Eastern Neurodiagnostic

Associates, P.C.

Electrodiagnostic Medicine and Pain Management

2301 Evesham Road, Pavilion 800, Suite 209, Voorhees NJ, 08043

Phone: 856-651-0060 Fax: 856-651-0061

Last Name: ____________________ First Name: ______________ Sex: M☐ F☐

If patient is a minor, name of parent or guardian accompanying patient: ______________

Relationship to Patient: Phone # (if different): ___________ Left Handed ☐ Right Handed ☐

Address: ____

City: ____________________ State: ______ Zip Code: ____________

Home Phone: ____________ 2nd Phone: _____________ Email: ______________

Date of Birth: _________ SS# ___________ Married☐ Single☐ Divorced☐ Widowed☐

Referred by: _____________ Phone: _____________ Location: _______________

Family Doctor: ________________ Phone: __________ Location: ______________

INSURANCE

Date of Accident (if applicable): ___________ **Type of Accident:** ________________

Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at this time: ____________________

____

Primary Insurance Name: ___________________ Auto☐ Health☐ Workers☐ Comp ☐

Adjuster: __________________ Ext: ______________

Claim or ID #: ___________________

Secondary Insurance Name: _______________ Auto☐ Health☐ Workers Comp☐

Claim or ID #: _________________________________

Attorney Name: __________________ Firm: __________________________

Location: ________________________ Phone: _____________________

Employer Name: ________________________ Phone: __________________

Emergency Contact: _________________________ Phone: _____________

Are we authorized to release your medical information to the listed Emergency Contact?

Yes☐ No☐

Signature: ____________________________ Date: _______________

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Patient Name: ______________________ Date: ______________

HISTORY OF PRESENT ILLNESS:

I was involved in a(n): Automobile Accident ☐ Slip and Fall Accident☐ Injury at work ☐ Neither ☐

If injury was related to an accident, did you go to the hospital after the accident? Yes☐ No☐ (If yes, answer A, B, C, and D)

A). By ambulance? Yes☐ No☐ That day? Yes ☐ No ☐ The next day? Yes☐ No☐

B). Which hospital did you go to? ______________

C). Were X-rays/CAT scans/MRI's taken? Yes☐ No ☐ If yes, taken of my: __________

D). If you did not go to the hospital, where and when did you first seek medical treatment?

____

PAST MEDICAL HISTORY:

Diabetes☐ High Blood Pressure☐ Asthma ☐ Thyroid Disease ☐ Heart Disease ☐ Kidney Disease ☐ Other ☐ :______________________

PAST SURGERIES:

Tonsils ☐ Appendix ☐ Gall Bladder ☐ Tubal Ligation ☐ Hysterectomy ☐ Back Surgery ☐ Neck Surgery ☐ Carpal Tunnel Release ☐ Hernia Repair ☐ Heart Surgery ☐

Other ☐ : ______________________

MEDICATIONS:(if you have a written list please provide it to the front desk staff)

____

____

____

DRUG ALLERGIES:

Are you allergic to any medications? Yes☐ No ☐ If yes, list all:

____

____

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Patient Name: ______________________ Date: ______________

SOCIAL HISTORY:

Do you smoke? Yes ☐ No☐

Do you drink alcohol? Yes ☐ No ☐

FAMILY HISTORY:

Diabetes ☐ High Blood Pressure ☐ Cardiac Disease ☐

Adopted ☐ Cancer ☐ - type: ______________________

Patient Signature: ______________________ **Date:** ______________

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THIS NOTICE IS A PRIVACY RELEASE FORM AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Eastern Neurodiagnostic Associates is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other health care providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis, radiology reports or other medical reports.
- For payment purposes, we may us the services of a billing service.
- During health care operations, we may need a second opinion.
- With your attorney, if applicable.

We here at Eastern Neurodiagnostic Associates are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law.

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Name: ______________________________ Relationship: ________________

Contact Phone: ____________________ Permission to leave voicemail: YES☐NO ☐

If you have any questions or comments regarding your Protected Health Information, feel free to contact our Business Administrator Thomas Carr at 856-651-0060.

I have read and understand the above Notice of Privacy Practices.

Signed: ______________________________ Date: ______________
(Patient Signature)

Witness: ______________________________ Date: ______________

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Shiva Gopal, M.
Board Certified – Neurology & Rehabilitation
Board Certified – Electrodiagnostic Medicine

RECORDS RELEASE AUTHORITY

I, X____, hereby request that

____ provide in writing to

____ a report of my diagnosis, treatment, prognosis, and recommendations, as well as other pertinent data to his treatment of me during the period from

__________________________ to __________________________________.

Signed: X_________________________

DOB: _____________________________

Witness: __________________

Date: ______________________

Eastern Neurodiagnostic Associates P.C.

Shiva Gopal-Vasishta, M.D.
Roger Kurlan, M.D.
Matthew McClure, M.D.
William Wolfe, M.D.

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21 DAY NOTIFICATION

INSURANCE NAME AND ADDRESS:

____

____

____

____

Patient: _______________________________

Date of Accident: _________________________

Claim Number: __________________________

Please be advised the above named patient has started treatment at our facility as of ____________. Our reports and bills will be sent to you in a timely fashion. If you have any questions, please contact our billing office at 609-704-1857.

Sincerely,

Eastern Neurodiagnostic Associates P.C.

Eastern Neurodiagnostic Associates P.C.

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ASSIGNMENT OF RIGHT OF ACTION

I, ______________________ do hereby assign any right of action that I may have against ______________________, my PIP insurance company, to Eastern Neurodiagnostic Associates P.C. for the non-payment of my medical bills arising from the injuries I sustained in an automobile accident that occurred on ________________.

I further authorize Eastern Neurodiagnostic Associates P.C. to institute suit against my insurance company in my name to recover medical fees, which shall include but not be limited to the filing of a PIP claim in the Superior Court of New Jersey, the Court of Common Pleas of the Commonwealth of Pennsylvania, or any court of arbitration in any appropriate forum, using an attorney of their choice. I acknowledge that Eastern Neurodiagnostic Associates P.C. would be pursuing any claims on my behalf; however this does negate my primary responsibility to pay Eastern Neurodiagnostic Associates P.C. the full value for services and/or equipment over and above any recovery against the insurance company.

______________________________ ____________________

Signature Date

Claim Number: ______________________________________

______________________________ ____________________

Witness Date

FOLD & HERE

YOUR NAME

PHONE NO. | HOME | BUSINESS

YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE AND ZIP CODE)

DATE OF BIRTH / /

SOCIAL SECURITY NO.

DATE AND TIME OF ACCIDENT / / | AM PM

PLACE OF ACCIDENT (STREET, CITY OR TOWN AND STATE)

BRIEF DESCRIPTION OF ACCIDENT

ARE THERE OTHER AUTOS IN YOUR HOUSEHOLD? ☐ YES ☐ NO

IF YES, LIST: OWNERS INSURERS POLICY #

WERE YOU THE DRIVER OF THE AUTOMOBILE? YES ☐ NO ☐

WERE YOU A PASSENGER IN THE AUTOMOBILE? YES ☐ NO ☐

WERE YOU A PEDESTRIAN? YES ☐ NO ☐

WERE YOU A MEMBER OF AUTOMOBILE OWNER'S HOUSEHOLD? YES ☐ NO ☐

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO IF YOUR ANSWER IS **YES**, COMPLETE THE REST OF THIS FORM.

IF **NO**, SIGN HERE AND RETURN THIS FORM TO US.

SIGNATURE: ____________________ DATE: ____________

DESCRIBE YOUR INJURY

WERE YOU TREATED BY A DOCTOR? YES ☐ NO ☐

DOCTOR'S NAME AND ADDRESS

IF YOU WERE TREATED IN A HOSPITAL, WERE YOU ☐ AN IN-PATIENT? ☐ AN OUT-PATIENT?

HOSPITAL'S NAME AND ADDRESS

AMOUNT OF MEDICAL BILLS TO DATE: $

WILL YOU HAVE MORE MEDICAL EXPENSES? YES ☐ NO ☐

WERE YOU ON WORK TIME WHEN THE ACCIDENT OCCURRED? YES ☐ NO ☐

HEALTH INSURANCE CARRIER:

MEMBER NAME:

POLICY #:

GROUP #:

CLAIMS PH #:

DID YOU LOSE WAGES OR SALARY AS A RESULT OF YOUR INJURY? YES ☐ NO ☐

IF YES, AMOUNT LOST TO DATE $

WHAT IS YOUR AVERAGE WEEKLY WAGE OR SALARY? $

IF YOU LOST WAGES: DATE DISABILITY FROM WORK BEGAN / /

DATE YOU RETURNED TO WORK / /

HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR ANY BENEFITS UNDER:

	YES	NO
(1) ANY WORKERS' COMPENSATION LAW?	☐	☐
(2) EMPLOYEES TEMPORARY DISABILITY BENEFIT STATUTE?	☐	☐
(3) MEDICARE?	☐	☐

IF YES, AMOUNT $ ____________ PER WEEK ☐ PER MONTH ☐

LIST THE NAMES AND ADDRESSES OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES? ☐ YES ☐ NO. IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

"Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal prosecution and civil penalties."

SIGNATURE: ____________________ DATE: ____________

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY HEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAY AND PHYSICAL FINDINGS DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE PERSONAL INJURY PROTECTION BENEFITS LAW. THIS AUTHORIZATION SHALL REMAIN VALID FOR THE DURATION OF THE CLAIM. I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS AUTHORIZATION FORM.

SIGNATURE ____________________

DATE

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I, ______________________________ UNDERSTAND THAT UNDER THE NEW MOTOR VEHICLE INSURANCE LAWS, THERE MAY BE A DEDUCTIBLE AND CO-PAYMENT FOR MEDICAL SERVICES RENDERED UNDER MY PERSONAL INJURY PROTECTION INSURANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCE TO EASTERN NEURODIAGNOSTIC ASSOCIATES RENDERED TO ME BY THEM REGARDLESS OF ANY SETTLEMENT. I AUTHORIZE AND ASSIGN MY ATTORNEY ________________________, TO WITHHOLD AND PAY TO EASTERN NEURODIAGNOSTIC ASSOCIATES ANY OUTSTANDING BALANCE NOT PAID BY MY PERSONAL INJURY PROTECTION CARRIER, WHICH MAY BE RECOVERED BY MY ATTORNEY THROUGH ANY VERDICT OR SETTLEMENT. I AUTHORIZE MY ATTORNEY TO SIGN THIS FORM. PLEASE NOTE THAT THIS WILL ACT AS A LETTER OF PROTECTION.

______________________________ ______________________________
PATIENT PRINT

______________________________ ______________________________
PATIENT SIGN DATE

______________________________ ______________________________
ATTORNEY'S NAME DATE

______________________________ ______________________________
ATTORNEY'S SIGNATURE DATE

DEAR ATTORNEY,

PLEASE SIGN AND RETURN THIS TO OUR OFFICE ACKNOWLEDGING THE ABOVE MENTIONED STATEMENT SIGNED BY YOUR CLIENT.

SINCERELY

EASTERN NEURODIAGNOSTIC ASSOCIATES, PC