BERGEN VEIN CLINIC
Non Surgical Solutions

48 S Franklin Turnpike, Suite 101
Ramsey, NJ 07446
P: (201)-962-9199 F: (201) 962-9198

Name: _____ DOB: ___ / ___ / _____ Gender: ○ Male ○ Female

Address: _____ Race: _____ Age: _____

City: _____ State: _____ Zip: _____ SS #: _____

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Marital Status: _____

Email: _____ Preferred Language: _____

HOW WERE YOU REFERRED TO THIS OFFICE?

○ Doctor- **Name**: _____ ○ Patient ○ Friend ○ Yellow Pages ○ Internet ○ Newspaper

○ Other _____

IN CASE OF EMERGENCY: *PLEASE FILL OUT*

Name: _____ Tel: (_____) _____ - _____

Relationship: _____

Primary Care Physician: _____ Phone#: (_____) _____ - _____

Pharmacy Name: _____ Phone#: (_____) _____ - _____

Pharmacy Address: _____

HEALTH INSURANCE INFORMATION (*PLEASE FILL OUT IF APPLICABLE):*

Name of Insured (*If different from above*): _____ Insured's DOB: ___ / ___ / _____

Primary Insurance Name: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

EMPLOYER INFORMATION

Name: _____ Occupation: _____

Address: _____ Phone #: (____) _____ - _____

City: _____ State: _____ Zip: _____

AUTO ACCIDENT & WORK RELATED INJURY: (*PLEASE FILL OUT IF APPLICABLE)*

Auto Insurance Company: _____

Policy #: _____ Claim #: _____ Date of Injury: ___ / ___ / _____

Adjuster's Name: _____ Adjuster's #: (_____) _____ - _____

WORKER'S COMP: *(FILL OUT ALL APPLICABLE)*

Comp Case #: _____ Date of Injury: ___ / ___ / _____

Adjuster's Name: _____ Adjuster's #: (_____) _____ - _____

Attorney's Name: _____ Attorney's #: (_____) ____ - _____

The above information is true to the best of my knowledge. I authorized my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorized my insurance company to release any information required to process my claims.

Signature: _____ Date: ___ / ___ / _____

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Financial Responsibility Form

PLEASE READ THIS NOTICE CAREFULLY AND SIGN AT THE BOTTOM

Please note that this facility does not participate in your medical insurance plan(s); in other words, Bergen Vein Clinic is "out-of-network" for you. However, we will submit a claim to your insurance company for our fees, and if your insurance pays a portion of our fee, we will accept that as partial payment and will bill you for the remaining balance, including applicable in-network co-insurance and deductible. The sum of these fees will be the total balance. We will require that at each visit, with a physician or physical therapist, the patient pay a normal "office visit fee" which will be applied toward the total balance. At the end of the treatment course, the remaining balance (the difference between the total balance and the accumulated visit fees) will be billed directly to you. Upon receipt of this bill, please notify is immediately as we may have payment options available to you.

Office Policy for Insurance Checks

As a courtesy to our patients, this office will submit claims and wait for payment to be issued by your insurance company. Your insurance company will, within 15-30 days, process the claims issued and mail payment and/or Explanation of Benefits (EOB) directly to you, the member/subscriber. If you receive payment directly from your insurance company in the form of insurance check, **PLEASE DO NOT CASH THE INSURANCE CHECK.**

Instead, please endorse the back of the check and write **"Payable to Bergen Vein Clinic"** below your signature. We ask that you bring all checks and EOB's promptly so we can credit your account as soon as possible and answer any questions you may have. This must be done even after your treatment has concluded. As an alternative you may mail the signed check to **Bergen Vein Clinic, 48 S. Franklin Tpke, Suite 101, Ramsey, NJ 07446** as soon as you receive the check. Ultimately it is your responsibility to forward all correspondence to this office.

In the event that my medical insurance does not cover the services provided to me by Bergen Vein Clinic, regardless of the reason, I hereby agree that I am financially responsible for the full payment of the fees set by Bergen Vein Clinic, for the services rendered. I understand that Bergen Vein Clinic, offers services that are innovative and progressive, which may be considered "experimental and investigational" by my insurance company. I agree to pay any and all fees associated with these services. I have fully read and understand the above waiver and agree to pay for any costs not covered by my insurance plan.

_____ Date: ____ /____ /_____

Signature of Patient or Authorized Representative

_____

Patient Name (Printed)

For any further questions regarding insurance or billing inquiries,

Please contact our Billing Department at (201) 799-4005

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Authorization to Release Information

Bergen Vein Clinic is authorized to release all or any part of the medical record and other information of the patient named on this form to such insurance companies, organizations or agencies including, if applicable, The Centers for Medicare & Medicaid Services and it's agents, as may be concerned with payment of the services rendered and is needed to determine benefits payable for services furnished. A copy of this authorization will be sent to the Centers for Medicare & Medicaid, if applicable, my insurance company or other entity if requested. The original authorization will be kept on file by Bergen Vein Clinic.

Assignment of Insurance Benefits

I request that payment for authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Bergen Vein Clinic for any services provided to me. I assign Bergen Vein Clinic all my rights, entitlements and interest under any policy under which I have benefits and medical insurance, automobile personal injury protection, workers compensation or other third-party payer benefits, otherwise payable to me for those services provided. I obtained any needed pre-certification or authorizations and have fulfilled other requirements or conditions of my insurance coverage that are my responsibility.

I further authorize Bergen Vein Clinic and its designated agents to pursue all appeal/settlement options available to me. In addition, I authorize payer to communicate with Bergen Vein Clinic and/or its agents with all pertinent documentation that I am entitled to, including but not limited to: 1) plan language; 2) certificate of benefits; 3) documentation of how the allowable amounts were calculated.

Your health care provider has the right to take certain claims to an independent claims arbitration process through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI). To arbitrate 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.

_____ Date: ____ /____ /_____

Signature of Patient or Authorized Representative

_____

Patient Name (Printed)

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Surgical Centers

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that Kevin McElroy, D.O. does have a financial interest in the following health care service(s) to which patients are referred:

Same Day Procedures, LLC

Same Day Procedures, LLC does not participate with all insurance plans and may bill your services as a non-participating facility. Please ask us any questions you may have regarding their billing policy. You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Accordingly, take notice that Steven Ferrer, M.D. does have a financial interest in the following health care service(s) to which patients are referred:

Surgicore Surgical Center

Surgicore Surgical Center does not participate with all insurance plans and may bill your services as a non-participating facility. Please ask us any questions you may have regarding their billing policy. You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

_____ Date: ____ /____ /_____

Signature of Patient or Authorized Representative

_____

Patient Name (Printed)

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Disclosure Form

Dear Patient:

On behalf of Bergen Vein Clinic (hereinafter "health service provider" or "Bergen Vein"), kindly accept this disclosure in accordance with P.L.2018 c. 32, ("Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act") as it applies to health care providers and physicians. Pursuant to this new legislation, notice is required to be provided by all physicians, including those at Bergen Vein, as follows:

Pursuant to the above captioned legislation, health care professionals are required to inform patients whether or not they participate in certain health insurance plans. Please note, in accordance with this requirement, accept notice that Bergen Vein **does not** currently participate in **any** private health insurance plan and is **not** considered an "in-network" provider for such plans. Bergen Vein, which includes Bergen Vein's treating physicians, are considered "Out-of-Network" Providers. Bergen Vein **is** a Medicare participant; meaning Bergen Vein will accept the rates of reimbursement in accordance with Medicare coverage provided to its patients.

Pursuant to the above captioned legislation, please take notice that, upon request prior to the scheduling of non-emergency procedure(s), you may receive, in writing, the amount, or estimated amount that will be billed by Bergen Vein for the medical treatment and/or health care service you receive from Bergen Vein. This disclosure will include the associated Current Procedural Terminology (CPT) Codes associated with the service or procedure.

Pursuant to the above captioned legislation, please take notice that you may be financially responsible for services provided that are deemed "out-of-network" by your health insurance carrier, including costs in excess of, but not limited to, co-pay, deductible, and/or coinsurance (if applicable). Bergen Vein reserves the right to seek additional reimbursement from you for procedures or services in excess of those benefits provided by your health insurance benefits plan and/or rates of reimbursement allowed by your health benefits plan for "out-of-network" providers, in excess of, and in addition to, co-pay, deductible, or co-insurance (if applicable).

Please take notice that it is advised that you contact your health benefits plan with any questions and for further consultation on costs.

Please take notice that a physician, including those physicians at Bergen Vein, is required to provide you with the name, practice name, mailing address, and telephone number (if that information is known or available) for a health care provider providing services in conjunction with those provided by Bergen Vein, to the extent applicable, when that health care provider is providing the following services:

- Anesthesiology;
- Laboratory;
- Pathology;
- Radiology; or
- Assistant surgeon services.

In the event that Bergen Vein schedules you for facility admission or outpatient facility services, please take notice that you are entitled to the following information:

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Disclosure Form

- When scheduling facility admission or outpatient facility services, a physician is required to:
  1. Provide you with the name, practice name, mailing address, and telephone number of any other physician whose services are scheduled at the time of pre- admission, testing, registration, or admission when non-emergency services are scheduled;
  2. Provide information on how to determine the health benefits plans in which the other physician participates; and
  3. Recommend that you contact your health benefits plan for consultation on costs.

Please take notice that if the status of a health care professional changes with respect to the health care professional(s) network status, including those physicians here at Bergen Vein, between the time of the disclosures and the provision of the procedure, the health care professional shall notify you of the change.

Please note that by signing this document, you acknowledge that you have reviewed this document and have received all of the required disclosures listed above and that you hereby waive any challenge to the notice requirements contained within P.L. 2018, c.32, also known as "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act".

UNDERSTOOD AND AGREED:

_____ _____

Patient Signature Date

_____

Patient Printed Name

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Affiliated Providers

Dear Patient:

On behalf of Bergen Vein Clinic (hereinafter "health service provider" or "Bergen Vein"), kindly accept this disclosure in accordance with P.L.2018 c. 32, ("Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act") as it applies to health care providers and physicians. Pursuant to this new legislation, notice is required to be provided by all physicians, including those at Bergen Vein, as follows:

Please take note that Bergen Vein is affiliated and/or refers patients to the following facilities and/or health care providers in conjunction with treatment rendered by physicians and medical personnel here at Bergen Vein. During the course of your care here at Bergen Vein, you may be referred to one of the following health care providers:

- Affinity Radiology

155 State Street
Hackensack, New Jersey
(201) 968-5544

- Ramic Medical Imaging

400 Franklin Turnpike
#B
Mahwah, New Jersey 07430
(201) 760-9500

- Radiology Associates of Ridgewood

20 Franklin Turnpike
Waldwick, New Jersey 07463
(201) 445-8822

- Progressive Diagnostic Imaging

44 Route 23 North
#100
Riverdale, New Jersey 07457
(973) 839-5004

- Same Day Procedures, LLC
  1060 Clifton Avenue
  Clifton New Jersey 07013
  (973) 773-0101

- Surgicore Surgical Centers
  4 Locations in New Jersey
  www.surgicoreasc.com

- Valley Hospital
  223 North Van Dien Avenue
  Ridgewood, New Jersey 07450
  (201) 447-8000

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Affiliated Providers

- St. Barnabas Medical Center

94 Old Short Hills Road
Livingston, New Jersey 07039
(973) 322-5000

Please be advised that Bergen Vein makes no representations or assertions regarding whether these secondary health care providers participate in any health insurance plans nor whether these secondary health care providers accept certain kinds of health insurance. Furthermore, Bergen Vein makes no representations or assertions regarding accepted insurance and additional health care providers that may provide you services in conjunction with treatment rendered at any of above listed health care providers. If you have further questions regarding a provider you have been referred to as a result of your care here at Bergen Vein, please contact the provider, or your health insurance provider/carrier directly for more information.

Please note that by signing this document, you acknowledge that you have reviewed this document and have received all of the required disclosures listed above and that you hereby waive any challenge to the notice requirements contained within P.L. 2018, c.32, also known as "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act".

UNDERSTOOD AND AGREED:

_____ _____

Patient Signature Date

_____

Patient Printed Name

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This notice is effective as of _____ / _____ / _____

I have read HIPAA and understand my rights contained in this notice.

By way of my signature, I provide Bergen Vein Clinic, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment healthcare operations as outlined and described in the Privacy Notice.

_____
Patient's Signature

_____
Patient's Name (printed)

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Clinical Intake Form

Today's Date: _____

Name: _____ DOB: _____

Age: _____ Height: _____ Weight: _____

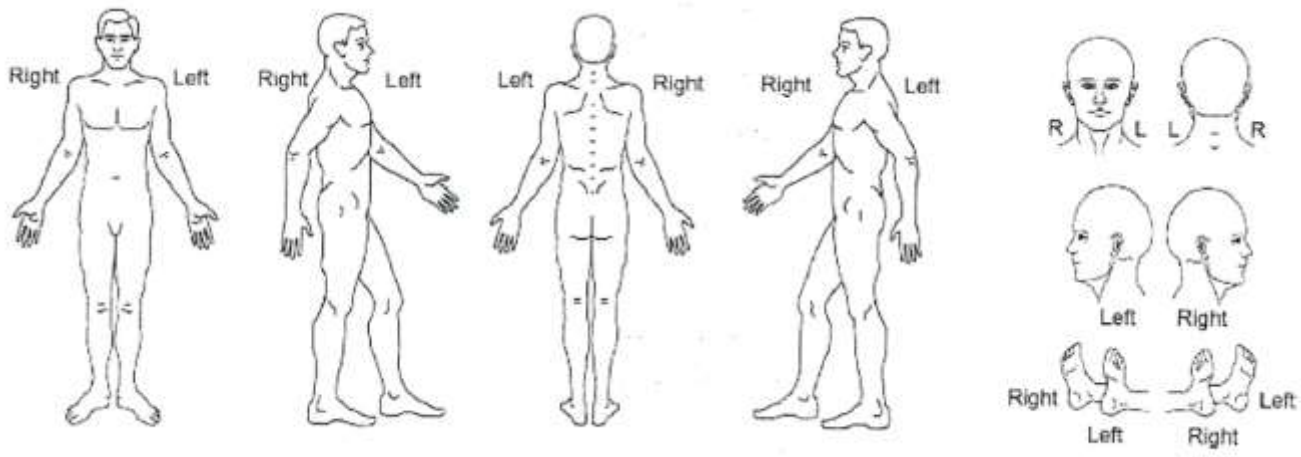
PAIN HISTORY

What is the reason for your visit today? _____

Location of pain (include side): _____ Are you left or right hand dominant? _____

Does this pain radiate? _____ If so, where? _____

Use this diagram to indicate the area of your pain. Circle or mark the location



On a scale of 1-10, 1 being very little and 10 being the worse, indicate how severe the pain is (*please circle*):

1 2 3 4 5 6 7 8 9 10

Approximately, when did this pain begin? _____

How did this pain occur? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

When does it occur? ☐At Rest ☐ With Activity ☐ At Night ☐ Other_____

How often does the pain occur? ☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

What makes your pain better? ☐ Pain Medicine ☐ Ice ☐Heat ☐ Rest ☐ Elevation

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Associated symptoms: ☐ Numbness/Tingling ☐ Weakness ☐ Balance Problems ☐ Bladder/Bowel Incontinence

☐ Fever/Chills ☐ Joint Swelling

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PAST MEDICAL HISTORY

Check all that apply:

☐Blood or plasma transfusions
☐Cancer
☐Clotting Disorders (DVT/PE)
☐Diabetes
☐Hypertension
☐Stomach/Intestinal Disorder
☐Heart Disease
☐Thyroid Issues
☐Anemia
☐Lung Disorders
☐Heart Attack
☐Stroke

Please list any other past medical conditions:

_____

_____

_____

_____

SOCIAL HISTORY

Do you exercise regularly? ☐Yes ☐No Is so, how many time per week? _____

Have you ever abused narcotic or prescription medications? ☐Yes ☐No

Alcohol Use: ☐Social Use ☐History of alcoholism ☐Current alcoholism ☐Daily use of alcohol ☐Never

Tobacco Use: ☐Current user ☐Former user ☐Never used ☐Packs per day_____ ☐How many years? _____

Illicit Drug Use: ☐Denies any illegal drug use ☐Currently uses illegal drugs ☐Formerly used illegal drugs (not currently using)

SURGICAL HISTORY

Please list any surgical procedures you have had done in the past including complications:

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____
4) _____ Date _____
5) _____ Date _____

☐ I have NEVER had any surgical procedures performed.

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MEDICATIONS: *Please list all current medication including vitamins below:*

	Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES: *Please list all allergies and reactions including medications, food, environmental, etc)*

	Allergy	Reaction
1.		
2.		
3.		
4.		
5.		

FAMILY HISTORY

Relative	Alive (age)	Deceased (age)	Cause of death	Health Issues
Mother				
Father				
Siblings				
Other				

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REVIEW OF SYSTEMS

Constitutional: ☐Difficulty sleeping ☐Fatigue ☐ Fevers ☐ Insomnia ☐ Tremors ☐ Unexplained Weight Loss

Eyes: ☐ Recent Visual changes ☐ Glasses

Ears/Nose/Throat/Neck: ☐ Jaw Discomfort ☐ Earaches ☐ Hearing Problems ☐ Nosebleeds ☐ Sinus problems

Cardiovascular: ☐ Chest Pain ☐ Bleeding Disorder ☐ High Cholesterol ☐ Palpitations ☐ Shortness of breath

Respiratory: ☐ Asthma ☐ Wheezing ☐ Shortness of breath ☐Cough

Gastrointestinal: ☐ Constipation ☐ Acid Reflux ☐Abdominal Cramps ☐ Diarrhea ☐ Nausea/Vomiting

Musculoskeletal: ☐ Joint Pains ☐ Joint Stiffness ☐ Joint Swelling ☐ Muscle Spasms ☐ History of Broken Bones

Integumentary: ☐ Rashes ☐ Skin Disorders ☐ Connective Tissue Disorders ☐ Hay Fever

Bladder: ☐ Urinary Tract Infections ☐ Blood in Urine ☐ Painful Urination ☐ Decreased Urine

Neurological: ☐ Dizziness ☐ Headaches ☐ Tremors ☐ Numbness/Tingling ☐ Seizures ☐ Fainting

Psychiatric: ☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Changes in mood or behavior

The above information is true to the best of my knowledge.

_____ Date: ____ /____ /_____

Signature of Patient or Authorized Representative

_____

Patient Name (Printed)

Kevin McElroy, DO
Steven Ferrer, MD
48 S. Franklin Tpke., Suite 101
Ramsey, NJ 07446
P: 201-962-9199
F: 201-962-9198

Consent and Authorization

I, _____, hereby grant to Bergen Vein Clinic, the authority to contact my insurers to obtain pertinent information regarding my health insurance benefits. This authorization shall include my automobile insurance carrier to the extent that there is a claim for my Personal Injury Protection (PIP) benefits, as well as my health insurer.

I hereby direct my insurers as identified below, to respond to and fully cooperate with all requests for information by Bergen Vein Clinic, regarding my health insurance benefits in connections with payment for any and all healthcare services provided to me.

Automobile Insurance Information:

Carrier:	
Policy #:	
Claim #:	
Date of Accident:	
Patient's Date of Birth	

Health Insurance Information:

Carrier:	
Member ID:	
Patient's Date of Birth	

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Where patient is not the policy holder, policy holder must sign below

Patient Signature: _____ Date: _____

Patient Name (Print): _____