PAIN MANAGEMENT INITIAL PATIENT INFORMATION

INITIAL PATIENT VISIT INFORMATION (please fill this form accurately & completely) DATE: _____

HEIGHT:_____ WEIGHT:_____

LAST: _____ FIRST: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: ( ) _____ CELL PHONE #: ( ) _____

DOB _____ AGE: _____ SEX _____ SOCIAL SECURITY #: _____-_____-_____

MARITAL STATUS: S M D W REFERRED BY: _____ PHONE #: ( ) _____

EMPLOYER: _____ PHONE #: ( ) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

VISIT REASON: WORKMEN'S COMP: ____ NO-FAULT: ____ SLIP & FALL: ____ IME: _____ PRIVATE INS: _____ OTHER: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO: _____ PHONE # ( ) _____

ADDRESS: _____

GROUP, PLAN, or POLICY #: _____ CLAIM#: _____

NAME of POLICY HOLDER and RELATION: _____ PHONE #: ( ) _____

SECONDARY INSURANCE CO. (IF APPLICABLE)

INSURANCE CO: _____ PHONE # ( ) _____

ADDRESS: _____

NAME of POLICY HOLDER and RELATION: _____ PHONE #( ) _____

NO-FAULT INSURANCE CASE

INSURANCE COMPANY NAME: _____ DATE OF ACCIDENT: _____

ADDRESS: _____

CLAIM #: _____ ADJUSTER'S NAME: _____

POLICY # _____ POLICY HOLDER'S NAME: _____

PHONE # ( ) _____

WORKER'S COMPENSATION CASE

INSURANCE CARRIER: _____ DATE OF INJURY: _____

ADDRESS: _____

CLAIM #: _____ ADJUSTER'S NAME: _____

PHONE # ( ) _____

WHERE DID INJURY OCCUR? _____

ARE YOU WORKING? _____ FULL-TIME: _____ PART-TIME: _____

IF NO, WHEN DID YOU STOP WORKING? _____

WHEN DID YOU BEGIN TO WORK? _____

ATTORNEY'S INFORMATION

ATTORNEY'S NAME: _____ PHONE # ( ) _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PAIN MANAGEMENT PATIENT HISTORY INITIAL VISIT FORM

PATIENT HISTORY FORM

Name:_____ **Date of Birth:**_____ **Age:** _____ **Date:** _____
SS #_____ **Sex: M** ____ **F**___ **Referred by:**_____

Where on your body is your main pain:

Head | Arm right / left | Hand right / left | Leg right / left

Neck | Chest right / left | Abdomen right / left | Back right / left

How long have you had this pain: months years

Is there another area on your body that you have pain: Yes / No

Describe the quality of the pain: Knife like Burning Electric Shock Throbbing Dull Ache

Describe the duration of the pain: Constant Comes & Goes Always present but gets worse at times.

Describe the intensity of the pain: Mild Discomforting Distressing Horrible Excruciating

Pick a number for your pain: Least 1 2 3 4 5 6 7 8 9 10 Worst

What makes the pain worse: Sitting Walking Damp Weather Other_____

What makes the pain better: Rest Hot Shower

What treatments have you received for pain:

Physical Therapy Injections None Others (specify) _____

What medications do you take for pain?_____ _____ _____

Do you take Aspirin / Baby Aspirin or Blood Thinning Medications? Yes No

How do you sleep at night? Poor Fair Normal

Have you had to cut down on normal activities because of your pain? Yes No
If yes, how much? Mildly Moderately Severely

Have you had any of these medical conditions (please circle):

Heart problems Asthma Kidney problems Liver problems Arthritis Stomach Ulcers
Diabetes Stroke High Blood Pressure Blood disorders Easy bruising Psychiatric problems

List the surgeries you have had in the past: _____ _____
_____ _____ _____

List all your medications: _____ _____ _____
_____ _____ _____ _____ _____

Are you allergic to any medications? _____ _____ _____

Do you smoke? Yes / No **If yes how many packs per day do you smoke?** _____

Do you drink alcohol? Yes / No / Socially

Do you use any recreational drugs like marijuana, cocaine, etc? Yes / No

Signature of Patient: _____

PAIN MANAGEMENT NARCOTIC ADMINISTRATION CONTRACT

NARCOTIC ADMINISTRATION CONTRACT

This agreement is between patient and the pain management physician. It is agreed that narcotic medications will be given by the physicians on a regular basis to patients ONLY if the following terms are met:

1. Pain Management Physician discusses the uses of narcotic medications with the patient, including the issues of appropriate realistic goals for pain relief, proper methods of taking the medications, risks of side effects and specific issues of developing tolerance, dependence, habitation, addiction and withdrawal problems due to these medications.

2. The patient has a chance to ask questions regarding the use of narcotic medications.

3. By signing a special consent form for chronic narcotic administration, the patient indicated that he/she has understood the discussion about the use of narcotic medications, including all the side effects, and is agreeable to start this treatment under the terms set by Pain Management Physician

4. Pain Management Physician should be the one and only source of narcotic medications unless written permission is given by Pain Management Physician for the patient to get narcotic prescriptions from another physician.

5. Only one pharmacy will be used for filling narcotic prescriptions. The name, address and telephone number will be given to Pain Management Physician

6. If it is found that the patient received prescriptions for narcotic medications from a source other than a Pain Management Physician physician, without written permission, Pain Management Physician may void this agreement and discontinue any prescription of narcotic medications to the patient.

7. The patient agrees to have urine tests (screening for medications) done randomly at the physician's request.

8. The patient must agree to allow the Pain Management Physician physician to communicate with the referring physician and any pharmacists regarding the patient's use of controlled substances.

9. The patient understands that Pain Management Physician will not replace any lost or inaccessible narcotic prescriptions or narcotic medications, for ANY REASON.

10. The patient must take the narcotic medications exactly as instructed by the Pain Management Physician physician.

11. Any unauthorized increase in the dose of narcotic medication may be viewed as a cause for discontinuation of the treatment with narcotic medications.

12. If the patient demonstrates unacceptable behavior patterns, the Pain Management Physician, physician may discontinue prescribing the narcotic medications for the patient.

13. The patient must keep all regular follow up appointments as recommended by the Pain Management Physician physicians. Failure to comply may cause discontinuation of narcotic prescriptions.

14. All triplicate prescriptions must be picked up by the patient himself. If the patient is too debilitated or sick, an exception may be allowed.

PAIN MANAGEMENT NARCOTIC ADMINISTRATION CONTRACT

NARCOTIC ADMINISTRATION CONTRACT

15. No triplicate (narcotic) prescriptions will be refilled on weekends or over the phone. Narcotic prescriptions cannot be refilled over the telephone - refills will only be issued at the time of your follow up visit. If your prescription does not last until your next visit, that indicates a problem. Please schedule an appointment at your earliest convenience, in order to discuss the reasons why you ran out of medication, and whether we can refill your narcotic prescription.

16. The patient understands that the benefit of the narcotic medications will be evaluated periodically using the following criteria of pain relief, increase in general functions, increase in exercise, completion of Rehabilitation program, return to work, maintenance of a job, etc.

17. The patient understands that narcotic medications can be discontinued immediately, at the treating physician's discretion, if the patient does not fulfill the terms of this agreement. Medication can also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or if significant side effects develop.

18. The patient certifies or agrees to the following:

a) That he/she is not currently abusing illicit or prescription drugs, and that he/she is not undergoing treatment for substance dependence or abuse.

b) That he/she has never been involved in the sale, illegal possession, diversion or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain killers).

c) That she is not pregnant and that she will use appropriate contraception during her course of treatment.

d) Sharing your narcotics is STRICTLY prohibited. Any sharing will result in the immediate cancellation of your prescription refills.

19. Evidence of medication hoarding, increasing the amount of medication without communication to your Pain Management Physician physician, refilling your prescription too frequently, getting the medication from multiple physicians, increasing the amount of the medication despite significant side effects, altering prescriptions, medication sales, unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment or other unacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this contract.

Date:_____

Patient Signature: _____

Patient Printed Name: _____

I have also received an informative letter reviewing the side effects of the narcotics that may be used in the treatment of my pain problem. I fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in the treatment of my pain problem.

Date:_____

Patient Signature: _____

Patient Printed Name: _____

Witness: _____

NAME AND ADDRESS OF PHARMACY:_____

PH# _____

PAIN MANAGEMENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

SS# NUMBER: _____ DATE OF BIRTH: _____

I hereby authorize Pain Management Center, to release or request from other Doctors or Hospitals, any and all information which they possess or require relating to my examinations and illness, which may be part of the medical record, including psychiatric/psychological, alcohol, drug abuse AIDS,, ARC, or HIV related diagnosis, treatments and rehabilitation for the following period:

_____

_____

_____

_____

_____

_____

(PHYSICIAN, HOSPITAL, AGENCY):

FULL NAME: _____ ___ _____

ADDRESS: _____ _____

CITY: _____ **STATE:** _____ **ZIP:** _____

INFORMATION IS BEING RELEASED OR REQUESTED FOR THE FOLLOWING REASON:

_____ **TO A PHYSICIAN FOR CONTINUED MEDICAL CARE**
_____ **INSURANCE**
_____ **ATTORNEY**
_____**OTHER:** _____

_____ _____

SIGNATURE OF PATIENT OR OTHER LEGAL REPRESENTATIVE DATE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**

PAIN MANAGEMENT PAYMENT POLICY

OUR PAYMENT POLICY

We are committed to providing you with the best care. Your clear understanding of our payment policy is important to our professional relationship. We, therefore encourage you to speak with us regarding any questions you may have about our fees and financial obligations.

It is important that you understand that Health insurance and/or your Managed Care Plan is a contract between you and your insurance company. We are not a party to this contract. The Insurance Company is responsible to you, the patient, and you're responsible to us.

If your insurance carrier does not pay the account within three (3) Months after rendering our services, or if you don't have insurance, you will be responsible for the payment amount including applicable deductibles if any.

Please inform our staff of the type of Insurance you have. Always bring your card with you. If the policy is in your spouse's name, please inform us.

If you are an HMO/PPO participant, it is your responsibility to bring in the Authorization and Referral Form. You are responsible for the co-payment amount.

If you have Medicare, you are responsible for the deductibles as well as the 20% co-payment, If you have a Senior care Supplemental Coverage Plan, we will file with your insurance.

AGREEMENT NOTES

This release authorizes Pain Management Center to release any information requesting to my carrier.

I hereby authorize payment directly to Pain Management Center for the medical benefits for services provided.

I hereby authorize signature:

Patient Name: _____ Date: _____

Witness: _____ Date: _____

PAIN CENTERS OF AMERICA, P.A. P.O. BOX 4253, CLIFTON, NJ 07013 Tel #: (973) 779-7246 Fax #: (973) 779-8989

ASSIGNMENT OF BENEFITS FORM

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Pain Centers of America, P.A. of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due on the regular charges. I understand that I am financially responsible to Pain Centers of America, P.A. for charges not covered by this authorization. Should the account be referred for collection after a default, the undersigned agrees to pay costs of collection, including a reasonable attorney's fee. All delinquent accounts have interest of legal rates.

Medicare Benefits:

I request payment of authorized benefits be made on my behalf for any services furnished to me by Pain Centers of America, P.A. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or those to related services.

Medical Benefits:

I certify that I am a recipient of the Medicaid, Title XIX program, and request that payment of authorized benefits is made on my behalf, I authorize Pain Centers of America, P.A. to make available to the Division of Family Services any required formation concerning medical insurance, and financial records relating to my treatment. I hereby certify all health insurance shall be assigned to Pain Centers of America, P.A. for the services provided.

RE: AUTOMOBILE ACCIDENT

Date of Accident: _____

I, _____, assign to Pain Centers of America, P.A._____ my rights and interest in the personal Injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the PIP benefits mentioned above:

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose filing said lawsuit.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered to me both by reason of this accident and by reason of any other bills that are due, their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for services rendered and this agreement is made solely for (assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

PAIN CENTERS OF AMERICA, P.A. P.O. BOX 4253, CLIFTON, NJ 07013 Tel #: (973) 779-7246 Fax #: (973) 779-8989

ASSIGNMENT OF BENEFITS FORM

RE: WORKMEN COMPENSATION

Date of Injury: _____

For consideration received, I, _____ assign to Pain Centers of America, P.A._____ my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assigners or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the injured benefits mentioned above;

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose of filing said lawsuit; Individually, in the injuries arbitration with the National Arbitration Forum on the bill for the assignee.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries/or which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient's Signature	**Date**	**Print Patient's Name**
_____	_____	_____
Signature of Person Authorized to Sign	**Date**	**Print name of Authorized person**
_____	_____	_____
Witness	**Date**	**Relationship to Patient**

PROFESSIONAL PAIN MANAGEMENT SERVICES, PA
P.O. BOX 4253, CLIFTON, NJ 07013 Tel #: (973) 779-7246 Fax #: (973) 779-8989

ASSIGNMENT OF BENEFITS FORM

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Professional Pain Management Services, PA of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due on the regular charges. I understand that I am financially responsible to Professional Pain Management Services, PA. for charges not covered by this authorization. Should the account be referred for collection after a default, the undersigned agrees to pay costs of collection, including a reasonable attorney's fee. All delinquent accounts have interest of legal rates.

Medicare Benefits:

I request payment of authorized benefits be made on my behalf for any services furnished to me by Professional Pain Management Services, PA I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or those to related services.

Medical Benefits:

I certify that I am a recipient of the Medicaid, Title XIX program, and request that payment of authorized benefits is made on my behalf, I authorize Professional Pain Management Services, PA. to make available to the Division of Family Services any required formation concerning medical insurance, and financial records relating to my treatment. I hereby certify all health insurance shall be assigned to Professional Pain Management Services, PA. for the services provided.

RE: AUTOMOBILE ACCIDENT

Date of Accident: _____

I, _____, assign to Professional Pain Management Services, PA._____ my rights and interest in the personal Injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the PIP benefits mentioned above:

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose filing said lawsuit.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered to me both by reason of this accident and by reason of any other bills that are due, their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for services rendered and this agreement is made solely for (assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

PROFESSIONAL PAIN MANAGEMENT SERVICES, PA
P.O. BOX 4253, CLIFTON, NJ 07013 Tel #: (973) 779-7246 Fax #: (973) 779-8989

ASSIGNMENT OF BENEFITS FORM

RE: WORKMEN COMPENSATION

Date of Injury: _____

For consideration received, I, _____ assign to Professional Pain Management Services, PA my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assigners or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the injured benefits mentioned above;

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose of filing said lawsuit; Individually, in the injuries arbitration with the National Arbitration Forum on the bill for the assignee.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries/or which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient's Signature	**Date**	**Print Patient's Name**
_____	_____	_____
Signature of Person Authorized to Sign	**Date**	**Print name of Authorized person**
_____	_____	_____
Witness	**Date**	**Relationship to Patient**

INTERVENTIONAL PAIN CONSULTANTS OF NJ, P.A.
P.O. BOX 4253, CLIFTON, NJ 07013 Tel #: (973) 779-7246 Fax #: (973) 779-8989

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Interventional Pain Consultants of NJ, P.A. of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due on the regular chargers. I understand that I am financially responsible to Interventional Pain Consultants of NJ, P.A. for charges not covered by this authorization. Should the account be referred for collection after a default, the undersigned agrees to pay costs of collection, including a reasonable attorney's fee. All delinquent accounts have interest of legal rates.

Medicare Benefits:

I request payment of authorized benefits be made on my behalf for any services furnished to me by Interventional Pain Consultants of NJ, P.A. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or those to related services.

Medical Benefits:

I certify that I am a recipient of the Medicaid, Title XIX program, and request that payment of authorized benefits is made on my behalf, I authorize Interventional Pain Consultants of NJ, P.A. to make available to the Division of Family Services any required formation concerning medical insurance, and financial records relating to my treatment. I hereby certify all health insurance shall be assigned to Pain Centers of America for the services provided.

RE; AUTOMOBILE ACCIDENT Date of Accident: _____

For consideration received, I, _____, assign to Interventional Pain Consultants of NJ, P.A._____ my rights and interest in the personal Injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees to or its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

I. The right to collect from the insurer the proceeds of the policy with respect to the PIP benefits mentioned above:

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose filing said lawsuit.

3. l agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered to me both by reason of this accident and by reason of any other bills that are due, their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am, directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for (lie assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

INTERVENTIONAL PAIN CONSULTANTS OF NJ, P.A.
P.O. BOX 4253, CLIFTON, NJ 07013 Tel #: (973) 779-7246 Fax #: (973) 779-8989

ASSIGNMENT OF BENEFITS FORM

RE: WORKMEN COMPENSATION **Date of Injury: _____**

For consideration received, I, _____ assign to Interventional Pain Consultants of NJ, P.A._____ my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assigners to or its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the injured benefits mentioned above;

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose of filing said lawsuit; Individually, in the injuries arbitration with the National Arbitration Forum on the bill for the assignee.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries/or which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient's Signature	**Date**	**Print Patient's Name**
_____	_____	_____
Signature of Person Authorized to Sign	**Date**	**Print name of Authorized person**
_____	_____	_____
Witness	**Date**	**Relationship to Patient**

NORTH JERSEY PERIOPERATIVE CONSULTANTS, PA
P.O. BOX 1258, CLIFTON, NJ 07013 Tel #: (973) 779-7963 Fax #: (973) 779-7385

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to North Jersey Perioperative Consultants, P.A. of the insurance benefits herein specified and otherwise payable to me but not to exceed the balance due on the regular charges. I understand that I am financially responsible to North Jersey Perioperative Consultants, P.A. for charges not covered by this authorization. Should the account be referred for collection after a default, the undersigned agrees to pay costs of collection, including a reasonable attorney's fee. All delinquent accounts have interest of legal rates.

Medicare Benefits:
I request payment of authorized benefits be made on my behalf for any services furnished to me by North Jersey Perioperative Consultants, P.A. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or those to related services.

Medical Benefits:
I certify that I am a recipient of the Medicaid, Title XIX program, and request that payment of authorized benefits is made on my behalf, I authorize North Jersey Perioperative Consultants, P.A. to make available to the Division of Family Services any required formation concerning medical insurance, and financial records relating to my treatment. I hereby certify all health insurance shall be assigned to North Jersey Perioperative Consultants, P.A. for the services provided.

RE: AUTOMOBILE ACCIDENT **Date of Accident:** _____

I, _____, assign to North Jersey Perioperative Consultants, P.A._____ my rights and interest in the personal Injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the PIP benefits mentioned above:

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose filing said lawsuit.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered to me both by reason of this accident and by reason of any other bills that are due, their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for services rendered and this agreement is made solely for (assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

RE: WORKMEN COMPENSATION **Date of Injury:** _____

For consideration received, I, _____ assign to North Jersey Perioperative Consultants, P.A._____ my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed above. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assigners or to its employees. By assigning these benefits, I have expressly agreed that the following rights are assigned to the assignees:

1. The right to collect from the insurer the proceeds of the policy with respect to the injured benefits mentioned above;

NORTH JERSEY PERIOPERATIVE CONSULTANTS
P.O. BOX 1258, CLIFTON, NJ 07013 Tel #: (973) 779-7963 Fax #: (973) 779-7385

ASSIGNMENT OF BENEFITS

2. The right to file a lawsuit directly against the insurance company in the name of the assignee, as Assignee, and to designate an attorney of their choosing for the purpose of filing said lawsuit; Individually, in the injuries arbitration with the National Arbitration Forum on the bill for the assignee.

3. I agree fully to cooperate with the Assignee in the collection of the personal injury protection claim from the insurance carrier, including full cooperation with the attorney chosen by the Assignee, the answering of any interrogatories, the appearance at any deposition and the appearance at any arbitration or trial if my attendance is required.

I hereby authorize and direct to you, my attorney, to pay directly to the assignee, such sums as may be due and owing them for medical/dental services rendered me both by reason of this accident and by reason of any other bills that are due their office, and to withhold such sums from any settlement judgment or verdict which may be paid to you, my attorney, or myself as the result of injuries/or which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the assignee for all medical bills submitted by them for service rendered and this agreement is made solely for the assignee additional protection and in consideration of their awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee, and that a payment on the account is due and payable upon demand.

_____	_____	_____
Patient's Signature	**Date**	**Print Patient's Name**
_____	_____	_____
Signature of Person Authorized to Sign	**Date**	**Print name of Authorized person**
_____	_____	_____
Witness	**Date**	**Relationship to Patient**