Robert Wood Johnson University Hospital Somerset | RWJBarnabas HEALTH

Welcome!

Thank you for choosing RWJBH Sports Physical Therapy to assist you in your recovery.

We ask that you arrive 15 minutes early and have the attached paperwork completed. Otherwise, you will need to arrive 30 minutes prior to you scheduled appointment time.

As a courtesy, we will verify your insurance benefits prior to your appointment. However, it is the patient's responsibility to understand his/her insurance coverage and we suggest you also call prior to your visit. We are an outpatient facility and you need to verify your coverage as such. For insurance verification, our NPI number is 1003236878, tax ID is 221487243 and our Medicare ID is 310048.

To facilitate the registration process, please arrive 15 minutes prior to your scheduled appointment time with the following:

- Current signed prescription from your doctor
- Enclosed paperwork filled out and signed
- Valid photo ID (driver's license, county ID, etc)
- Medical Insurance Cards
- Any referrals that may be required by your insurance company
- A list of your current medications
- Sneakers (NO open toe shoes/sandals) any braces or assistive device your doctor has prescribed
- Shorts (if we are treating your knee) or sweatpants and a T-shirt, locker rooms are available to change
- Payment for copays/coinsurance is expected at the time of service. We accept cash, check or credit card

The staff at Sports Physical Therapy strives to provide outstanding care and service. If at any time during the course of your rehabilitation process you have any recommendations, please do not hesitate to let us know. The best time to address your concerns is while you are here. Please call the office with any questions.

Sincerely,

The Staff at RWJBH Sports Physical Therapy

Robert Wood Johnson University Hospital Somerset | **RWJBarnabas HEALTH**

Outpatient Intake Sheet

Date:	Birthplace:	Race:	
Smoker: Y / N	Primary Language:	Previous Patient: Y / N	Email Address:
Have you traveled to West Africa (Guinea, Liberia, Sierra Leone and Nigeria) in the last 21 days? Y / N If Yes, have you had a fever in the last 24 hours? Y / N			

PATIENT INFORMATION

Last Name:	First Name:		
Street Address:	City:	State:	Zip Code:
County:	Phone: Can we leave a message? Y / N	Cell: Can we leave a message? Y / N	
DOB:	SS#:	Sex: M / F	Marital Status: (Single / Married / Divorced / Widowed / Separated)
Living Will: Y / N	Employment Status: FullTime / Part Time / Self / Student / Not employed / Retired		
Employer Name:	Occupation:		
Auto Related: Y / N If yes, State:_____	Work Related: Y / N	Date of Injury/Accident:	Adjustor/Claim Rep. Name & Phone#
Work Comp/MVA Insurance Co.:			Work Comp/MVA Claim#
Have you had PT this year: Y N # of visits:_____			Have you treated for this condition previously: Y N

PRIMARY INSURANCE INFORMATION

Name of Insurance Company:			
Policy Holder's Name:	Relation:	DOB:	M / F
Address:	Phone:		

SECONDARY INSURANCE INFORMATION

Name of Insurance Company:			
Policy Holder's Name:	Relation:	DOB:	M / F
Address:	Phone:		

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Relation:	Phone:

Medical History and Systems Review

Robert Wood Johnson University Hospital Somerset | **RWJBarnabas HEALTH**

Name: _____
Date: _____
Date of Birth: _____

Age: ____ Gender: M / F Occupation: _____ Physician: _____

Date of injury or most recent episode of pain: _____ Date of Surgery: _____

When is your follow up appointment with your physician? _____

Briefly describe how injury occurred: _____

Have you had any previous or similar problems? _____

Is this a work or motor vehicle accident related injury (Please circle)? Yes No

What activities aggravate your symptoms? _____

What eases your symptoms? _____

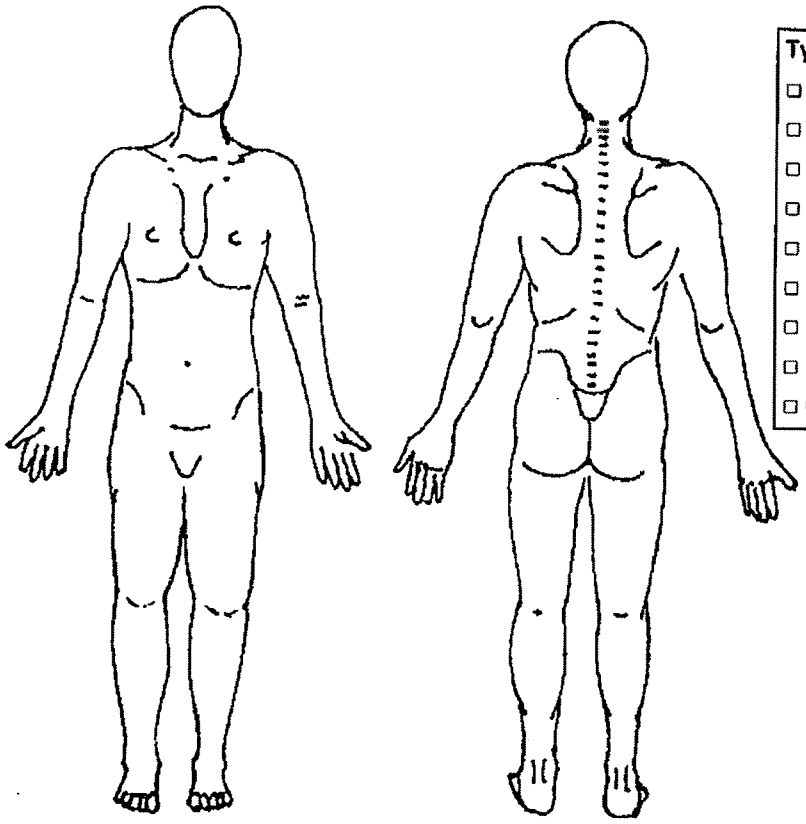
Leisure activities/Hobbies: _____

What are your goals for physical therapy? _____

In the diagram below, please circle involved areas of the body and check all options that apply.

Chief Complaint:
- ☐ Pain
- ☐ Soreness
- ☐ Swelling
- ☐ Stiffness
- ☐ Locking
- ☐ Instability
- ☐ Weakness
- ☐ Numbness/ Tingling

Duration of pain:
- ☐ Constant
- ☐ Intermittent
- ☐ During Rest
- ☐ During Activity
- ☐ Following Activity
- ☐ Night Pain



Type of pain:
- ☐ Sharp
- ☐ Burning
- ☐ Spasm
- ☐ Dull
- ☐ Radiating
- ☐ Achy
- ☐ Numbness/Tingling
- ☐ Fatigue
- ☐ Other

Please rate your current level of pain on the following scale:

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)

Robert Wood Johnson University Hospital Somerset | **RWJBarnabas HEALTH**

Name: _____
Date: _____
Date of Birth: _____

Are you currently under another physician's/health professional's care at this time? If so, please indicate:

☐ Medical Doctor (MD)	☐ Chiropractor	☐ Athletic Trainer
☐ Doctor of Osteopathy (DO)	☐ Psychiatrist/Psychologist	☐ Other: _____
☐ Podiatrist	☐ Acupuncturist	
☐ Physical Therapist	☐ Massage Therapist	

Have you had any of the following tests for this condition? Please check the appropriate box(s):

☐ X-ray	☐ CAT Scan	☐ Ultrasound
☐ MRI	☐ EMG/NCV	☐ Other _____
☐ Bone Scan	☐ Doppler	

During the past 2 weeks, have you taken any of the following over-the-counter medications? If yes, please check the appropriate box(s):

☐ Aspirin	☐ Antacids	☐ Tylenol
☐ Advil/Ibuprofen/Motrin	☐ Decongestants	☐ Vitamins
☐ Antihistamines	☐ Herbal Medications	☐ Other_____

Please list any prescription medications: _____

_____

Are you allergic to latex? Y / N

Please list any additional allergies: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, approximately how many days per week? _____

If yes, approximately how much each day? _____

Have you ever been diagnosed as having any of the following conditions? Please check the appropriate box(s):

☐ Anemia	☐ Fibromyalgia	☐ Parkinson's
☐ Asthma	☐ Headaches/Migraines	☐ Pregnant or think you may be pregnant
☐ Blood Clots	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hepatitis	☐ Stomach Ulcers
☐ Chemical Dependency	☐ High Blood Pressure	☐ Stroke
☐ Circulation Problems	☐ HIV	☐ Thyroid Problem (Hyper/Hypo)
☐ Concussion	☐ High Cholesterol	☐ Tuberculosis
☐ Depression	☐ Kidney Disease	☐ Other
☐ Diabetes	☐ Lyme's Disease	
☐ Dizziness	☐ Multiple Sclerosis	
☐ Emphysema	☐ Osteoarthritis	
☐ Epilepsy	☐ Osteoporosis	

Have you recently experienced any of the following? Please check the appropriate box(s):

☐ Fever/chills/sweats	☐ Dizziness/Lightheadedness/headaches
☐ Unexplained weight loss/gain	☐ Weakness
☐ Fatigue	☐ Numbness or Tingling
☐ Nausea/Vomiting	☐ Shortness of breath
☐ Bowel/Urinary Problems	☐ Night pain/Loss of Sleep
☐ Vision Problems	☐ Coordination/balance problems

Robert Wood Johnson University Hospital Somerset | **RWJBarnabas HEALTH**

Place patient ID sticker here.

GENERAL CONSENT

1. **CONSENT TO CARE:** I request and authorize RWJUH SOMERSET, the Hospital and its employees, attending physician(s) and such associates, assistants and/or residents as may be selected by the said physician(s), and all the persons caring for me, and to provide such medical care and to administer such routine diagnostic, radiological and/or therapeutic procedures and treatment including, but not limited to, the administration of pharmaceutical products, and intravenous medication, as in the judgment of the above persons deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine and surgery is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that it may be necessary for my healthcare providers to take photographs, film and record and/or take other like images for medical, educational and other continuity of care purposes. [INSERT FOR TEACHING HOSPITALS: I understand that the Hospital is a teaching hospital, medical students, interns and/or residents may participate in my care and treatment.] I understand that no guarantees have been made to me about the outcome of this care.

   Please initial here_____. This consent for treatment will remain in effect and apply to all outpatient services through the end of the calendar year.

2. **MATERNITY DIVISION:** If I am admitted to have a baby (ies), this consent shall also apply to the admission and Hospital treatment of the baby (ies) who is/are delivered by me during this hospitalization.

3. **RECURRING VISITS/MULTIPLE TREATMENTS:** I understand that many conditions being treated will require multiple treatments or therapy sessions to obtain the desired results. These include radiation therapy, respiratory therapy, physical therapy, occupational therapy, speech pathology, home health visits, kidney dialysis treatments, cardiac rehabilitation services, wound care and psychological services. In the event that there is a change to the course of treatment, I understand that I will be required to execute a new consent form for such change in treatment. If, during this period, any of my registration information changes, i.e. address, phone, employment, insurance, guarantor, etc., I will notify the department where the registration originated of the change.

4. **PERSONAL VALUABLES:** I have been informed to send all valuables home. I understand that if I choose to keep any valuables at the Hospital not deposited for safekeeping, the Hospital will be released from all responsibilities in the event of the loss of my personal property such as eyeglasses, dentures, artificial devices, contact lenses, hearing aids, money or any other items. I hereby certify that I have been advised and fully understand that the Hospital and its employees are not responsible for any and all personal articles, clothing or cash that I retain in my possession or on my person while a patient in the hospital. I acknowledge being advised not to retain cash and to deposit valuables in excess of that amount for safekeeping with the hospital Security Department.

5. **RELEASE OF INFORMATION:** I understand that my patient information is kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. The Hospital may access electronic information about me from pharmacies I use, including prescriptions to treat AIDS/HIV, mental health issues, substance abuse and sexually transmitted diseases, if applicable. The pharmacy information will become part of my hospital medical record. I understand that if I do not wish the Hospital to access my pharmacy information, I must submit a written request to the Hospital's Privacy Officer. The Hospital also participates in electronic health information exchanges (HIEs) with various other health care providers. I authorize the Hospital and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to 'opt-out' of having my information shared through HIEs and instructions on how to do that can be found in the Notice of Privacy Practices, or may be requested from the Hospital's Privacy Officer. The Hospital may seek, release and verify all or part of my medical and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to me, the hospital, my family member, or my employer, for all or part of the Hospital's charges.

   I grant permission and consent to the Hospital, its assignees, all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account. I HAVE CHECKED ALL DEMOGRAPHIC INFORMATION [attached] AND IT IS ACCURATE.

6. **AUTHORIZATION FOR TESTING:** In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not

GENERAL CONSENT

limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me, the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing my name.

7. **DISPOSAL OF SPECIMENS:** I authorize the Hospital to dispose of all specimens and tissues taken for laboratory or pathology examination as well as all equipment and devices removed from my body (such as artificial joints, pacemakers, etc.).

8. **FINANCIAL AGREEMENT:** For and in consideration of services rendered, I agree to make prompt payment to the Hospital when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, co-payments, and/or co-insurance. If I am classified as a self-pay patient, a deposit will be requested. I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services. I understand that the hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's ability to pay. If the Hospital, or my insurance carrier, or its intermediaries, or the Quality Improvement Organization deems that medical and/or professional services to be given or already given are not medically necessary and/or are on-covered services; I must pay for those services deemed to be a patient responsibility.

   PRE-CERTIFICATION: I acknowledge that precertification requirements have all been met: ☐ Yes ☐ No

9. **APPEALS:** BY MY SIGNATURE BELOW, I HEREBY CONSENT TO THE HOSPITAL ACTING ON MY BEHALF, DISCUSSING WITH OR APPEALING TO MY GOVERNMENT OR COMMERCIAL INSURANCE, ITS MEDICAL DIRECTOR AND/OR ITS PHYSICIAN DESIGNEE OR OTHERWISE TAKING ACTIONS WITH RESPECT TO ANY UTILIZATION MANAGEMENT, PAYMENT, OBLIGATORY OR OTHER DETERMINATION MADE CONCERNING THE PROFESSIONAL MEDICAL SERVICES PROVIDED OR TO BE PROVIDED TO ME BY THE HOSPITAL AND ITS PROFESSIONAL STAFF, IN ACCORDANCE WITH MY INSURANCE'S INFORMAL (STAGE I) AND FORMAL (STAGE II) APPEALS PROCESS AND APPLICABLE LAW. I CONSENT TO THE HOSPITAL PURSUING SUCH APPEALS ON MY BEHALF, HOWEVER, I RECOGNIZE THAT THE HOSPITAL HAS NO OBLIGATION TO PURSUE SUCH APPEALS. **I understand that the Hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's inability to pay.**

10. **AUTHORIZATION OF PAYMENT OF INSURANCE BENEFITS:** In consideration of the medical and/or physician services furnished to the patient by the Hospital and/or its authorized representatives, the undersigned patient, guarantor or policy holder, hereby assign all rights, title, and interest in any health care insurance policy, as it pertains to these medical and/or physician services to the Hospital. I authorize and request payment directly to the Hospital of all monies and/or benefits to which I may be entitled from government agencies, insurance carriers, self-funded employer plans, or others who are financially liable for my medical care and treatment to cover the costs of care and treatment, including for health insurance benefits payable under terms of my policy or self-funded welfare benefit plan. I hereby authorize the release of any/all medical records about me for the purposes of payment of the services rendered to me.

11. **FINANCIAL ASSISTANCE:** I have received a copy of the notice of Financial Assistance and reduced Charge Financial Assistance. I understand I may be eligible for Hospital Care Payment Assistance or other forms of financial assistance but must apply to receive it.

12. **MEDICARE AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that direct payment or authorized benefits be made on my behalf. I assign benefits payable for physicians' services to the physician or organization furnishing the services or authorize such a physician or organization to submit a claim to Medicare for payment. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THIS EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

13. **DESIGNATED CAREGIVER:** I understand I will have the opportunity to designate at least one (1) caregiver after I have entered the Hospital and prior to my discharge. If I do choose to designate a caregiver, I understand that the Hospital will request my written consent to release my medical information to the designated caregiver in accordance with privacy laws, including HIPAA. I also understand that if I do not provide this written consent, the Hospital will not give my caregiver notice of my discharge plan.

14. **[New Jersey Department of Health (IMM-32) Consent to Participate Form for the New Jersey Immunization Information System (NJIIS):** I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history. I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3. There is no cost to participate in this program. I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH Vaccine Preventable Disease Program may be contacted at website or telephone number listed below: P.O. Box 369, Trenton, NJ 08625-0369, Phone: (609) 826-4860, Fax: (609) 826-4866, www.njiis.nj.gov.]

   ☐ Yes, I would like to participate in this program. ☐ No, I do not want to participate in this program.

GENERAL CONSENT

15. **ADVANCE DIRECTIVE:**

I have an Advance Directive/Living Will/Health Care Agent ☐ YES ☐ NO ☐ UNKNOWN

I am providing a copy to: _____

By my signature below; I acknowledge that I am in receipt of the Advance Directive Information.

_____ _____

Patient Signature/Authorized Representative Relationship

Date/Time:_____

Acknowledgment Form

* I acknowledge receipt of the Hospital's Privacy Notice. I received this notice at ☐ Today's visit ☐ Prior visit
* I acknowledge receipt of the "Important Message from TRICARE". My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review.
* I acknowledge receipt of the Patient's Bill of Rights.
* I understand that if I do not comply with the pre-certification/authorization requirements, I will be responsible for hospital charges.

I have read this form, my questions have been answered, and I understand and agree to its content.

_____ _____

Patient Signature/Authorized Representative Relationship

_____ _____

The Patient is unable to sign because: Witness to signature only:

Date/Time:_____

Patient refused to sign the Acknowledgment form.

Date:_____

Reason:_____

_____

_____

_____

_____ _____

Signature of Hospital Representative Title

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

01-4072

COMMUNICATION ASSESSMENT

In order to assure that the services that are provided to you (or to the patient that you are legally responsible for) are not compromised by ineffective communication, we ask that you complete this form so that we can assess your communication needs and preferences. Kindly check each appropriate item.

☐ I have no special communication needs

1. Deaf and Hard of Hearing
   - ☐ I require the use of TDD/TTY
   - ☐ I require the use of an amplified telephone receiver
   - ☐ I require a closed caption television
   - ☐ I prefer written notes for brief communication
   - ☐ I prefer written notes for all communication
   - ☐ I prefer to lip-read and speak for myself for brief communications
   - ☐ I prefer to lip-read and speak for myself for all communications
   - ☐ I require a qualified sign language interpreter (at no cost to me)

   Other (please specify) _____

2. Visually Impaired/Blind
   - ☐ I require assistance with printed materials
   - ☐ Other (please specify) _____

3. Non-English Speaking
   - ☐ I require a translator in my language for communication. My language is: _____
   - ☐ I request that any of the individuals below serve as my translator:

   Name: _____ Telephone Number: _____

   Name: _____ Telephone Number: _____

4. Special Needs Assistance For special needs assistance, contact the Patient Satisfaction department at ext. 42177 or Nursing Administration. For TDD/TTY contact the Operator.

☐ I have read this form or have had it read to me.

_____ _____

Signature of Patient or person authorized to sign for patient Date/Time:

Relationship to Patient: _____

Patient is unable to sign because: _____

_____

Interpreter signature, if applicable: _____ Registrar electronic signature: _____

REFUSAL OF SERVICES OFFERED

☐ Patient declined sign language interpreter

☐ Patient declined other auxiliary aids and services offered

Patient: _____ Date/Time: _____

Witness: _____

Electronic Signature

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

01-80057

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.[1] This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, _____, by marking ☑ (or ☒) and signing below, agree to:

☐ representation by Robert Wood Johnson University Hospital in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

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

Signature: _____ Ins. ID#: _____ Date: _____ Time: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

[1] If the patient is a minor

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

01-80057

New Jersey Department of Banking and Insurance

NOTICE OF REVOCATION OF CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND OF AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

You may, at any time, revoke the consent you gave allowing a health care provider to represent you in an appeal of a UM determination and allowing the release of your medical records to the DOBI, the IURO and medical professionals that contract with the IURO. You may use this form to revoke your consent, or you may submit some other written evidence of your intent to revoke consent, if you prefer. Either way, if you have not yet received a Stage 2 UM determination from the carrier, send the written and signed revocation to the carrier at the address indicated in the carrier's written notice to you regarding the carrier's initial UM determination. If you have received a Stage 2 UM determination, then your revocation should be sent to:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care – Attn: IHCAP
P.O. Box 329
Trenton, NJ 08625-0329
OR for courier service to: 20 West State Street OR by fax to: (609) 633-0807

You may also want to send a copy of your notice of revocation to the health care provider.

ONLY COMPLETE AND SEND THIS IN WHEN AND IF YOU WISH TO REVOKE YOUR CONSENT!

REVOCATION OF CONSENT TO REPRESENTATION AND RELEASE OF MEDICAL RECORDS IN UM DETERMINATION APPEALS

☐ I hereby revoke my consent to representation by _____ and my authorization to the release of medical information in an appeal of an adverse UM determination. I understand that by revoking consent, the UM appeal may not be pursued further by my health care provider. I understand that this revocation may occur after my personal and medical information has already been shared with the DOBI, the IUROs and medical professionals with whom the IUROs contract, but that no further distribution of records in this matter will occur based on my authorization, and that all of my medical and personal information is required to be maintained as confidential by all parties.

Signature: _____ Ins. ID#: _____ Date: _____ Time: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

Please provide the following contact information IF it is different from the patient's contact information:

PRINT NAME: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____ EMAIL: _____

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

NOTICE OF CHARITYCARE AND REDUCED CHARGE CHARITYCARE

RWJUH will provide services without charge or at a reduced charge to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill; and

2. Are ineligible for any private or government sponsored coverage (such as Medicaid); and

3. Meet both the income and assets eligibility criteria listed below.

The charges not paid by the patient are reimbursed by the New Jersey Uncompensated Care Trust Fund.

INCOME CRITERIA

INCOME AS A PERCENTAGE OF HHS POVERTY INCOME GUIDELINES	PERCENTAGE OF CHARGE PAID BY PATIENT
less than or equal to 200%	0%
greater than 200% but less than or equal to 225%	20%
greater than 225% but less than or equal to 250%	40%
greater than 250% but less than or equal to 275%	60%
greater than 275% but less than or equal to 300%	80%
greater than 300%	100%

If patients on the 20% to 80% sliding fee scale are responsible for Chapter 83 hospital bills in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered charity care.

ASSETS CRITERIA

Individual liquid assets cannot exceed $7,500 and family liquid assets cannot exceed $15,000.

When determining eligibility, a spouse's income and assets must be used for an adult, and parent's(s') income and assets must be used for a minor child.

Anyone seeking a determination of eligibility for charity care or reduced charge charity care should contact Patient Accounts at (732) 418-8450.

RWJUH will make a written determination of whether the applicant is eligible as soon as possible, but no more than five working days from the time a completed application is submitted. If the request does not include adequate documentation to make a determination, the request shall be denied. The applicant will then be allowed to present additional documentation.

Applicants found ineligible may reapply at a future time when they present themselves for services and believe their financial circumstances have changed.

Charity care and reduced charge charity care are available only for medically necessary care.

I hereby acknowledge receipt of the above notice of Charity Care.