of privacy practices.

PATIENT IMAGE & LIKENESS AUTHORIZATION & RELEASE (NEW JERSEY)

Permission for Use (check all that apply):

- ☐ Practice website
- ☐ Social media platforms
- ☐ Online / digital advertising
- ☐ Printed marketing materials

Authorization

I authorize Jersey Joint Spine & Regen and Dr. Gerald M. Vernon to capture and use my image and likeness for the purposes selected above. My care will not be affected.

Duration of Authorization

This authorization shall remain in effect until revoked by the patient in writing.

HIPAA Authorization

I understand images may be Protected Health Information (PHI). Revocation does not affect prior use.

Revocation requests must be submitted in writing to:

Jersey Joint Spine & Regen
Attn: Privacy Officer
Email: admin@jerseyjsr.com

Governing Law: This authorization is governed by the laws of the State of New Jersey.

By signing below, I acknowledge that I have read and understand the information above and voluntarily authorize and consent to the communication preferences, marketing authorization, and image and likeness release selections indicated on this form.

_____	_____	_____
Patient Name	Signature	Date

If the patient is not the person executing this authorization, please complete the information below:

_____	_____	_____	_____
Legal Relationship	Patient Name	Signature	Date

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CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS
(In accordance with New Jersey Department of Banking and Insurance requirements)
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 than 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.

C**ONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS**

I, _____ 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 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.

REVOCATION OF CONSENT NOTICE
(For patient reference only — no action required unless consent is revoked in the future)

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 revoke your consent by submitting written notice of your intent to revoke consent. 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.
If consent is revoked after your personal and medical information has already been shared with DOBI, the IUROs, and medical professionals with whom the IUROs contract, no further distribution of records in this matter will occur based on your authorization.
All medical and personal information already shared in connection with the appeal process is required to be maintained as confidential by all parties.
No action is required unless you choose to revoke your consent in the future.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay for your health care bills and to support the operation of your physician’s practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice’s premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers’ Compensation: We may disclose your protected health information as authorized to comply with workers’ compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

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Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received and/or been provided access to the **Notice of Privacy Practices** of **Jersey JSR | Joint | Spine | Regen** ("Practice"), which describes how my protected health information may be used and disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law.

I understand that this Notice explains my rights regarding my protected health information, including my rights to access, inspect, amend, request restrictions, request confidential communications, receive an accounting of disclosures, and file a complaint if I believe my privacy rights have been violated.

By signing below, I acknowledge that I have read, understand, and have been given the opportunity to review the Practice's Notice of Privacy Practices.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

If signed by Personal Representative:

Representative Name: _____

Relationship to Patient: _____

Representative Signature: _____ **Date:** _____