Ilya Kupershtein, MD, PC
Spine and Scoliosis Surgery
Board Certified and Fellowship Trained

TO THE PATIENTS OF SPINE SURGERY

Please complete all new patient history forms prior to your appointment. If you do not have your form or have them completed prior to your appointment, you MUST ARRIVE 30 MINUTES PRIOR TO COMPLETE THEM. If you are previous

patient and have not seen the physician in over ci year, please complete the forms again with an update on your symptoms.

Please bring in all imaging CD's or Films to your appointment.

Please bring in all office notes and/or procedure reports from any physician (s) who have treated your condition. This includes any

injection and/or surgery reports.

In the event you need to reschedule or cancel your appointment, please call our office 48 hours prior to your scheduled appointment. Failure to do so may results in a cancellation fee and/or discharge from our practice.

Please note that if you do not have all the proper information for your appointment, your appointment may be rescheduled

If you would like to submit your records to our office prior to your appointment you can do so be either faxing it to 908-396-1320 or send it via email: ikupershtein@njss.net

We are located at:
33 Overlook Road STE305
Summit NJ 07901-356
908-376-1525
Fax#908-396-1320

Ilya Kupershtein MD PC
Spine and Scoliosis Surgery
T : (908) 376-1525 / F: (908) 396-1320

MAC Building, I – Suite 305
33 Overlook Rd, Summit, NJ 07901

Harries Pavilion – 2nd Floor
1 Bay Avenue, Montclair, NJ 07028

1. Patient Information

please print clearly and complete ALL fields

Name: _____ Social Security No: _____ - ___ - _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: _____

Address: _____ City, State, Zip: _____

Home phone: (___) _____ Cell: (___) _____ Work: (___) _____ Ext. _____

Email: _____ Personal info. ☐ may ☐may not be sent to this e-mail

Height: _____ **Weight:**_____

Family Physician: _____ Phone: ( ) _____

Address: _____ City_____, State_____, Zip: _____

Do you want your medical records sent to this physician? Yes No

How were you referred: Physician Patient/Friend Insurance Other: _____

Referred by: _____ Address: _____

City, State, Zip: _____

Do you want your medical records sent to this physician? Yes No

Patient Employer: _____ Occupation: _____ Phone: ( ) _____

Employer Address: _____ City, State, Zip: _____

Spouse's Name: _____ Spouse's Employer: _____

Employer Address: _____ City, State, Zip: _____

Spouse's Work Phone: Work: ( ) _____ Ext. _____ Spouse's Date of Birth: _____

Party response for Payment (if minor): _____ Relationship to patient: _____

Address: _____ City, State, Zip: _____

Reason for Visit: Major Complaint: _____

Injury/accident: ☐ yes ☐ no (If yes check one and complete #3 below): ☐ motor vehicle ☐ work-injury ☐ other

Date of Injury or Onset of Problem: _____ Injury Location: _____

Injury details: _____

_____

2. Work/Auto Related Injuries

for Work or Auto Related Injuries Only

Insurance Company: _____ Claim Number: _____

Address: _____ City, State, Zip: _____

Insurance Phone # : (___) _____ Insurance

Contact Person : _____

Was work injury reported to employer? ☐ yes ☐ no If so, to whom? _____

4. In Case of Emergency

Name of Friend or Relative not living with you (other than spouse): _____

Address: _____ City, State, Zip: _____

Home phone#: ( )_____ Work#: ( )_____ Ext._____ Cell#: ( )_____

5. Medication Allergies

☐ I do not have any allergies that I know of.

Please list all allergies: _____

_____

_____

_____

6. Pharmacy Information

Name: _____

Address: _____

City, State: _____

Phone #: _____

Treatment Authorization

Personal information ☐ may be ☐ may is not left on my ☐ home phone ☐ cell phone

I authorize the release of my personal information to the following individual(s): _____

_____

I hereby authorize **Ilya Kupershtein MD PC** to furnish any designated insurance company all information necessary to file an insurance claim.

Legal Assignment of Benefits and Release of Medical and Plan Documents

I have provided complete and accurate demographic and insurance information, allowing **Ilya Kupershtein MD PC** to act as my billing agent for services rendered. In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to **Ilya Kupershtein MD PC** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments which I am entitled to, including Medicare, other government sponsored programs, private insurance, personal injury protection, workman's compensation, and any other insurance plans to **Ilya Kupershtein MD PC**.

I hereby authorize the doctor to release all medical information necessary to process this claim and all claims associated with his care whether billed directly by him. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Arbitration

I authorize **Ilya Kupershtein MD PC** to arbitrate any Personal Injury protection (PIP) insurance-based denials of coverage/claims on my behalf and to release all pertinent medical records required to pursue such arbitration.

I certify that I have read the foregoing information and understand the above contents. I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Signature of Insured or Guardian: _____

Date: _____

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SUMMIT OFFICE
33 Overlook Road, Suite 305
Summit, New Jersey 07901
T: (908) 608-9610
F: (908) 608-9611

MONTCLAIR OFFICE
1 Bay Avenue, Harries Pavilion
Montclair, NJ 07028
T: (908) 608-9610
F: (908) 608-9611

ACKNOWLEDGEMENT & AGREEMENT

I _____ acknowledge that I have been advised that Iyla Kupershtein MD PC does not participate with my insurance carrier and I have been advised that I will be utilizing my out-of-network benefits. I understand that as a courtesy, his office will bill my insurance company directly for services rendered.

I acknowledge that I have been advised that my insurance carrier may issue payment for services rendered directly to me. I will immediately forward all insurance checks and copies of correspondence enclosed with the check directly to Iyla Kupershtein MD PC without delay.

Failure to promptly forward the payment may result in:
Late Payment Penalties, Interest, Collection and Legal Action

_____ _____
Signature Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Iyla Kupershtein MD PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Iyla Kupershtein MD PC is not required to agree to the restrictions requested. I understand that I may revoke this consent, in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Iyla Kupershtein MD PC reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Iyla Kupershtein MD PC change their notice, they will send a copy of and revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health insurance:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I understand that Iyla Kupershtein MD PC may provide my PHI to a family member, friend or other person that I indicate is involved in my care or the payment for my health care, unless I object in whole or in part.

I fully understand and accept / decline the terms of this consent.

_____

Patient's Signature

_____

Date

FOR OFFICE USE ONLY

[ ] Consent received by_____on _____.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on _____.

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Summit NJ 07901
908-376-1525

REQUEST AND AUTHORIZATION TO USE OUTSIDE HEALTH INFORMATION

PLEASE COMPLETE THE FOLLOWING FORM IN FULL

I,_____
[PATIENT'S NAME] First Middle Last Date of Birth (mm/dd/yyyy)

Hereby authorize: _____
Provider's Name

Address: _____

Telephone #:_____ **Fax #:**_____

To receive all the following Health Information about me (*check each box that applies*):

☐ **My entire medical record** ☐ **Office visit notes** ☐ **Diagnostic test results**

☐ **Radiology Studies (MRI, X-ray, etc)** ☐ **Hospital abstract** ☐ **Op report**

☐ **Other - Specify Information Required:**_____

_____

_____

RELATING TO THE TIME PERIOD_____through_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment, payment, enrollment, or eligibility for benefits. I understand that I may inspect or obtain a copy of the information to be used and disclosed, as provided in 45 CFR 164.524.

I understand that once my information is disclosed to the recipient above, it may be re-disclosed to individuals not subject to HIPAA. I further understand that any disclosure of information carries with it the potential for an un- authorized re-disclosure and the information may not be protected by federal and/or state confidentiality rules.

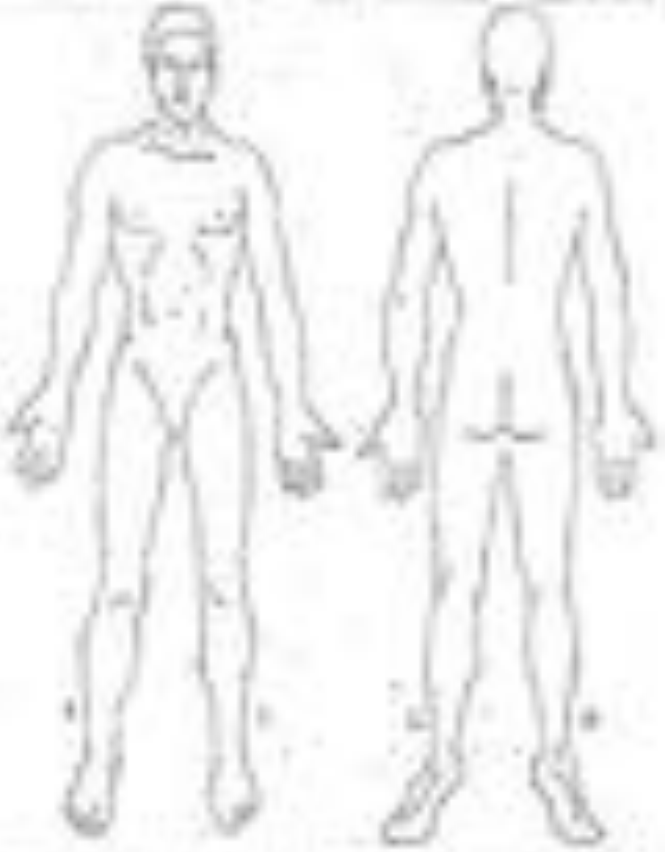
I understand that I have the right to revoke this Authorization, at any time before the provider's reliance thereon, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this Authorization is set forth in Provider's Notice of Privacy Practices.

_____

Signature of Patient or Personal Representative Date_____

Description of Personal Representative's Authority:_____

(please explain and attach required documentation)_____



HISTORY OF PRESENT COMPLAINT

1. Age ______ ☐ Male ☐ Female

2. Where is your problem located? ☐ Neck ☐ Lower Back ☐ Arm ☐ Leg
☐ Right ☐ Left

3. How long have you had this problem? ______________________ Onset? ___/___/___
month day year

4. Briefly, please give the details of how this problem originally started.

____

____

____

____

5. Was this from a work-related injury? ☐ No ☐ Yes
Have you missed any work days because of this problem? ☐ No ☐ Yes, how many? ________

6. Please describe your present (and previous) care (what you had, where, when, etc.)

____

____

____

7. List all other physicians with whom you have consulted in the past year for this problem.

____

8. Have you had spinal surgery in the past? (Check one) ☐ Yes ☐ No How many times? ________

What type of surgery has been performed? ☐ Discectomy ☐ Laminectomy ☐ Fusion

☐ Unknown ☐ Other ______________ What spinal level? ________

What was the date of your most recent spine surgery? ______________________

[illegible] ☐ Yes ☐ No

9. Which of the following best describes the percentage of back & arm or back & leg [illegible]

Back

A. 100% back pain and 0% leg pain
B. 80% back pain and 20% leg pain
C. [illegible]
D. [illegible]
E. [illegible]
F. [illegible]
G. 0% back pain and 100% leg pain

Neck

A. 100% neck pain and 0% arm pain
B. 80% neck pain and 20% arm pain
C. [illegible]
D. [illegible]
E. [illegible]
F. [illegible]
G. 0% neck pain and 100% arm pain

CURRENT PAIN PROFILE

10. Please choose letters A–F (in first column) to answer the question(s) in column two.

A. Unable to tolerate	How long can you sit? ________
B. About 15 minutes only	How long can you stand? ________
C. About 30 minutes only	How long can you walk? ________
D. About 45 minutes	
E. About 1 hour	
F. Indefinitely	

11. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Leaning forward (bending neck)	☐	☐	☐
Bending forward	☐	☐	☐
Lying on your side	☐	☐	☐
Lying on your back	☐	☐	☐
Lying on your stomach	☐	☐	☐
Rising from sitting	☐	☐	☐
Changing positions	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐

Now go back and CIRCLE the box to indicate the <u>most aggravating activity</u> and the <u>most relieving activity</u>.

12. Does your pain wake you up at night?

☐No ☐Yes ☐Daily ☐less than 3 days a week ☐more than 3 days a week

13. If your pain has changed, please indicate the most appropriate statement (Circle one)

A. My symptoms are **more** severe since the time of onset.
B. My symptoms have **remained the same** since the time of onset.
C. My symptoms are less severe since the time of onset.

14. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	YES	NO	When/Where
Regular X-rays of spine	☐	☐	________
CT scan of spine	☐	☐	________
MRI	☐	☐	________
Myelogram	☐	☐	________
Bone Scan	☐	☐	________

[illegible]. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury (Check one of each):

	Type/Duration (number/months)	Helpful	No Help	Not Used
Anti-inflammatory		☐	☐	☐
Muscle Relaxants		☐	☐	☐
Narcotic Pain Medications		☐	☐	☐
Hot Packs		☐	☐	☐
Ice		☐	☐	☐
Ultrasound		☐	☐	☐
TENS Unit/ Muscle Stim		☐	☐	☐
Physical Therapy (Duration)		☐	☐	☐
Back/Neck Exercises		☐	☐	☐
Chiropractor		☐	☐	☐
Epidural Steroid Injection		☐	☐	☐
Facet Block Injection		☐	☐	☐
Trigger Point Injection		☐	☐	☐
Acupuncture		☐	☐	☐
Other:		☐	☐	☐

Allergies	
Medication	Reaction

Current Medications	
Name	Dose

MEDICAL HISTORY

- ☐ No medical problems
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart failure
- ☐ Abnormal heart rhythm
- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other illness
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Stomach ulcers
- ☐ Irritable bowel
- ☐ Stroke
- ☐ Seizures
- ☐ Cancer - where? ________
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Bleeding disorders
- ☐ Anemia
- ☐ Blood clots in legs/ lung
- ☐ Fibromyalgia
- ☐ Ovarian cysts
- ☐ Anxiety
- ☐ Depression
- ☐ Schizophrenia
- ☐ Substance abuse
- ☐ Alcoholism
- ☐ Seen a psychiatrist
- ☐ HIV

Are you under a doctor's care for any other medical condition? ☐ Yes ☐ No
If yes, please explain

SURGICAL HISTORY

Please choose all surgeries you have had

- ☐ Spine: Neck
- ☐ Spine: Lower back
- ☐ Brain
- ☐ Heart
- ☐ Angioplasty / ☐ Stent
- ☐ Lung
- ☐ Appendix / ☐ Hernia
- ☐ [illegible] / ☐ Colon / ☐ [illegible]
- ☐ Hysterectomy / ☐ Ovaries / ☐ [illegible]
- ☐ Kidneys / ☐ Bladder / ☐ Ureters
- ☐ Shoulders / ☐ Arms / ☐ Hands
- ☐ Hips / ☐ Knees / ☐ Legs / ☐ Feet
- ☐ Eyes
- ☐ Ears
- ☐ Nose
- ☐ Breast / ☐ [illegible]
- ☐ Prostate
- ☐ Pacemaker/ ☐ [illegible]

Other: ________________________________

SOCIAL HISTORY

[illegible] Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

[illegible] Number of Children ________

[illegible] ☐ Live ☐ Alone ☐ With: ____________________

[illegible] Are you a cigarette smoker? ☐ Yes ☐ Never ☐ Quit – How long ago did you quit? ____

If you answered "yes" or "quit", how much do or did you smoke per day?
☐ Less than ½ pack ☐ ½ pack ☐ More (how many?) ________

[illegible] Do you drink any alcoholic beverages? (Check one)
☐ None ☐ 1 to 2 drinks per day ☐ Socially ☐ Occasionally

[illegible] Current work status: ☐ Working full time ☐ Working restricted duty (Hours ____)
☐ Retired ☐ Disabled (Since ______) ☐ Student ☐ Homemaker ☐ Unemployed

Employer: ______________ Occupation: ______________ Title: ______________

[redacted]

[redacted]

Please check off any current or recent problems you have.

[redacted]

- [ ] [redacted]
- [ ] [redacted]
- [ ] [redacted]
- [ ] [redacted]
- [ ] [redacted]
- [ ] [redacted]

[redacted]

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- [ ] [redacted]
- [ ] [redacted]

THE OSWESTRY DISABILITY INDEX FOR BACK PAIN

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section and mark in each section the one box that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your present day situation.

Section 1: Pain Intensity

☐ A. My pain is mild to moderate. I do not need pain killers.
☐ B. The pain is bad, but I manage without taking pain killers.
☐ C. Pain killers give complete relief from pain.
☐ D. Pain killers give moderate relief from pain.
☐ E. Pain killers give very little relief from pain.
☐ F. Pain killers have no effect on the pain.

Section 2: Personal Care

☐ A. I can look after myself normally without causing extra pain.
☐ B. I can look after myself normally, but it causes extra pain.
☐ C. It is painful to look after myself and I am slow and careful.
☐ D. I need some help, but manage most of my personal care.
☐ E. I need help every day in most aspects of self-care.
☐ F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3: Lifting

☐ A. I can lift heavy weights without causing extra pain.
☐ B. I can lift heavy weights, but it gives me extra pain.
☐ C. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ E. I can lift only light weights.
☐ F. I cannot lift or carry anything at all.

Section 4: Walking

☐ A. I can walk as far as I wish.
☐ B. Pain prevents me from walking more than 1 mile.
☐ C. Pain prevents me from walking more than ½ mile.
☐ D. Pain prevents me from walking more than ¼ mile.
☐ E. I can walk only if I use a cane or crutches.
☐ F. I am in bed or in a chair for most of every day.

Section 5: Sitting

☐ A. I can sit in any chair for as long as I like.
☐ B. I can sit in my favorite chair only, but for as long as I like.
☐ C. Pain prevents me from sitting for more than 1 hour.
☐ D. Pain prevents me from sitting more than ½ hour.
☐ E. Pain prevents me from sitting for more than 10 minutes.
☐ F. Pain prevents me from sitting at all.

Section 6: Standing

☐ A. I can stand as long as I want without extra pain.
☐ B. I can stand as long as I want, but it gives me extra pain.
☐ C. Pain prevents me from standing for more than 1 hour.
☐ D. Pain prevents me from standing more than ½ hour.
☐ E. Pain prevents me from standing more than 10 minutes.
☐ F. Pain prevents me from standing at all.

Section 7: Sleeping

☐ A. Pain does not prevent me from sleeping well.
☐ B. I sleep well, but only when taking medication.
☐ C. Even when I take medication, I sleep less than 6 hours.
☐ D. Even when I take medication, I sleep less than 4 hours.
☐ E. Even when I take medication, I sleep less than 2 hours.
☐ F. Pain prevents me from sleeping at all.

Section 8: Social Life

☐ A. My social life is normal and causes me no extra pain.
☐ B. My social life is normal, but increases the degree of pain.
☐ C. Pain affects my social life by limiting only my more energetic interests such as dancing, sports, etc.
☐ D. Pain has restricted my social life and I do not go out as often.
☐ E. Pain has restricted my social life to my home.
☐ F. I have no social life because of pain.

Section 9: Sexual Activity

☐ A. My sexual activity is normal and causes no extra pain.
☐ B. My sexual activity is normal, but causes some extra pain.
☐ C. My sexual activity is nearly normal, but is very painful.
☐ D. My sexual activity is severely restricted by pain.
☐ E. My sexual activity is nearly absent because of pain.
☐ F. Pain prevents any sexual activity at all.

Section 10: Traveling

☐ A. I can travel anywhere without extra pain.
☐ B. I can travel anywhere, but it gives me extra pain.
☐ C. Pain is bad, but I manage journeys over 2 hours.
☐ D. Pain restricts me to journeys of less than 1 hour.
☐ E. Pain restricts me to necessary journeys under ½ hour.
☐ F. Pain prevents traveling except to the doctor/hospital.

Patient Name: ______________________

Date: ____________ Score: ____________

New Jersey Department of Banking and Insurance

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

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

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

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

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

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

INDEPENDENT ARBITRATION OF CLAIMS

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

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

I, [PRINT NAME], by marking [√] (or [x]) and signing below, agree to:

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

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

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

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

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

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

New Jersey Department of Banking and Insurance

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

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

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

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

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

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

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

Signature: _____ Ins. ID#_____ Date:_____
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

Contact Information of Personal Representative

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

PRINT NAME: _____

ADDRESS:_____

_____

PHONE: _____ FAX: _____ EMAIL: _____

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