Altair Health
PT & Wellness Center

60 Columbia Road
Building A
Morristown, NJ

Altair Health
Surgery Center

83 Hanover Rd.
Suite 100
Florham Park, NJ

ANS | Altair Health
Office Locations

310 Madison Ave.
Suite 300
Morristown, NJ

3700 Route 33
Suite B
Neptune, NJ

781 Route 15 South
Jefferson, NJ

242 West Pkwy
Pompton Plains, NJ

1121 Route 22 West
Suite 204
Bridgewater, NJ

Gerald J. Glasser
Brain Tumor Center

Overlook
Medical Center
99 Beauvoir Ave.
Summit, NJ

Morristown
Medical Center
100 Madison Ave.
Morristown, NJ

833.4 ALTAIR
T: 833.425.8247

ansdocs.com
altairhealth.com

Altair Health

Dear Patient,

We're honored that you've chosen Altair Health for your health care needs.

Please fill out the enclosed medical forms in advance and do one of the following:

- **Fax forms to 973.285.7839**
- **Bring them to your next visit.**

Do not mail forms.

If you have not completed your new patient paperwork, you must arrive 30 minutes prior to your visit or your visit will be rescheduled.

If you are coming in with images, you must bring the CD and the report. If you do not have the report, the facility will need to fax it to us prior to your appointment.

Please note payment is due at the time of service.

If you need to cancel or reschedule your appointment, please give us 24-hour advance notice.

We look forward to meeting you. Feel free to contact us with any questions before then.

Sincerely,

Altair Health
Guiding patients. Delivering outcomes.

REGISTRATION FORM

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Patient's Legal Name: Last:	First:	Middle:				
Social Security #:	❑ Mr. ❑ Dr. ❑ Mrs. ❑ Miss	Marital status (circle one) Single / Mar / Div / Sep / Wid				
Preferred Contact # ❑ Home ❑ Cell ❑ Work	Home Phone:	Cell:	Work: ext:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Email Address:	Street Address:	City:	State:	Zip Code:		
Employer & Position:	Employer Address:					

Primary Care Physician:	Referring Physician:
Primary Care (Town/State):	Referring (Town/State):
Primary Care Phone:	Referring Phone:
Specialty Doctor: Specialty:	Town/State:
Specialty Doctor: Specialty:	Town/State:

We are now required to collect Race, Ethnicity and preferred language. You may choose "Prefer not to answer".

Race:	**Ethnicity:**	**Preferred Language:**
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ Prefer not to answer ❑ Other ❑ White	❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer	❑ English ❑ Spanish ❑ Prefer not to answer ❑ Other:_____

INSURANCE INFORMATION

❑ Worker's Compensation: Claim #_____ ❑ Motor Vehicle Claim

Primary Insurance:		Member ID:
Policy Holder Name & Relationship:	Policy Holder DOB:	Group#:
Secondary Insurance:		Member ID:
Policyholder Name:	Policy Holder DOB:	Group#:

EMERGENCY & RECORDS CONTACT: EMERGENCY CONTACT: _____

Emergency Contact # :	Contact Relationship:
Authorized Contact's for Information Release: These individuals have been selected by the patient to be contacted for the specified information.	Information **ONLY** to be released to "Authorized Contact" listed to the left. Initial all items that can be released to the "Authorized Contacts".
Authorized Contact 1: Relationship:	_____ Medical Information (Health diagnosis, treatment, etc.) _____ Financial Information (Insurance, payment, balances, etc.)
Authorized Contact 2: Relationship:	_____ Prescription Pick up _____ Documentation Pick Up

May we leave a voicemail containing medical/personal information? ❑ Yes ❑ No If yes, which number(s)? ❑ Home ❑ Cell ❑ Work

Patient Signature: _____ ❑ I Authorize Above Contact(s) to discuss initialed information ❑ I do **NOT** authorize release to anyone else

Assignment of Benefits: I hereby authorize Atlantic Neurosurgical Specialists to apply for Medicare/Medigap, and other health insurance benefits (if applicable No-Fault and Worker's Compensation) on my behalf. I request that payment of all Medicare/Medigap and commercial insurance carriers be made directly to Atlantic Neurosurgical Specialists. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information and records about me to my health insurance carrier and HCFA (Health Care and Finance Administration) agents, and any and all other information needed to determine the benefits payable for related service(s). I hereby authorize payment of Medicare/Medigap and/or Commercial Insurance Carrier benefits be made on my behalf to Atlantic Neurosurgical Specialists. I release any holder of Medicare/Medigap information about me to my insurance carrier(s) necessary to determine benefits payable for related service(s). I hereby authorize this medical provider and its associates to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, claims adjuster, or attorney if applicable.

Signature:_____ **Date:**_____

Financial Policy/Agreement: You will be responsible for payment of any and all services provided to you by the Physicians/ Nurse Practitioners/ Physician Assistants/ Registered Nurse First Assist at Atlantic Neurosurgical Specialists regardless of your insurance coverage. If surgery is necessary, a claim will be submitted to your insurance company with the medical insurance information you have provided to Atlantic Neurosurgical Specialists at the time of service and Atlantic Neurosurgical Specialists will wait 90 days for the insurance carrier to make payment. **At the end of 90 days, you are responsible for the payment of the account in full**. You will be responsible for all co-payments, co-insurance and deductibles not met for the year as well as any non-covered services under your health plan. With the exception of payments which are payable at the time of service, you will be billed for any of the aforementioned fees and payment is due upon receipt of a billing statement. If the correct insurance information is not presented at the time of service, you will be responsible for the full amount of charges incurred. If you do not have medical insurance, financial agreements can be made prior to services rendered; otherwise, full payment is expected at the time of service. Atlantic Neurosurgical does not accept lien letters from attorneys in lieu of payment. We will attempt to resolve all past due balances amicably, but non-payment will be subject to the collection process after 90 days from the date of service. Atlantic Neurosurgical Specialists is an independent private practice and our policies, procedures, and billing process is completely separate from any/all hospitals, surgical centers, facilities or entities. All charges other than Medicare or Medicaid will be submitted to your insurance carrier as an Out of Network provider. You further agree to relinquish all/any checks or correspondence that you receive from your insurance carrier to Atlantic Neurosurgical Specialists within five (5) business days of receipt to properly reflect on your account. **Failure to comply will result in delinquent account and further collection actions. By signing below, you fully understand and agree to the above and take full financial responsibility for your account.**

Signature:_____ **Date:**_____

Privacy Notice/ Acknowledgement (HIPPA): Atlantic Neurosurgical Specialists assures each patient the safety of protecting their healthcare information. The plan is in a binder in the waiting area and is available for reading. This plan describes how Atlantic Neurosurgical assures the safety of my protected health information and explains my rights and their responsibilities to my privacy in regard to the medical care that I am seeking. I understand that I have the right to limit access of my protected health information at any time of service. I also understand that any questions that I have regarding my privacy can and will be answered by the Director of Operations. By signing this acknowledgement form, I agree to the Atlantic Neurosurgical Specialists privacy policy as stated here and in their plan.

Signature:_____ **Date:**_____

Consent to treatment: I consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

Signature:_____ **Date:**_____

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ASSIGNMENT OF BENEFITS/DESIGNATED AUTHORIZED REPRESENTATIVE/LIMITED SPECIAL POWER OF ATTORNEY

It is our policy, for your convenience, as well as to facilitate payment, to file health benefit claims on your behalf. To enable your insurance policy or benefit plan to deal with us directly, please read the following, sign and print your name below and enter today's date.

ASSIGNMENT OF BENEFITS

I hereby assign and convey to the fullest extent permitted by law any and all benefit and non-benefit rights (including the right to any penalties or equitable relief) under my health insurance policy or benefit plan to **Atlantic NeuroSurgical Specialists** and **Dr. Jonathan Baskin, Dr. Ronald Benitez, Dr. Brian Beyerl, Dr. Kyle Chapple, Dr. Jay Chun, Dr. Pinakin Jethwa, Dr. John Knightly, Dr. Scott Meyer, Dr. Yaron Moshel, Dr. Louis Noce, Dr. Henry Park, Dr. Paul Saphier, Dr. Edward Scheid, Dr. Charles Stillerman, Dr. Igor Ugorec, Dr. David Wells-Roth (collectively, the "Providers")** with respect to any and all medical/facility services provided by the Providers to me for all dates of service, including without limitation, the right of one or more of the Providers, or their attorney (or other representative) to (i) execute, in my name and on my behalf, any form, document or instrument required under any applicable insurance policy or benefit plan to further evidence my intent as set forth herein and to avoid any delay in pursuing rights under applicable Federal and State laws, rules, regulations or requirements (collectively, "Laws"), (ii) pursue penalties for and exclusively on behalf of Providers against any insurance policy or benefit plan for failure of the plan administrator (or other fiduciary) to timely produce or respond to requests (including appeals) for all information relating to any plan documents as required by any applicable Laws, (iii) to assert claims and initiate legal action for breach of fiduciary duty against any person or entity, and (iv) to endorse for me any checks made payable to me for benefits and claims collected toward my account.

In the event the insurance carrier responsible for making medical payments to **Atlantic NeuroSurgical Specialists** and **Providers** for medical services rendered to me does not accept my assignment of benefit rights, or my assignment is challenged or deemed invalid, I execute this limited/ special power of attorney and appoint and authorize Provider and his/her/its attorney (or other representative) as my agent and attorney, in fact, to assert any and all of my benefit and non-benefit rights for and on my behalf, including, without limitation, to bring any appeal, pre-litigation demand, demand for payment, arbitration, lawsuit, independent dispute resolution or administrative proceeding, for and on my behalf, in my name against any person and/or entity involved in the determination and payment of benefits under any insurance policy or benefit plan. I agree that any recovery shall be applied to payment due my provider including attorney fees and costs. To this end, Provider has exclusive settlement authority.

DESIGNATED AUTHORIZED REPRESENTATIVE

I hereby appoint as a Designated Authorized Representative each of my Providers and each of their respective assistant surgeons, physician assistants, teaching assistants, billing staff, lawyers (including Cohen Howard, LLP) or any other person or business that provides healthcare activity services as a "business associate' under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and their respective designees (collectively referred to herein as an "Authorized Representative"). This authorization is intended to comply with all requirements of the Employment Retirement Income Security Act of 1974, as amended (ERISA") and any applicable State law. Each Authorized Representative is granted the same rights which I have as a member or beneficiary under my insurance policy or benefit plan, including without limitation:

1. The right of my Authorized Representative to file claims for benefits on my behalf and directly receive payment for benefits and non-benefits under my insurance
2. policy or benefit plan, including the right to penalties, interest and attorney fees.
3. The right of my Authorized Representative to communicate with insurers, plan fiduciaries, employers and plan and claim administrators relative to all my benefit information and protected health information ("PHI" as further defined under HIPAA) and to share and exchange such information with a "covered person" or "business associate" as those terms are defined under HIPAA.
4. The right of my Authorized Representative to send and receive follow-up information and obtain all documentation that ERISA or any State law requires to be provided to me, including, without limitation, plan documents, explanation of benefits, adverse benefit determinations, all relevant documents involving my claim, identity of all persons involved in determining my claim and all documents relied upon in making any determination as to the payment of any amount under the applicable plan documents.
5. The right of my Authorized Representative to file any internal or external member appeal for payment of benefits under any applicable insurance policy or benefit plan.
6. The right of my Authorized Representative to pursue any rights, claim or cause of action through pre-litigation demands, demands for payment, arbitration, independent dispute resolution or administrative proceeding, litigation or otherwise under any Federal or State law with respect to payment for services provided by a Provider to me, including penalties, interest and attorney fees.

RELEASE OF PRIVATE HEALTH INFORMATION

It is specifically intended that any Provider or Authorized Representative is authorized and directed to provide and release my PHI for purposes of exercising all rights and benefits set forth in this Assignment of Benefits/Designated Authorized Representative authorization to any "covered person" or "business associate", including third-party payors, internal and external utilization review organizations, regulatory review entities and other organizations and/or companies that may/will assist with claims processing/reimbursement. I also direct any plan or claim administrator or plan sponsor to share all PHI with any Provider or Authorized Representative and not to inhibit the exercise of rights under my insurance policy or benefit plan by requiring any further authorization signed by me.

I understand that I remain fully responsible for any billed charges remaining due for services provided to me by a Provider, including co-pays, co-insurance and deductibles. If I receive any check or other payment from an insurance company or third-party payor for services rendered to me by a Provider, I will immediately endorse the check over to the Provider or otherwise make payment to the Provider for the amount of payment received from such insurance company or third- party payor. I agree that if the Provider is required to pursue collection efforts against me for these amounts, I will be responsible for all legal fees, interest and costs associated therewith.

This Assignment of Benefits/Designated Authorized Representative authorization/ Limited Special Power of Attorney shall remain in full force and effect for all current and future dates of service, until such time that all rights have been exercised under applicable Federal and State law as determined by Providers. I may revoke or withdraw this authority upon written notice to the Providers. In the event of any revocation, I will be responsible for payment of all outstanding amounts then due to the Providers.

Patient Name:_____ Date:_____

Patient Signature: _____

History and Review of Systems

Reason for visit: ❑ Brain ❑ Spine ❑ Neurovascular				Date:
Patient's last name: First: Middle:		❑ Mr. ❑ Mrs.	❑ Ms. ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Religious beliefs that may direct treatment? ❑ Yes ❑ No	Children? ❑ Yes ❑ No How many? _____	Education: ❑ H.S./GED ❑ college degree (2 year / 4 year) ❑ post-college	Birth date: / /	Age: Sex: ❑ M ❑ F
Height: _____ Weight:_____	Occupation? ❑ Retired		Litigation Pending ❑ Yes ❑ No	
Tobacco use ❑ Yes ❑ No Type:_____ Packs per day ___ for ___ years [Year quit _____]	Alcohol Use: Drinks _____ per ❑ day ❑ week ❑ month		Illicit Drug Use? ❑ Yes ❑ No	
Caffeine (coffee, tea, soda, chocolate) servings / day: ____ [circle which applies]	❑ Left-Handed ❑ Right-Handed ❑ Ambidextrous			
Physical Activity: ❑ Sedentary ❑ Light ❑ Moderate ❑ Strenuous	Type: _____	Frequency:		

Have you EVER been diagnosed with the following conditions (If yes, check appropriate boxes):

- ☐ None
- ☐ HIV/Aids
- ☐ Aneurysm
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Blood Clot
- ☐ Enlarged Prostate
- ☐ Clotting Disorder
- ☐ Heart Disease
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A, B, or C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Memory Loss
- ☐ Multiple Sclerosis
- ☐ Neuromuscular disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ PVD
- ☐ Stroke
- ☐ Seizure disorder
- ☐ Thyroid/Parathyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Disorder
- ☐ Cancer: _____ _____
- ☐ Other: _____

Do you CURRENTLY have any of these symptoms? (Check appropriate boxes)

- ☐ None
- ☐ Abnormal Bruising
- ☐ Arm Pain L R
- ☐ Arm Weakness
- ☐ Anxiety
- ☐ Chest Pain
- ☐ Depression
- ☐ Difficulty in swallowing
- ☐ Dizziness
- ☐ Double Vision
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Headaches
- ☐ Hoarseness
- ☐ Incontinence
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Leg Pain L R
- ☐ Leg Weakness
- ☐ Memory Loss
- ☐ Neck Pain
- ☐ Numbness
- ☐ Palpitations
- ☐ Rash
- ☐ Ringing in the Ears
- ☐ Seizures
- ☐ Sexual Problems
- ☐ Shortness of Breath
- ☐ Tingling
- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Vomiting/Nausea
- ☐ Weight Gain
- ☐ Weight Loss, Unintentional
- ☐ Persistent Infection

Surgical History

Surgery Performed	Year

Has anyone in your Family Ever had? (If yes check box and mark relationship) (M: mother, F: father, S: Sibling)

- ☐ Alcoholism_____
- ☐ Bleeding Disorder_____
- ☐ CAD_____
- ☐ Cancer & Type _____
- ☐ Depression_____
- ☐ Diabetes_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Mental Illness_____
- ☐ Seizures_____
- ☐ Stroke_____

PHARMACY INFORMATION			
Pharmacy Name:			
Street address:	City:	State:	Zip:
Phone:			

Medications:

Name	Dosage	Times a Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies	Reaction
1.	
2.	
3.	
4.	
5.	

Altair Health

Medication Treatment Agreement

1. All controlled substance prescriptions must come from the treating pain management provider or a provider within the same practice. I will not seek prescriptions for pain control from any other physician, healthcare provider, emergency physician or dentist, without prior authorization. I understand it is unlawful to be prescribed the same medication by more than one physician without each physician's knowledge. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a medication by knowingly misrepresenting or withholding information/facts to the physician or staff. This includes failure to *inform* the physician or staff of medications I have been prescribed.
2. All pain related medications must be obtained at the same pharmacy, when possible. I will notify the prescriber if a change in pharmacy is made.
3. I will not share, sell or otherwise permit others to have access to any pain medications written by my physician or practitioner.
4. **SAFE and SECURE MEDICINE DISPOSAL policy must be followed.** Unused medications that remain in your medicine cabinet are susceptible to theft and misuse. To prevent medications from getting into the wrong hands, New Jersey's Office of the Attorney General and Division of Consumer Affairs urge you to properly dispose of your expired and unwanted prescription medicine at a nearby Project Medicine Drop location. DROP OFF IS SIMPLE, ANONYMOUS AND AVAILABLE 24 HOURS A DAY – 365 DAYS A YEAR, NO QUESTIONS ASKED. Simply bring in your prescription and over-the-counter medications and discard them in an environmentally safe manner. Always scratch out the identifying information on any medicine container you are discarding. For a list of Project Medicine Drop locations, please visit www.NJConsumerAffairs.gov/meddrop.
5. Unannounced urine, serum, or saliva specimens may be requested. Presence of unauthorized substances in urine or serum may result in discharge from the practice. Continued prescribing of medications is dependent on compliance with giving specimens.
6. I will not consume excessive amounts of alcohol in conjunction with the medication prescribed. I will not use, purchase or obtain any other controlled drugs except as specifically authorized by the practitioner. I will not purchase or obtain illegal drugs. I understand that driving while under the influence of any substance, including a prescribed controlled substance or any combination of substances can impair my driving ability.
7. Medications or written prescriptions may not be replaced if they are lost, stolen or destroyed. If such a loss is reported, I may be responsible for obtaining a police report.
8. Renewals are based upon keeping scheduled appointments. While New Jersey state law mandates a minimum of 90 days for re-evaluation, my provider may require more frequent follow-up appointments.
9. I will take the medication as prescribed. I will not take more than prescribed. Requests for refills may not be granted.
10. I agree to participate in any non-pharmacologic recommendations made by the provider, including, but not limited to physical therapy, psychological evaluation and treatment, surgical evaluation or other modalities.
11. Potential side effects/risks from medication prescribed by the provider have been discussed with me. I understand and am satisfied with the explanation.
12. I affirm that I have full right and power to sign this agreement. I have read, understand and accept all of its terms. A copy of this agreement has been given to me.
13. I understand that failure to follow these requirements may result in the provider prescribing a safe discontinuation of therapies or dismissal from Altair Health. If it is determined by the practitioner that detox is the best option, I agree to follow through with this as well.

_____ _____

Patient Printed Name Patient Signature

_____ _____

Pharmacy Name and Phone Number Witness and Date

Altair Health

Treatment Plan and Informed Consent for Medications Used to Treat Pain

Please read the entire consent, **initial each paragraph** and **sign below.**

I, _____, understand the following (initial each):

_____ One of the goals of this medication treatment plan is to improve my ability to perform various functions, including return to work. If significant demonstrable improvement in my **functional capability** does not result from this treatment, my prescriber may decide to discontinue the use of pain medications.

Goal for improved function: _____

_____ Pain medications are being prescribed to make my pain tolerable, but MAY NOT cause it to disappear completely. If that goal is not reached, my prescriber may discontinue the medication regimen.

Goal for pain reduction: _____

_____ Drowsiness and **slowed reflexes** can be a side effect of opioids, as well as other medications used to treat pain, especially during dosage adjustments. If I am experiencing drowsiness, fatigue or dizziness while taking these medications, I agree not to drive a vehicle or perform other activities that could involve danger to myself or others.

_____ Use of pain medications can cause significant **side effects** such as constipation, nausea, mood changes, depression, fatigue, respiratory depression, difficulty breathing, shortness of breath, confusion, impaired mental ability, impaired balance, decreased testosterone, dental decay.

_____ Using opioids to treat chronic pain may result in the development of **physical dependence** on this medication and sudden decreases or discontinuation of the medication may lead to signs of withdrawal. These symptoms may include: runny nose, yawning, abdominal pain and cramping, diarrhea, vomiting, irritability, pain, aches and flu-like symptoms, sweating or palpitations.

_____ There is a risk that **opioid addiction** can occur. This risk is higher if there is a family history of substance abuse. I will make my prescriber aware of any such history. Addiction is a behavioral issue that can lead to impaired control over medication use, craving and/or compulsive use despite harm. If it appears that I may be developing an addiction, my provider may decide to discontinue the medication regimen.

Initials: _____ Signature: _____ Date: _____