ORTHOPEDIC SPINE AND SPORTS MEDICINE CENTER
2 FOREST AVENUE
PARAMUS, NEW JERSEY 07652
201-587-1111

To our new patients:

Enclosed please find a Patient Information Form and our practice brochure. Kindly complete the form and bring it with you on the day of your appointment. Please be sure to also bring your insurance card with you and arrive 15 minutes before your scheduled appointment. This will enable us to prepare your chart in a more timely fashion.

As you can see, the brochure gives you directions to our office and points out the insurance information that is needed.

We have a software product that will call you to confirm your appointment with our physicians. You will be called a few days prior to your appointment. Please listen carefully to the instructions, as you will be asked to reply by touching your phone keys. You will be called again if you do not respond to the software prompts. You will be able to confirm or cancel your appointment as well as leave a message for our office staff.

Our office requires a 24 hour cancellation notice or there will be a $100 No Show Charge.

If you have any questions, please don't hesitate to call our office staff. We thank you for your confidence in us and look forward to meeting your medical needs.

Thank you,

Gary J. Savatsky, MD
Bernard P. Newman MD
Peter H. Schmaus, MD
Paul E. Kovatis, MD
Michael E. Loreti, MD

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The past few years have brought many changes in healthcare. Insurance companies have several types of plans with varying patient responsibilities. It is difficult for each medical office to know or to keep up with each plan.

It has become more important for you, as the patient, to know and advise us of any changes in your healthcare coverage. The information makes the reimbursement process smoother and it ensures that your medical services will be covered.

Your co-pay is due at the time of medical services. If you are covered by a managed care program you are responsible for a referral from your primary care physician, if required.

You are responsible for your deductible, if applicable.

Please understand that as the patient, you are ultimately responsible for payment for your medical care.

We thank you for your confidence in us and hope you will continue to be pleased with the medical care we provide.

Sincerely,

Orthopedic Spine and Sports Medicine Center

NOTICE OF PRIVACY PRACTICES AND PATIENT ACKNOWLEDGEMENT

To Our Valued Patient,

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services to our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

It is our policy to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of privacy and integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

NOTICE OF PRIVACY

The Department of Health and Human Services has established a 'Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule provides standards for health care providers to follow when disclosing health information about the patient that is needed to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information. We want to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. You may request restrictions pertaining to parties you do not want PHI released to. You will be asked to authorize release of PHI to any party that is not directly connected to your treatment, payment or health care operations.

If you have any questions, comments or objections to the privacy policies on this form, please speak with one of our staff.

For office use

A "good faith effort" was made to get a signature from patient. Signature was not obtained due to the following:

Orthopedic Spine And Sports Medicine

2 Forest Avenue
Paramus, NJ 07652
(201) 587-1111

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	REFERRING PHYSICIAN	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize payment of medical benefits to the undersigned physician or supplier for these services and all future claims.
I authorize the release of any medical information necessary to process this claim and all future claims.
I acknowledge that I have been given an opportunity to read a copy of the Notice of Privacy Practices for OSSMC.
I acknowledge that I have read and understand the policy regarding my financial responsibility.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____