Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

New Orthopedic Patient Intake Form

Patient Name: _____ **DOB**: _____ **Age**: _____

I identify as: Male Female Non-binary

I was referred here by:

Myself Dr._____ who is located in _____

I am: Right-Handed Left-Handed

My job is: _____

My work involves: mostly desk work heavy lifting manual labor

My sports/ activities/ hobbies include: _____

_____

I am here to for my: Right Left

Shoulder Elbow Hand Knee

Pain type: My pain started suddenly after an injury My pain came on slowly over time

My injury occurred around this date: _____ N/A

My injury was from: A Fall Workplace Injury Car Accident N/A

I have had pain for _____ days / weeks / months

I rate my pain the in the body part I am here for as

0 1 2 3 4 5 6 7 8 9 10

My biggest complaint is:

pain lack of motion weakness numbness/tingling

Scheduling:
1 (609) 521-2661

info@naspacmd.com
www.naspacmd.com

Orthopedic Main:
1601 Kings Hwy N Ste 800
Cherry Hill, NJ 08034

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

I have had previous surgery on the body part I am here for: Yes No

Type of surgery/date/location/surgeon:

_____

_____

_____

I have tried the following treatments:

Tylenol/Ibuprofen Narcotics Injections Physical Therapy Brace Chiropractor

My last shoulder/elbow/hand/knee injection was _____weeks / months / years ago

Injection Type: Steroid Gel PRP Stem cell

My last physical therapy treatment was _____ days / weeks / months ago

I smoke: _____ cigarettes/day and have been for _____years N/A

MEDICAL HISTORY (select all that apply):

I have a bleeding or clotting disorder	I take blood thinners
I take insulin	I have kidney disease and/or on dialysis
I have a heart pacemaker or defibrillator	I have had a heart attack, heart failure, or stroke
I wear a CPAP machine at night	I can't walk 2 blocks without getting short of breath
I have a spinal cord stimulator	I have a rheumatoid condition
I have an active infection	I have had MRSA in the past

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

CONSENT FOR MEDICAL SERVICES

I hereby authorize North American Spine and Pain (NASPAC) providers to conduct a full orthopedic evaluation and administer treatment, medication management, therapy, and to make necessary referrals.

By signing below, I am indicating that I have read and that I understand the terms of this Consent and Agreement to Treatment with NASPAC. I give consent to NASPAC to perform necessary or appropriate tasks for proper orthopedic evaluation, diagnosis, monitoring, and referrals, as clinically indicated.

_____ _____

Patient or Patient Representative Signature Date

PAYMENT FOR MEDICAL SERVICES

Dear Patient,

Although we will submit all necessary information to your insurance company for timely reimbursement, your insurance company may send insurance payments (checks) directly to you. However, we will be submitting both a signed limited power of attorney and an assignment of benefits on your behalf which will require them to send the checks to us for payment of your treatments.

Payments sent to you for our treatments, whether from primary or secondary insurance companies, are required to be used to pay outstanding charges to North American Spine & Pain.

If you receive a check, either deposit the insurance check and send us a personal check or forward the insurance check to us as soon as possible.

You will remain financially responsible for all outstanding charges should you choose to keep the check.

Thank You,

North American Spine & Pain

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges Insured for services rendered as allowed under state and/or federal law. I understand that I may be required to pay co-payments, amounts applied to deductibles and balances of bills not paid in accordance with the benefits of my current insurance policy if allowable. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements.

I hereby authorize payment for all medical Insurance benefits, which are payable under the terms of my insurance policy, to be paid directly to North American Spine & Pain or designated for services rendered. If I receive such payment, I agree to deliver same to North American Spine & Pain within 10 days of receiving same.

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that in the event of non-payment, if any third party bills North American Pain & Spine, it is my full responsibility, in accordance with the benefits of my current insurance policy to pay immediately.

It is further agreed that in the events I fail to pay upon demand, should my account be referred to an outside collection agency and/or attorney, I accept full responsibility to pay all collection costs not to exceed 30% of the amount then due with interest of 1.5% per month and not to exceed 18% per annum and reasonable court cost and reasonable attorney's fees. I also agree that any action commenced to collect my account shall be brought in Burlington County, New Jersey.

_____ _____

Patient or Legal Guardian Signature Date

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

Assignment of Benefits Form & Release

I, the undersigned, hereby authorize the assignment of the benefits and rights available to me under my insurance plan with the insurance company listed on the copy of the current insurance card I have provided to North American Spine & Pain (hereinafter "NASPAC") for medical services and care provided to me by the NASPAC. I hereby authorize payment be made directly to NASPAC for all my covered health insurance benefits from all Third-Party payers, including my employer in the event of a Worker's Compensation case. I further understand that I am financially responsible for services denied as non-covered. I certify that the insurance information I have provided to NASPAC is true and accurate and that I am responsible for keeping said information updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that the charges for the professional services and care rendered to me by NASPAC (hereinafter "charges") are paid in full. I also understand that my insurance company may not pay at 100% of the amount of the charges and that I may be responsible for all charges not paid to NASPAC by my insurance company, including any portion paid and not applied to in-network benefits for any out-of-network services. **I agree to pay the full amount of all charges pursuant to NASPAC's scheduled rates, copies of which are available to me upon request prior to treatment.**

I authorize NASPAC to release (1) information necessary to secure payment of benefits and/or (2) records of any treatment or examination rendered to me to other medical providers. This information may relate to (a) age; (b) medical history, condition, and/or care; (c) physical and/or mental health; (d) occupation; (e) income; (f) avocations; (g) driving records; and/or (h) other personal characteristics. This authorization extends to information on the use of alcohol, drugs and/or tobacco; the diagnosis and/or treatment of HIV infection and other sexually transmitted disease(s); and the diagnosis and/or treatment of mental illness.

I authorize NASPAC to submit claims on my behalf to my insurance company. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure that all charges are paid in full. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

I irrevocably designate, authorize, and appoint NASPAC as my true and lawful attorney-in-fact. This power of attorney is provided for the limited purpose of receiving all payments due under my insurance plan on account of medical services and care rendered or to be rendered to me by NASPAC. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I authorize my insurance company to assign and transfer all my applicable plan benefits and rights to NASPAC, including the right to receive any applicable plan documents and remedies and to pursue appeals and/or litigation on my behalf. This authorization includes any rights due me permissible under state and federal laws.

I instruct and direct my insurance company to pay NASPAC directly. This includes any event where NASPAC may be Out of Network. **I understand that under ERISA, I have the right and authority to direct where payment for services rendered is sent.** If my current policy prohibits direct payment to NASPAC; under my rights per state and federal ERISA regulations, I instruct and direct my insurance company to provide SPD documentation stating such non-assignability clause to me and NASPAC upon

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

demand and immediately if in dispute. Upon proof of non-assignability, I instruct my insurance company to make the check out to me and mail it directly to NASPAC for the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges. I agree and understand that any funds I receive from my insurance company for services and care rendered by NASPAC will be immediately signed over and sent directly to NASPAC. If my insurance company sends a check for payment directly to me, I agree to immediately deliver the check to NASPAC, as I understand that NASPAC has the right to immediate possession of the check.

This is a direct assignment of my rights and benefits under my insurance policy. I have agreed to pay any balance of the charges over and above any such insurance payment. I authorize NASPAC to receive any checks from my insurance company on my account, endorse them for deposit, and deposit and apply the proceeds toward payment on my account. I further authorize NASPAC to deposit checks received on my account when made out to me.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case. I authorize NASPAC to be my personal representative, which allows it to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled; (2) submit any and all requests for benefit information from my insurance company; and (3) initiate formal complaints to any state and/or federal agency that has jurisdiction over my benefits; and (4) initiate and defend any litigation on my behalf.

I understand and agree that I am responsible for full payment of the total charges if my insurance company has refused to pay 100% of my benefits based on billed charges within ninety days of all appeals or requests for information. Should my account be referred to an attorney or outside agency for collection, I agree to pay NASPAC reasonably attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the maximum rate not more than 30% interest per anum. I understand and agree that fines levied against my insurance company will be paid to NASPAC for acting as my personal representative.

I authorize NASPAC and its associates to provide medical care and treatment to me by today's standards. Any action stemming from this Assignment of Benefits Form & Release shall be instituted, prosecuted, and maintained in Burlington County, New Jersey. A photocopy of this Assignment of Benefits Form & Release shall be considered as effective and valid as the original. If any part or provision of this Assignment of Benefits Form & Release should be held void or invalid, the remaining provisions shall remain in full force and effect.

_____

Print Patient Name

_____

Patient Signature Date

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

HIPAA/Patients' Rights

1. The patient has the right to receive considerate and respectful care.

2. The patient has the right to know the name of the physician responsible for coordinating his/her care.

3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatments.

4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.

5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.

7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.

8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.

9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge.

11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.

12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.

Patient Responsibilities

1. It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

2. It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed, and ask questions that immerge concerning his or her own health care.

3. It is the patient's responsibility to provide name of support person in case of emergency and have this support person available when advised to do so.

HIPAA NOTICE OF PRIVACY PRACTICES

North American Spine and Pain, PLLC is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices with respect to protected health information. If I have any questions, I understand I can speak with the HIPAA Compliance Officer in person or by phone. Signature below is only acknowledgment that I have been given the option of receiving a copy or been offered an opportunity to review North American Spine and Pain, PLLC notice of privacy practice:

Patient Name_____ Patient Signature_____

Date: _____

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our practice. To better serve all our patients, we require a 24-hour notification should you need to cancel or reschedule your appointment. Should you miss or reschedule your appointment with less than 24-hour notice, you may be charged $35 for office visits and $65 for procedures. This payment will be due at the time of your next appointment. Your insurance company does not cover the missed appointment fee, therefore, it is be your responsibility to pay it.

_____

Patient or Legal Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICES

I hereby acknowledge that North American Spine and Pain, upon request, will provide me with a copy of HIPAA Notice of Privacy Practices, and I acknowledge that they may use and disclose my health information for HIPAA authorized purposes, such as the purpose of treating me, obtaining payment for services rendered to me, and performing routine healthcare operations and services.

I also acknowledge that I have been provided with the opportunity to determine alternate means of communication by voicemail and electronic notices. I have also been provided the opportunity to determine what information I would like precluded from disclosure as my right and whom North American Spine and Pain can disclose my information to as my choice, which will include information up to and including protected health information (PHI).

I acknowledge that I agree bring or provide for an escort to take me home on the day of a procedure.

A copy of information regarding my rights as a patient (Patient Rights) can be provided to me, upon my request.

_____

Patient or Legal Guardian Signature Date

_____

Printed Patient Name or Legal Guardian

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

CONTROLLED SUBSTANCE AGREEMENT

I, _____ phone# (_____) _____, have read and understand the following agreement. (Please initial every paragraph). I agree to abide by it if I am placed on time contingent or as needed controlled substances. I have been fully open with my pain management physician and have revealed any history of previous substance abuse and all currently prescribed medication by other physicians.

_____**1.** Medications will be taken as directed by my physician. I will have enough medication to last until my next visit. If I run out of medication PRIOR to my next appointment, NO ADDITIONAL MEDICATION CAN BE AUTHORIZED.

_____**2.** I understand that I need to have a monthly appointment with my physician or nurse practitioner for medication management. I further understand that refill issues will only be discussed by phone on Mondays and Thursdays in an urgent situation. Phone calls will not be returned on refill issues other days of the week. Refills are NEVER made over the weekends.

_____**3.** I understand that controlled substance prescriptions general CANNOT be phoned or faxed to a pharmacy. All prescriptions **must** be filled in the state where they were prescribed.

_____**4.** I understand that controlled substance prescriptions are MY responsibility. If anything happens to my prescriptions (lost, stolen, flushed down the toilet, etc.), I am personally responsible. Under such circumstances, prescriptions will not be rewritten or reordered.

_____**5.** I understand that I am to obtain ALL my prescriptions for controlled substances only from North American Spine & Pain while under their care. I will notify my pain physician if I receive a controlled substance from any other physician or source. If I violate this and obtain a controlled substance from any other source, or if I give or sell any controlled substance or prescriptions, then I have violated this agreement.

_____**6.** If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medications as prescribed by the physician. I will not hold North American Spine & Pain or any staff member of North American Spine & Pain liable for problems caused by misuse, abuse, or discontinuance of controlled substances.

_____**7.** I will inform my physician immediately if I develop serious side effects, go to an emergency room due to pain, or if I become pregnant, because if I am of childbearing age, I could give birth to a child physical dependent upon a controlled substance. These issues will be reviewed with my pain management physicians.

_____**8.** I understand that if I develop another pain condition (toothache, abdominal pain, etc.) this does not allow me to self-increase my medications. I will see my local doctor, disclose all medication that I am taking and inform North American Spine & Pain of any additional medication that have been ordered prior to taking them.

_____**9.** Signs of addiction and psychological dependence will be interpreted as a need for weaning and detoxification.

_____**10.** I agree to submit to a urine and / or blood screen to document appropriate blood levels of prescribed analgesics and to detect the use of non-prescribed medication at any time.

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

I understand that I may be discharged from North American Spine & Pain for any positive result for illegal drugs, for a urine sample that has a temperature reading below 90 degrees, for refusing to give a urine sample when requested or for not showing up at designated off-site lab in the allotted amount of time I am given to arrive there.

_____**11.** There is risk of excessive sedation when controlled substances are combined with sedatives, hypnotics, or depressants such as alcohol. Therefore, I agree to avoid concurrent use of such non- prescribed substances.

_____**12.** I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral modifications strategies to secure increased functioning and improved coping skills. I also recognize that my active participation is extremely important, I will actively participate in ALL aspects of the Pain Management Program and / or any recommendations that I am given for additional treatment.

_____**13.** I understand my pain management physician may need to discuss my care with family members or other physicians. I will allow such communication but only with my prior consent and if it maintains the confidence of my doctor – patient relationship.

_____**14.** I understand that I may be randomly contacted and requested to engage in a pill counting procedure. I will be given 24 hours to present myself to the practice with all my prescribed controlled substances from the practice or I may be asked to do so prior to my next visit without prior notice. If I am unable to present myself to the practice within 24 hours as asked, I will present to the nearest pharmacy within 24 hours and follow the instructions provided to me by the medical staff contacting me.

_____**15.** I understand that my insurance company will be billed for any testing which North American Spine & Pain feels is necessary in conjunction with my care. If my insurance company does not pay for drug screens or other testing, I will be responsible to pay for these myself, directly to the lab I am assigned if it is appropriate under my payor obligations.

I fully understand that if I do not abide by the above paragraphs, then I may (at my physician's discretion) no longer receive any type of controlled substance medication from North American Spine & Pain. I understand that if I have a problem or questions with any of the above paragraphs, I can make an appointment to discuss this with my physician and receive clarification.

_____

Printed Patient Name Date

Patient Signature _____

Physician Signature _____

Witness Signature _____

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN
ORTHOPEDICS &
SPORTS MEDICINE

Scheduling:
1 (609) 521-2661

info@naspacmd.com
www.naspacmd.com

Orthopedic Main:
1601 Kings Hwy N Ste 800
Cherry Hill, NJ 08034

Adnan Cheema, MD Megan Selnek, PA
Orthopedic Medicine

NORTH AMERICAN ORTHOPEDICS & SPORTS MEDICINE

RELEASE OF MEDICAL RECORDS

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ **Date of Birth**: _____

I authorize _____ (healthcare provider) to release all protected health information as outlined below to

North American Spine and Pain

1601 N. Kings Highway, Suite 800, Cherry Hill, NJ 08034

This request and authorization applies to:

☐ All healthcare information

☐ Operation Report

☐ X-ray, MRI, CT, EMG imaging reports

☐ Other: _____

Please send all records to fax # (856) 283-4400

North American Spine and Pain

Attention: NASPAC Ortho

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____

Patient/Guardian Signature Date

_____

Printed name of patient/personal representative and their relationship to patient