SEAVIEW ORTHOPAEDICS

Seaview Pavilion
1200 Eagle Avenue
Ocean, NJ 07712
Ph: 732-660-6200

Clearbrook Commons
294 Applegarth Rd, Suite C
Monroe, NJ 08831
Ph: 609-495-1888

Brick Medical Arts Building
1640 Route 88 West, Suite 101
Brick, NJ 08724
Ph: 732-458-7866

Atlantic Commons
500 Barnegat Blvd N, Bldg 200
Barnegat, NJ 08724
Ph: 609-488-3988

Central Fax: 732-660-6201
Website: www.seavieworthо.com

Patriot's Park
222 Schanck Road, Suite 300
Freehold, NJ 07728
Ph: 732-462-1700

Holmdel Corp Plaza
2139 Route 35 North, Suite 140
Holmdel, NJ 07753
Ph: 732-897-4800

PATIENT ASSESSMENT FORM
MOTOR VEHICLE ACCIDENT

Doctor _____

PATIENT NAME _____ **AGE** _____ **SEX** _____

Date of Accident: _____

Location of Accident: _____

Time of Accident: _____

Road Conditions: _____

Where was the car hit? _____

Patient was the:	**Driver** ☐	**Passenger** ☐
Was set belt worn?	**YES** ☐	**NO** ☐
Prepared for impact?	**YES** ☐	**NO** ☐
Was there a loss of consciousness?	**YES** ☐	**NO** ☐
Were the police notified?	**YES** ☐	**NO** ☐
Did you go to an Emergency Room?	**YES** ☐	**NO** ☐
Were you admitted into the hospital?	**YES** ☐	**NO** ☐

_____

Patient Signature

_____

Date

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Patient Medical History Questionnaire

Patient Name: _____ Date of Birth: _____ Age: ___ Sex: ___

Name of Referring Doctor: _____ Name of Family Doctor: _____

Reason for today's visit: _____

_____

How long have you had this problem? *(Days, weeks, months, etc.)* _____

What makes it better or worse? *(Include any prior medical treatments, i.e. medications, physical therapy injections, etc.)* _____

Rate the pain 0 (no pain) – 10 (worst imaginable pain) _____

Are you allergic to any drugs? *Circle one* YES or NO *If yes, please list those drugs below:*

Drug	**REACTION (i.e. rash, hives, palpitations, etc.)**	**Drug**	**REACTION (i.e. rash, hives, palpitations, etc.)**

List all current medications and dosages:

Medication	**Dose**	**Medication**	**Dose**

Past Medical History *(Please **circle** all that apply to you):*			Diabetes
High blood pressure	Coronary artery disease	Vascular disease	Emphysema
Heart disease/attacks	Congestive heart failure	Thyroid disease	Depression
Lyme disease	Bleeding disorder	Seizures	Gastric reflux
Multiple Sclerosis	Enlarged prostate	Hepatitis	Liver disease
Osteoarthritis	Rheumatoid arthritis	Stomach ulcers	Kidney disease
Asthma	COPD	Cancer	Scoliosis

Have you had a **flu shot** this year? ☐ YES ☐ NO If so, when _____

Do you have an Advance Directive? ☐ YES ☐ NO

Family History	Status (Alive/Deceased)	Age	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Unknown
Mother			☐	☐	☐	☐	☐	☐
Father			☐	☐	☐	☐	☐	☐
Siblings			☐	☐	☐	☐	☐	☐
Children			☐	☐	☐	☐	☐	☐

Please list any medical disease that a member of your family may have that is not mentioned above:

_____

Past Surgical History *(Please **circle** all that apply to you and list the date of surgery)*			
Surgery	Date	Surgery	Date
Knee arthroscopy (Right/Left)		Shoulder arthroscopy (Right/Left)	
Spine surgery (Neck/Back)		Joint replacement surgery	
Hernia repair		Laparotomy	
Eye surgery		Thyroid surgery	
Peripheral bypass surgery		Cardiac catheterization	
Coronary artery bypass graft		Hysterectomy	

Please list any other surgery you may have had in the past not mentioned : _____

_____

Ethnicity: _____ Race: _____ Primary Language: _____

Social History: *Please **circle** one:* Single / Married / Partnered / Widowed / Divorced

- Do you smoke? ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker ☐ Pipe Smoker ☐ Cigar Smoker
  If yes, how much do you smoke? ☐ 3 cigarettes or less per day ☐ Half a pack per day ☐ More than a pack per day
- Do you drink alcohol? YES NO
  If yes, how frequent? ☐ Social only ☐ Several times per week ☐ Everyday
- Do you or have you used illicit drugs? YES NO
  If yes, what kind? ☐ IV Drugs ☐ Pills ☐ Marijuana ☐ Other

Education Level: ☐ Graduate Level ☐ College ☐ Some College ☐ HS Diploma ☐ Other

Occupation: _____

Sports Participation: Yes No
If yes, which sports? ☐ Golf ☐ Tennis ☐ Football ☐ Soccer ☐ Baseball ☐ Basketball ☐ Run

List any other sports that you play: _____

*Please **circle** any of the following symptoms that you've experienced recently:*			
Constitutional	Fever	Night sweats	Weight loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pain	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomiting	Diarrhea
Genitourinary	Burning w/urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have related to the problems checked above: _____

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____

AUTOMOBILE ACCIDENT INJURY FORM

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY, OR OTHER PERSONS, 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, SUBJECT TO CRIMINAL PROSECUTION AND CIVIL PENALTIES."

THIS STATEMENT IS REQUIRED BY THE NEW JERSEY FRAUD PREVENTION ACT OF 1983.

Date	Policyholder	Date of Accident	File Number

SEAVIEW ORTHOPAEDICS **TO:**
1200 Eagle Avenue
Ocean, NJ 07712

YOUR NAME		HOME PHONE	WORK PHONE
YOUR ADDRESS		DOB	SS#
DATE & TIME OF ACCIDENT ☐AM ☐PM	PLACE OF ACCIDENT (STREET)	CITY	STATE
BRIEF DESCRIPTION OF ACCIDENT:			

Do you or any member of your household own an automobile? ☐ YES ☐ NO

Name of Insurance Co_____

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 your automobile owner's household?	☐ YES ☐ NO
As a result of the accident, were you injured?	☐ YES ☐ NO

If yes, complete the remainder of this form.

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 ☐ OUT-PATIENT	Hospital Name and Address	
Amount of medical bills to date: $	Will you have more medical expense? ☐ YES ☐ NO	At the time of your accident, were you in the course of your employment? ☐ YES ☐ NO

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 benefit under:

				If yes, Amount per Week	Per Month
(1)	Any Workman's Compensation Law?	☐ YES	☐ NO	$_____	$_____
(2)	Employees Temporary Disability Benefits Statute?	☐ YES	☐ NO	$_____	$_____
(3)	Medicare?	☐ YES	☐ NO	$_____	$_____

List Names and Address 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

Signature _____ Date _____

.....

DO NOT DETACH

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization of 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 progress. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

.....

DO NOT DETACH

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wages or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Social Security No. _____ Date: _____

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No Fault Authorization for Health Information Disclosure

Patient Information

Patient Name: _____ Street Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Claim Number: _____ Date of Injury: _____

I hereby authorize: _____
Insurance Company Name

REQUESTOR/RECIPIENT INFORMAION

Please disclose the following protected health information to:

Seaview Orthopaedics
1200 Eagle Avenue
Ocean, NJ 07712
Ph: (732) 660-6200
Fax: (732) 988-4705

Please indicate the information or type of information to be disclosed:
All Independent Medical Examination Report's for Orthopaedic and Pain Management & Rehabilitation.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the Privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released to this authorization. I understand that the information release pursuant to this authorization is subject to redisclosure by the recipient and may not longer be protected by the HIPAA rule. Unless otherwise revoked, this authorization will expire in six months or on the following date: _____.

I understand that any disclosure of information may be subject to re-disclosure and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.
IF YOU DO NOT WISH THIS INFORMATION NOTED IN THE PRECEDING PARAGRAPH TO BE RELEASED, PLEASE INITIAL; DO NOT RELEASE _____.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Description of Representative's Authority (witness signature required) Signature of Witness

** A photostatic copy of the within authorization shall be as effective and valid as the original.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION
SEAVIEW ORTHOPAEDIC AND MEDICAL ASSOCIATES

By completing this form, you will help ensure payment to Seaview Orthopaedic and Medical Associates ("Seaview") for services under your health insurance policy or benefit plan.

I hereby assign to Seaview my right to receive reimbursement for health care services provided to me and/or to any beneficiary under my health benefits plan and assign my legal claim to benefits under the plan, including but not limited to, my right to appeal and sue for such reimbursement and benefits. This assignment applies to all medical benefits, i.e., Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I or my beneficiary am entitled. I hereby authorize Seaview to file claims with all such plans and carriers for services rendered to me and/or my beneficiary and further authorize and direct my insurance benefits to be paid directly to Seaview. I understand and agree that, if a reimbursement check is made payable to Seaview and me, that I promptly will take such action as requested by Seaview to endorse the check so that Seaview can be paid for services rendered.

I understand that I am financially responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no way releases me from this responsibility and imposes no obligation on Seaview to collect money on my behalf. I have been given a list of Seaview Orthopaedic and Medical Associates participating insurances and agree that if my insurance is out of network, I will be responsible for fees that may be in excess of my copayment, coinsurance or deductible.

I hereby authorize Seaview to release to my insurer, health plan and/or any authorized employee or agent of same such of my medical information and records necessary to secure payment for services rendered.

I have read, understand and agree to the above. A photocopy of this agreement shall be considered as effective and valid as the original. This Assignment of Benefits will be effective until revoked by me in writing. Any revocation shall have a prospective effect only.

Patient's Name: _____

Patient/Guardian Signature: _____

Primary Insured's Signature (if different): _____

Date: _____

Seaview Orthopaedic and Medical Associates
Financial Policy and Patient Agreement

We understand that choosing a health care provider is an important decision and we appreciate you choosing Seaview Orthopaedic & Medical Associates. We are happy to explain our services, our financial policies, and the fees for our services, or the basis for determining the fees to be charged, and answer any questions you may have. We will provide a list of our current fees for standard services, upon request.

We do not charge a fee for preparing an insurance claim form on your behalf. We will charge a missed appointment fee if you fail to notify us at least twenty-four (24) hours in advance of your scheduled appointment.

We also know that insurance plans and payments are increasingly complex for our patients. We want you to understand your benefits and the financial arrangements for paying for the cost of your care. We will provide you a list of health insurers with which we are in-network, including Medicare. We do accept out-of-network benefits for all other insurance plans. These out-of-network benefits are different than if you received services from an in-network provider. Your insurance plan may require multiple copays, higher deductibles, and coinsurance. Coverage will depend on the type of plan you have chosen. The amount, or estimated amount, that we will bill you for our services is available to you upon request and will be explained to you prior to providing services.

Financial Responsibility

As used below, “you” and “your” mean the patient/person financially responsible for payment for the patient’s care.

Although you are responsible for the entire bill when the services are rendered, it is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you. While we will make a good faith attempt to verify your benefits prior to the first appointment, this is no guarantee that our services will be completely covered. You are responsible for understanding the details of your health insurance coverage, as well as fulfilling any requirements for coverage, such as pre-authorizations. Required co-payments and estimated co-insurances are to be made as services are rendered. Arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known.

If any payments of medical benefits are made directly to you for services rendered by Seaview Orthopaedic, you must remit such payment directly to Seaview Orthopaedic within ten (10) days of receipt. We will ask you to sign an Assignment of Benefits authorizing us to receive payments from your health plan for the services we rendered to you.

If you are a Workers’ Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for the total amount of your charges if your Workers’ Compensation claim is denied.

As a service to you, we will keep a copy of your insurance card on file and will submit an insurance claim on your behalf to your insurance company with the information you have provided us. You must provide accurate information and any updates to your insurance information. Payment options at the time of service include cash, check or credit card. With your authorization, we will charge an approved credit card for the patient balance as determined by the insurance company once we have submitted a claim and received the Explanation of Benefits.

If your medical benefits are not paid within thirty (30) days, the balance will be due in full from you.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and reasonable attorney fees, as allowed by law.

Financial hardship should never stand in the way of needed services. A determination of financial hardship can only be made on a case-by-case basis, in compliance with all of the rules applicable to our practice. Upon obtaining necessary information from you, we can make a good faith determination as to whether your circumstances constitute a financial hardship and what payment plan options you may have, including installment payments. Please speak to our patient advocate if you have any questions about our financial hardship policy.

Patient Agreement:

I have been informed if any of the services rendered to me by Seaview Orthopaedic and Medical Associates will be reimbursed at an out-of-network level. I knowingly, voluntarily and specifically select Seaview Orthopaedic and Medical Associates as my provider. I have read the above information and I understand and accept the terms and conditions of the above and I or my Guarantor will be responsible for the payment of my account.

Signature: _____ **Date:** _____

Please circle one: Patient / Guardian / Guarantor

Print Patient Name:

_____

Print Guardian/Guarantor Name:

_____

Seaview Orthopaedic and Medical Associates

Opioid Medication Agreement

Please read through each statement carefully and sign the last page of this packet. By signing this packet you are agreeing with all terms listed. Should you be prescribed an opioid medication you would be expected to follow all rules listed.

- I understand that my provider may recommend opioid medication to treat my pain.
- I understand that this medication may be prescribed if the provider believes it is needed to treat moderate to severe pain after other treatments are unsuccessful.
- I understand that many medications can have interactions with opioids and may increase or decrease their effect.
- I understand that I must regularly update my current medication list with my provider.
- I will tell my provider the truth about my complete personal drug and/or alcohol history as well as the complete drug and/or alcohol history of my family.
- I understand that the start of an opioid medication is a test. Continuation of this medication is based on evidence of benefit, side effects, and compliance of this medication.
- I have received the opioid information packet informing me of certain risks associated with opioid medication as well as the proper methods of disposal for opioid medications.
- I understand that if I suspect that I may be pregnant, or plan on becoming pregnant, I will notify my provider immediately.
- I understand that there are many non-opioid medications and alternative treatments that do not involve the use of opioids. Having been informed of these non-opioid medications and alternative treatments, I freely consent to the use of opioid medications.
- I understand that I will take my medications only as prescribed and I will not change the amount or dosage frequency without approval from my provider.
- I understand that unauthorized changes to my medications may result in my medications running out early. Early refills may not be allowed.
- I understand that I am responsible for my medication and it may not be replaced if it is lost, damaged, or stolen.
- I understand that if I do not stop my medications correctly, I may have withdrawal reactions that may include stomach pain, nausea, vomiting, sweating, anxiety, and general discomfort.

- I understand that I will obtain all opioid prescriptions from my provider or, during his or her absence, by the covering provider.
- I understand that I must keep (and be on time for) all of my scheduled appointments with my provider.
- I understand that requests for medication refills must be made Monday through Friday from 8am – 4pm, two working days ahead of when my prescription runs out.
- I understand that my provider may request to assess my response to my medication prior to giving a refill.
- I will obtain all controlled schedule medications from one pharmacy. I will notify my provider any changes to my current pharmacy.
- I hereby permit my provider to discuss all diagnostic and treatment details of my condition with all of my other providers and the pharmacists at the dispensing pharmacy.
- I understand that my provider will have access to and frequently check my controlled medication prescription history.
- I understand that I may have to submit random pill counts as well as urine and/or blood drug tests as requested by my provider to monitor my treatment. If I refuse or skip my appointment for drug testing, I understand that my treatment may be stopped.
- I will not share, sell, or otherwise permit others to have access to my medication.
- I will not consume alcohol while taking opioid medications.
- I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do my treatment may be stopped.
- I will treat the staff respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment may be stopped.
- Upon completion of opioid medication I will give my left over medication to the police station or any prescription drug drop box. (for a list of medicine drop box locations please ask the front desk)
- I understand that if I, at any time, do not follow the rules of this contract or I am found to be untruthful about my drug, alcohol, medical, or prescription history, it could result in the discontinuation of further treatments, discharge from practice, and/or a prompt referral for assessment of addiction or chemical dependency.

We here at Seaview Orthopedics and Medical Associates are committed to work with you in your efforts to get better. To aid in you in this work, we agree that:

- We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointments for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
- We will keep track of your prescriptions and test for drug use every so often to help you feel like you are being monitored well.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set up treatment goals and monitor your progress in reaching those goals.
- We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
- If you become addicted to these medications, we will help you get treatment so you can get off the medications safely.

I have read and understand the terms and conditions in the Opioid Medication Agreement. I have had the opportunity to ask questions. I agree to fill my prescriptions with only one pharmacy. If I need to change pharmacies, I will notify my physician about the change. I understand each of the statements written in the Opioid Medications Agreement and by signing, give my consent for treatment of my pain condition with opioid medications.

Pharmacy name and Address: _____

Phone number: _____ Fax number: _____

_____ _____ _____

Patient signature Printed name Date

_____ _____ _____

Provider signature Printed name Date

SEAVIEW ORTHOPAEDICS

Communication Preference Form

Patient Name (please print): _____

Date of Birth: _____

Please indicate which of the following numbers you would like for us to use:

❑ Home Phone: (____) _____-_____

❑ Work Phone: (____) _____-_____

❑ Cell Phone: (____) _____-_____

E-mail: _____

Please note, if you supply a cell phone number and/or an email address, you will receive appointment reminders through these methods. You may later opt-out of them if you wish.

What is your preferred communication method? ❑ Email ❑ Phone ❑ Text

In an effort to guard your privacy, please answer the following questions on how best to contact you regarding communication from Seaview Orthopaedic and Medical Associates.
In regards to messages left on voicemail or an answering machine, you authorize your doctor or staff (*please choose one*):

❑ To leave messages regarding your medical condition(s), as well as appointment reminders, billing/financial questions, and requests to call the office.

❑ To leave only messages regarding appointment reminders and requests to call the office. Do not reference your medical condition(s) in the message.

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize Seaview Orthopaedic and Medical Associates to disclose your PHI to the following individuals (check all that apply):

Name: _____ Relationship to Patient: _____
Telephone: ( ) _____ Email: _____

Name: _____ Relationship to Patient: _____
Telephone: ( ) _____ Email: _____

Name: _____ Relationship to Patient: _____
Telephone: ( ) _____ Email: _____

Authorization

All of the above information has been approved by the patient and/or their representative. I understand I may notify the doctor's office at any time of changes to this consent, which would require a new form and authorization to be completed.

I understand that during the transmission of text/email messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure.

Signature: _____ **Date:** _____

This acknowledgement was signed by: _____

Printed Name – Patient or Representative: _____

Relationship to Patient (if other than patient): _____

Seaview Orthopaedic and Medical Associates
Notice of Privacy Practices

This notice describes how medical information (Protected Health Information or "PHI") about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Our Uses and Disclosures

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: During the course of your treatment, the physician determines that he/she will need to consult with your primary care physician. The physician will share information with that physician and obtain the physician's input.

Health Information Exchange – We, along with other New Jersey health care providers, participate in Jersey Health Connect, a health information exchange (HIE) which allows patient information to be shared electronically through a secured network that is accessible to the providers treating you. We may disclose your PHI to Jersey Health Connect HIE, unless you opt out of participating in the HIE.

Run our organization (our health care operations)

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurer so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, for example, with the U.S. Dept of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests - We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests - We can use or share health information about you, in accordance with applicable law:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Occupational Health - We may disclose your Protected Health Information to your employer in accordance with applicable law, if We are retained to conduct evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or as required by applicable law.

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy.
- We will not use or share your information other than as described here unless you authorize us in writing. You can revoke your authorization at any time, for future uses and disclosures of your information. Let us know in writing if you want to revoke an authorization.

Your Rights

When it comes to your health information, you have certain rights. The health and billing records we maintain are the physical property of our office but the information in those records belongs to you, unless limited by applicable law. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to inspect or get an electronic or paper copy of your medical record. Ask us how to do this (including through our patient portal).
- We will provide a copy of your medical record within 30 days of your request. We will charge a reasonable, cost-based fee as allowed by law, which you will be advised of in advance.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home rather than office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information (for the purpose of payment or our operations) with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why, except for certain disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Alcohol or substance abuse treatment information
- Confidential HIV-related information
- Genetic information
- Mental Health/Psychotherapy notes

We may contact you for fundraising efforts, but you can tell us not to contact you again.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting our Privacy Officer at 1200 Eagle Avenue, Ocean, NJ 07712 or at (732) 660-6200. You can file a complaint with the U.S. Dept of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Notice revised and effective: March 05, 2018

SEAVIEW ORTHOPAEDIC AND MEDICAL ASSOCIATES
NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____

This acknowledgement was signed by: _____

Printed Name – Patient or Representative: _____

Relationship to Patient (if other than patient): _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Reason:
Employee Name:	Employee Signature:

DISCRIMINATION IS AGAINST THE LAW

Seaview Orthopaedics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Seaview Orthopaedics does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Seaview Orthopaedics provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters;
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Seaview Orthopaedics provides free language services to people whose primary language is not English, such as information written in other languages.

If you need these services, contact Seaview Orthopaedics' Compliance Officer.
Name: Jeanette Jepson
Mailing Address: 1200 Eagle Avenue, Ocean, NJ 07712
Telephone number: 732-660-6200 Ext. 1013
Fax: 732-660-6226
Email: jjepson@seavieworthо.com

If you believe that Seaview Orthopaedics has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Seaview Orthopaedics' Compliance Officer. You can file a grievance in person or by mail, fax, or email. If you need help ling a grievance, Seaview Orthopaedics' Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, Language assistance services, free of charge, are available to you. Call 1-800-225-5254.	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-225-5254.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-225-5254.	**تفم تامدخ یک ددم یک نابز وک پآ وت ،دیه ےتلوب ودرا پآ رکا :رادربخ دیرک .1-800-225-5254 .لاک ـ دیه بایتسد دیم**
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-225-5254.	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-225-5254.
注意:如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-225-5254.	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-xxx-xxx-xxxx. Call 1-800-225-5254.
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-225-5254.	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-225-5254**. पर कॉल करें।
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-225-5254.	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-225-5254.
ةظوحلم: قيوغللا ةدعاسملا تامدخ نإف ،ةغللا ركذا ثدحتت تنك اذإ .ناجملاب كل رفاوتت 1-800-225-5254 مقرب لصتا.	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-225-5254.
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-225-5254.	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-225-5254.

Insurance Disclosure Form

Updated May 2024

Seaview Orthopaedic and Medical Associates participates with the following health benefits insurance plans:

Horizon BCBS of NJ

Horizon PPO Network

- Horizon MyWay HRA PPO
- Horizon MyWay HSA PPO
- Horizon PPO

Horizon Managed Care Network

- Horizon Advantage EPO
- Horizon Blue Card
- Horizon Braven Medicare
- Horizon Direct Access
- Horizon EPO/EPO Plus
- Horizon HMO
- Horizon Medicare Blue (PPO)
- Horizon Medicare Blue Access (HMO-POS)
- Horizon Medicare Blue Advantage (HMO)
- Horizon Medicare Blue Choice w/Rx (HMO)
- Horizon Medicare Blue Group (PPO) Horizon Medicare Blue Group w/Rx (PPO)
- Horizon Medicare Blue Value (HMO)
- Horizon Medicare Blue Value w/Rx (HMO)
- Horizon MyWay HRA Direct Access
- Horizon MyWay HSA Direct Access
- Horizon POS
- Horizon Patient-Centered Adv EPO
- NJ Direct
- NJ Direct MA PPO
- OMNIA
- OMNIA Bronze
- OMNIA Gold
- OMNIA HSA
- OMNIA Platinum
- OMNIA Silver
- OMNIA Silver HSA

United HealthCare

Commercial

- Charter Balanced
- Charter HMO
- Charter Plus
- Choice
- Choice Plus
- Core
- Core Essential
- Core HMO
- Navigate
- Navigate Balanced
- Navigate Plus
- Options PPO
- Select
- Select Plus

Oxford

- Oxford Freedom
- Oxford Metro
- Oxford Liberty

Qualcare

- HMO Network
- PPO Network
- POS Network
- QualLynx Worker's Compensation Products

Aetna

- HMO Network
- PPO Network
- EPO Network
- POS Network
- QPOS Network
- Elect Choice
- Open Choice
- Managed Choice POS
- Aetna Choice POS II
- Aetna Select
- Aetna Student Health
- Aetna Medicare HMO
- Aetna Medicare PPO
- Aetna Meicare PPO with Extended Service

Medicare

Medicare Advantage

- AARP Medicare Complete (HMO)
- AARP MedicareComplete Plan 1 (HMO)
- AARP MedicareComplete Plan 2 (HMO)
- AARP MedicareComplete Plan 3 (HMO)
- AARP MedicareComplete Plan 4 (HMO)
- AARPMedicareComplete Essential (HMO)
- Erickson Advantage Champion (HMO-POS SNP)
- Erickson Advantage Freedom (HMO-POS)
- Erickson Advantage Guardian (HMO-POS SNP)
- Erickson Advantage Signature with Drug (HMO-POS)
- Erickson Advantage Signature without Drug (HMO-POS)
- UnitedHealthcare Assisted Living Plan (HMO SNP)
- UnitedHealthcare Assisted Living Plan (HMO-POS SNP)
- UnitedHealthcare Assisted Living Plan (PPO SNP)
- UnitedHealthcare Dual Complete (HMO SNP)
- UnitedHealthcare Dual Complete (PPO SNP)
- UnitedHealthcare Dual Complete One (HMO SNP)
- UnitedHealthcare Group Medicare Advantage (HMO)
- UnitedHealthcare Group Medicare Advantage (PPO)
- UnitedHealthcare MedicareComplete Focus (HMO)
- UnitedHealthcare Nursing Home Plan (HMO SNP)
- UnitedHealthcare Nursing Home Plan (HMO-POS SNP)
- UnitedHealthcare Nursing Home Plan (PPO SNP)

Cigna

- Cigna Healthcare of NJ - Northern NJ HMO Seamless - Metro New York
- Open Access Plus
- Choicefund OA Plus with Carelink
- Choicefund OA Plus PPO
- Choicefund PPO

Seaview Orthopaedic and Medical Associates is afflilated with the following facilities, however specific provider participation may vary. For a detailed list, you can refer to our website at seavieworthо.com or speak to one of our billing specialists:

Hospital Affiliation: Jersey Shore University Medical Center, Ocean Medical Center, Monmouth Medical Center, CentraState Hospital, Bay Shore Hospital, St. Peter's Hospital

Ambulatory Surgery Center Affiliation: Shrewsbury Surgery Center, Toms River Surgery Center, Surgicare of Freehold, Lakewood Surgery Center, Surgical Institute, Metropolitan Surgical Institute (Dr. Sunil Thacker) , Specialty Surgery Center of Middletown (Dr. Keiron Greaves), Center for Advanced Surgery (Dr. Frederick Depaola)