SHOMAF NAKHJO, DO LLC

PATIENT INFORMATION

I HAVE READ AND UNDERSTAND THE PRIVACY NOTICES

Name:_____
Last First Middle Initial

Date of Birth:_____ Sex: Male Female Marital Status:_____ Name of Spouse:_____

Social Security #:_____ Complete Address:_____

Tel # Home_____ Cell_____ Email_____

Emergency Contact Name & Telephone _____

Name of Primary Doctor_____ Name of Referring Doctor_____

Primary Insurance Information (Please give us our insurance card to make a copy)

Medicare #:_____

Name of Commercial Insurance Company:_____

Address:_____

Policy #:_____ Group #:_____ Referral:_____ Copay:_____

Tel #:_____ Subscriber:_____ Relationship to Patient:_____

Subscriber's Information if Different from Patient: Tel #_____ DOB:_____

Address:_____ Employer Tel #:_____

Employer:_____ Address:_____

Secondary Insurance Information (Please give us your insurance card to make a copy)

Name of Commercial Insurance Company:_____

Address:_____

Policy #:_____ Group #:_____ Referral:_____ Copay:_____

Tel #:_____ Subscriber:_____ Relationship to Patient:_____

Subscriber's Information if Different from Patient: Tel #_____ DOB:_____

Address:_____ Employer Tel #:_____

Employer:_____ Address:_____

THE UNDERSIGNED ALLOWS TO BE RELEASED THOSE RECORDS PERTAINING TO TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Payment Guarantee, Assignment of Medical Benefits & Release of Records

I realize that it is ultimately and lastly my responsibility to pay any bill for services rendered even though Shomaf Nakhjo, DO is submitting an insurance claim for me. I also realize that if the services that Shomaf Nakhjo, DO is rendering me are not covered by my insurance, then I am liable for any balance. I further realize that I am liable for any remaining balance on my account after my insurance company has made their payment towards my bill and I realize that I must pay the outstanding balance.
I hereby request that payment of authorized benefits be made directly to Shomaf Nakhjo, DO LLC for any services furnished to me by those physicians. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient/Guardian Signature Date

SHOMAF NAKHJO, DO LLC

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage with the carrier indicated on my personal review/patient information sheet, and hereby assign and convey directly to Shomaf Nakhjo, DO all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and practice. I agree that if I am reimbursed directly by the insurance carrier, I will immediately endorse all said checks to Shomaf Nakhjo, DO and remit them to him promptly. If said check/s are not received by Shomaf Nakhjo, DO within 10 days of issuance by the insurance carrier, I am aware that my account will be referred to our collection attorneys immediately with interest calculated at 1.40% compounded monthly and collection fees of 33.3% added. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and practice any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and practice 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 practice 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 healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and practice 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 practice in any attempts by such doctor and practice 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 practice's expenses.

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.

_____ _____

Signature of Insured/Guardian Date

_____ _____

Patient Name (please print) Date of Birth

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please ask to speak with our HIPAA Compliance Officer in person or by phone at (908) 490-0036

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is posted in our office or available to you upon request.

Signature below is only an acknowledgement that you have been informed of the Notice of our privacy practices:

Print Name:_____ Signature:_____ Date:_____

Is it ok for Shomaf Nakhjo, DO LLC to leave a voice message and/or text message on your phone: YES OR NO

Pharmacy Name and Address:_____

Release of Medical Information

Please release any and all medical information to the following parties:

Name:_____ Phone #_____

Name:_____ Phone #_____

Signature of Patient:_____ Date:_____

Shomaf Nakhjo, DO

ADVANCED MINIMALLY INVASIVE SURGERY

NEW PATIENT CLINICAL REVIEW Today's Date:_____

Please print and fill out completely

Patient's Name:_____ Date of Birth_____/_____/_____

Please list any allergies to medications and specify type of reaction:_____

_____

Please list any current medical CONDITIONS:_____

_____

Do you have sleep apnea? YES NO Do you use a C-Pap? YES NO

List all previous surgeries you have had and include the dates and place of surgery:

Operation	Where	Date

List any serious illnesses you have had in the past:_____

_____

Do you drink alcohol? YES NO How much do you drink per week?_____

Do you smoke? YES NO If yes, how long and how many cigarettes per day_____ Year Quit:_____

Do you vape? YES NO Do you use chewing tobacco? YES NO

What is your occupation_____

Please list any significant family illness: Mother:_____

Father:_____ Other:_____

Please give us any additional information that you feel is important to your healthcare:_____

_____

183 High Street, Suite 1100, Newton, NJ 07860 • 16 Pocono Road, Suite 208, Denville, NJ 07834
Phone: 973-383-2222 • Fax: 973-383-3344 • advancedsurgeryNJ.com

Shomaf Nakhjo, DO
ADVANCED MINIMALLY INVASIVE SURGERY
183 High Street, Suite 1100, Newton, NJ 07860

MEDICATION RECONCILIATION FORM

NAME: ______________________________

DATE OF BIRTH ______________________ DRUG ALLERGIES: ______________________

MEDICATION	DOSE	HOW OFTEN	REASON FOR TAKING

Shomaf Nakhjo, DO
ADVANCED MINIMALLY INVASIVE SURGERY

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____