Registration :

Advanced Musculoskeletal Centers, PA

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician

Physician	Family Physician	Referring Physician

Medical Insurance

Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Advanced Musculoskeletal Centers, PA , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Advanced Musculoskeletal Centers, PA

131 Madison Avenue, Suite 130 Phone: 973-538-8336

Morristown, NJ 07960 Email: Amcortho@optonline.net

Please attach all pertinent insurance ID cards for photocopying.

ADVANCED MUSCULOSKELETAL CENTERS, PA

Brian F. Aurori, MD
Kevin C. Aurori, MD

131 Madison Ave., Suite 130
Morristown, NJ 07960
Telephone: (973) 538-8336
FAX: (973) 538-8307

Medical History If yes, please explain

Do/did you have any heart problems? ☐ Yes ☐ No
____

Do/did you have any breathing/lung problems? ☐ Yes ☐ No
____

Do/did you have any kidney problems? ☐ Yes ☐ No
____

Do/did you have diabetes? ☐ Yes ☐ No
____

Do/did you have ulcers/gastritis? ☐ Yes ☐ No
____

Do/did you have any intestinal problems? ☐ Yes ☐ No
____

Do/did you have liver problems? ☐ Yes ☐ No
____

Do/did you have cancer? ☐ Yes ☐ No
____

Do/did you high blood pressure? ☐ Yes ☐ No
____

Do/did you have any other medical problems? ☐ Yes ☐ No
____

Surgical History

List any prior surgeries with dates ______________________________

____

____

____

Allergies

Allergy to Latex? ☐ Yes ☐ No

Allergy to Metal(s)? ☐ Yes ☐ No

Allergies to Medication? ☐ Yes ☐ No

If yes, please list: ______________________________

Medications

Please list names and dosage(s) of any medications you are now taking ______________________________

____

____

Social History

Do/did you smoke or chew tobacco? ☐ Yes ☐ No

Do/did you drink alcohol? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No ☐ Retired

FAMILY HISTORY: ☐ Cancer ☐ Heart Disease ☐ Diabetes ☐ Alzheimer's ☐ Stroke
☐ Seizures/Epilepsy ☐ Blood Clots ☐ Osteoporosis ☐ Sudden Death
☐ Death before age 50 ☐ Rheumatoid Arthritis

Please Describe: ____________________

____

Review of Systems

1. Constitutional General — ☐ None ☐ Recent weight changes ☐ Chills ☐ Fever ☐ Weakness / Fatigue
☐ Other ____________________

2. Eyes — ☐ None ☐ Vision Change ☐ Glass / Contacts ☐ Cataracts ☐ Glaucoma
☐ Other ____________________

3. Ears, Nose, Throat — ☐ None ☐ Loss of hearing ☐ Ear ache or infection ☐ Ringing in the ear ☐ Hoarseness
☐ Other ____________________

4. Cardiovascular — ☐ None ☐ Chest Pain ☐ Swelling in legs ☐ Shortness of breath ☐ Palpitations
☐ Pacemaker
☐ Other ____________________

5. Respiratory — ☐ None ☐ Shortness of Breath ☐ Wheezing / Asthma ☐ Frequent Cough
☐ Other ____________________

6. Gastrointestinal — ☐ None ☐ Heartburn ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal Pain
☐ Other ____________________

7. Musculoskeletal — ☐ None ☐ Arthritis / Joint Stiffness ☐ Muscle Aches ☐ Swelling of joints
☐ Fractures / Dislocations
☐ Other ____________________

8. Skin — ☐ None ☐ Rash ☐ Ulcers ☐ Abnormal Scars ☐ Sores ☐ Psoriasis
☐ Other ____________________

9. Neurologic — ☐ None ☐ Headaches ☐ Fainting/blackouts ☐ Dizziness
☐ Numbness / tingling / loss of sensation
☐ Other ____________________

10. Psychiatric — ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swings
☐ Other ____________________

11. Endocrine — ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes
☐ Other ____________________

12. Hematologic — ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia
☐ Other ____________________

Signature ____________________ Relation to Patient ____________________

Date ____________________

ADVANCED MUSCULOSKELETAL CENTERS, PA

Brian F. Aurori, MD
Kevin C. Aurori, MD

131 Madison Ave., Suite 130
Morristown, NJ 07960
Telephone: (973) 538-8336
FAX: (973) 538-8307

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.

- All patients must complete and sign our "Patient Information Form" before seeing the doctor.

- PRIVATE HEALTH INSURANCE: An insurance form will be filed for you. Office visit co-payment portions will be expected at each visit to our office. Any deductible or additional co-payment will be billed to you after your insurance pays.

- HMO-PPO MANAGED CARE PLANS: You will be expected to pay any co-payment or deductible portion in accordance with your policy at each visit to our office. If we do not participate in your plan, you will follow the policy for private health insurance patients. IF A REFERRAL IS REQUIRED, YOU ARE RESPONSIBLE FOR BRINGING THE FORM OR AUTHORIZATION NUMBER WITH YOU; WITHOUT IT, YOU WILL NOT SEE THE DOCTOR.

- MEDICARE: A claim will be submitted for you. Both doctors participate.

- WORKER'S COMPENSATION: All office visits must be pre-authorized with your insurance carrier before your visit.

- NO FAULT/AUTO: Any deductible or co-payment will be billed to you after your insurance pays. If you have health insurance, we will balance bill for you.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER

MINORS MUST BE ACCOMPANIED BY AN ADULT: The adult accompanying a minor, and his/her parents (or guardians), are responsible for full payment.

UNACCOMPANIED MINORS: The parents (or guardians) must present written notification to the physician that identifies that they are responsible for full payment. Non-emergency treatment will be denied unless charges have been pre-authorized or paid by cash or check at the time of service.

ACCOUNTS 90 DAYS PAST DUE WILL BE SENT TO COLLECTION.
If the account is assigned to any attorney for collection and/or suit, reasonable attorney's fees and costs of collection will be added to the unpaid balance.

I HAVE FULLY REVIEWED THIS FINANCIAL POLICY STATEMENT AND AGREE TO HONOR THE TERMS OUTLINED. I FURTHER AUTHORIZE DISCLOSURE OF PORTIONS OF THE PATIENT RECORD WHICH ARE REQUESTED BY THE INSURANCE CARRIER. (These may be necessary to determine reimbursement.)

______________________________ ____________________
Responsible Signature Date

ADVANCED MUSCULOSKELETAL CENTERS, PA

Brian F. Aurori, MD
Kevin C. Aurori, MD

131 Madison Ave., Suite 130
Morristown, NJ 07960
Telephone: (973) 538-8336
FAX: (973) 538-8307

Privacy Policy

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review the below carefully.

At AMC we are committed to treating & using protected health information about you responsibly. This notice describes the personal information we collect and how & when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 3/15/03 and applies to all protected health information as defined by federal regulations.

Understanding your health record: Each time you visit our office a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment plan and recommendations. This information, often referred to as your health or medical record, serves as a basis for planning your care *I* treatment, means of communicating with other health professionals regarding your care, legal documents describing the care you received, means by which an insurance company can verify services billed were actually provided, source of data for medical research, source of information for state/federal public health officials, a tool with which we can assess & continually work to improve the care we render and outcomes we achieve. Understanding what is in your record and how your health information is used helps you ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Our responsibilities: AMC is required to: maintain the privacy of your health information, provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. Should our practices change we will notify you in writing during your next office visit. We will not use or disclose your health information without your authorization, except as described in this notice. We will discontinue to us or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem: If you have questions and would like additional information you may contact our Privacy Officer at 973-538-8336. If you believe your privacy has been violated, you can file a complaint with our Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either aforementioned.

Examples of disclosures for treatment, payment and health operations: We will use your health information for treatment purposes; we will use your health information for payment purposes; we will use your health information for regular health operations; we will use your health information to communicate to authorized family members / guardians; we will use your information to communicate with your insurance company &/or workmans' compensation carrier and nurse case managers; we will use your health information to communicate with appropriate public health / law enforcement departments as mandated; we will use your health information to respond to valid legal subpoena's.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

HIPAA Patient Consent Form

Patient consent to the use and disclosure of health information for treatment, payment or healthcare operations

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile. I authorize the office to contact me at any of my personal phone numbers (home &/or cell phone) listed in this chart and authorize them to leave detailed information regarding my medical care.

I fully understand and accept the terms of this consent.

______________________________ ____________________

Responsible Signature Date