

Montvale Health Associates

305 W Grand Avenue, Suite 500

Montvale, NJ 07645

201-391-8282

Last Name: _____ First Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip Code: _____

SS #: _____ DOB: ____/____/____ Age: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

E-mail Address: _____

Do we have permission to contact you at: home # Y/N work # Y/N cell# Y/N e-mail: Y/N text msg: Y/N

Marital Status: M S D W Number of Children: _____

Spouse's Name (Parent if minor): _____

Employer (name & address) _____

Occupation _____ years at current position _____

How were you referred to our office? Dr. _____ Advertisement: _____

Friend/Co-Worker: _____ Other: _____

Chief Complaint of Visit: _____

Primary Physician: _____ Chiropractor: _____

Insurance Information: (please bring card up to front desk)

Primary Cardholder Name: _____ DOB: ____/____/____

Employer: _____ SS #: _____

Secondary Insurance Co. Name: _____

Secondary Card Holder SS #: _____ DOB: ____/____/____

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the doctor and his associates have my permission to Perform x-rays (if needed). I am aware that an x-ray can be harmful to an unborn child.

Date of last menstrual cycle ____/____/____ Initials: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers or any other entity which may be concerned with the payment of charges incurred for the treatment services of the physician.

X _____ Date ____/____/____

AUTHORIZATION OF INSURANCE BENEFITS: I hereby authorize payment directly to the physician. I am responsible for payment of all non-covered services rendered by the physician.

X _____ Date ____/____/____

Montvale Health Associates

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PATIENT AUTHORIZATION FOR CONTACT REGARDING HEALTH RELATED SERVICES
THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND
HOW YOU CAN HAVE ACCESS TO OBTAIN THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

In the course of your care as a patient at Montvale Health Associates, we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further testing, assessment, or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine or one may be sent to your e-mail address. Furthermore, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office regarding those matters. Should you decide to not provide us such authorization, your care will not be affected in this office.

Under federal law, we are also permitted or require using or disclosing your health information without consent or authorization under the following circumstances:

- Should we provide health care services to you based on the orders of another health care provider
- Should we provide health care services to you as an emergency
- Should we be required by law to provide care to you and are unable to obtain your consent after attempting to do so
- Should there be substantial communication barriers between you and our office and our office's professional judgment believes you intend for our office to provide care
- Should we be ordered by the courts or another appropriate agency

Any use or disclosure of your protected health information, other than as described in the examples outlined above will only be made upon your written authorization. We normally provide information about your health care to you in person at the time you receive care.

You have the right to inspect and/or copy your health information for seven years from the date the record was created or for as long as the information remains in ours files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy, or amend your health related information should be provided to us in writing.

We are required by the state and federal law to maintain the privacy of your patient files and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. Should changes be made to our privacy notice, we will notify you in writing as soon as possible. Should you have any concern regarding: the information that we use or disclose based on this privacy notice, our privacy practices, or any aspect of our privacy activities, please direct your concerns to Lainie M. Saint. If you would like further information about our privacy practices, please contact Lainie M. Saint at the office.

This notice is effective as of April 1, 2010 and will expire seven years after the date it was created.

Patient Name

Patient Signature

Date

Patient Name: _____ **Date:** _____

Montvale Health Associates
Assignment of Benefits

I irrevocably assign to Montvale Health Associates all of my rights and benefits under any insurance contracts for payment for services rendered to me by Montvale Health Associates. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claim by Montvale Health Associates to be released to Montvale Health Associates. I irrevocably direct that all such payments go directly to Montvale Health Associates. I irrevocably authorize Montvale Health Associates to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I irrevocably authorize Montvale Health Associates to obtain counsel and enter legal or other actions on my behalf and or in my name, including the arbitration/dispute resolution process, and to collect such sums due it, should sums not be paid within the legally prescribed time frame. In the event that Montvale Health Associates selects to bring a lawsuit or petition for arbitration/dispute resolution against the insurance carrier, I am irrevocably assigning my rights, title and interest under medical expense benefits and/or PIP section of any insurance policy which I am entitled to proceed for benefits. This assignment shall allow an attorney of Montvale Health Associates choosing to bring suit or submit to arbitration/dispute resolution their claim for any unpaid bills for services rendered for injuries that I sustained in this or any accident.

In the event that this assignment is held invalid for any reason, I hereby authorize Montvale Health Associates to appoint an attorney of its choice to represent me directly against an insurer for which I may collect PIP benefits and to bring a claim in a forum of its choice. This appointment is intended in enabling the attorney to collect the bills of Montvale Health Associates.

The undersigned patient does hereby agree and acknowledge that he or she may receive benefit checks directly from the insurance carrier for services rendered by the provider. The undersigned patient hereby agrees to immediately forward said checks to Montvale health Associates upon receipt of the same.

A photocopy of this assignment shall be valid as the original. The assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient

Date

Parent or Guardian (if patient is a minor)

Date

Montvale Health Associates

Informed Consent for Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked” and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, or traction may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of the bone, muscular strain, ligament sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A small percentage of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could cause skin irritation, burns, or other minor complications.

Probability of Complications Occurring: Complications from chiropractic treatment are rare. The risk of cerebrovascular injury or stroke has been estimated to occur at a rate of 1 in 1 million to 1 in 10 million and can be further reduced by screening procedures. The probability of an adverse reaction due to ancillary procedures is also considered rare.

Other treatment options that could be considered include:

-Over the counter analgesics: The risks of these medications include irritation to the stomach, liver and kidneys among other side effects in a significant number of cases.

-Medical care: On average anti-inflammatory drugs, tranquilizers, and analgesics consist of a multitude of undesirable side effects including patient dependence in a considerable number of cases.

-Hospitalization: In conjunction with medical care, hospitalization notably adds to the risk of exposure to virulent communicable disease.

-Surgery: Along with medical care, surgery particularly increases the risks of adverse reactions to anesthesia as well as an extended recuperative period.

Risks of Non-Treatment: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and may include chronic pain cycles. It is fairly probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

.....
I have read the above explanation of chiropractic care and fully understand the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent for chiropractic treatment.

Patient Name (Printed)

Patient Signature

Date

Witness Signature

MONTVALE HEALTH ASSOCIATES

Patient Questionnaire

Patient Name: _____

Date: _____

Chief Complaint:

Primary:

Secondary:

Do You Presently Suffer From Any Of The Following:

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hip Pain |
| <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Ankle Pain | <input type="checkbox"/> Foot Pain |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Headaches | <input type="checkbox"/> Jaw Clicking | <input type="checkbox"/> Clenching of Teeth |
| <input type="checkbox"/> Ringing in Ears | | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Chewing Pain | <input type="checkbox"/> Inbalance |

Doctors Seen For Your Complaints (Current or Previous Condition):

Discipline	Name:	Date:	Results:
<input type="checkbox"/> Primary Care Physician	_____	_____	_____
<input type="checkbox"/> Chiropractor	_____	_____	_____
<input type="checkbox"/> Orthopedist	_____	_____	_____
<input type="checkbox"/> Psychiatrist	_____	_____	_____
<input type="checkbox"/> Neurologist	_____	_____	_____
<input type="checkbox"/> Pain Management	_____	_____	_____
<input type="checkbox"/> Podiatrist	_____	_____	_____
<input type="checkbox"/> Acupuncturist	_____	_____	_____
<input type="checkbox"/> Dentist	_____	_____	_____

Diagnostic Imaging Studies Performed For Your Chief Complaint

	Facility:	Dates:
<input type="checkbox"/> X-Ray	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> CT	_____	_____
<input type="checkbox"/> Bone Scan	_____	_____
<input type="checkbox"/> EMG/NCV	_____	_____

Past Medical History/Review Of Systems

Please mark all that apply

Endocrine <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> Other: _____	Eyes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other: _____	Cardiovascular/Heart <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Valve Problem <input type="checkbox"/> Angina <input type="checkbox"/> Other: _____
Circulation <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Chronic Edema <input type="checkbox"/> Other: _____	Neurological <input type="checkbox"/> CVA/Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____	Respiratory <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Other: _____
Gastrointestinal/Stomach <input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Liver Problems <input type="checkbox"/> Other: _____	Genitourinary <input type="checkbox"/> Urinary Problems <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Erectile Dysfunction <input type="checkbox"/> Other: _____	Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Other: _____
Psychiatric Difficulties <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Claustrophobia <input type="checkbox"/> Other: _____	Hematologic/Blood <input type="checkbox"/> Low Platelets <input type="checkbox"/> Bleeding <input type="checkbox"/> Poor Clotting <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other: _____	Allergies <input type="checkbox"/> Environmental <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Sinusitis <input type="checkbox"/> Other: _____
Other <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Parkinsons Disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Sleep Apnea	Other <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Dizziness <input type="checkbox"/> Nausea <input type="checkbox"/> Changes to bowel/bladder functn <input type="checkbox"/> Personal history of cancer <input type="checkbox"/> Pain prevents sleep <input type="checkbox"/> Pain interrupts sleep	Other _____ _____ _____ _____ _____ _____ _____

Family History

Patient Name: _____

Signature: _____

QUADRUPLE VISUAL ANALOGUE SCALE

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

EXAMPLE:

	headache	neck		low back													
no pain	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">10</td> </tr> </table>					0	1	2	3	4	5	6	7	8	9	10	worst possible pain
0	1	2	3	4	5	6	7	8	9	10							
#####																	

1. What is your pain RIGHT NOW?

no pain	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">10</td> </tr> </table>										0	1	2	3	4	5	6	7	8	9	10	worst possible pain
0	1	2	3	4	5	6	7	8	9	10												

2. What is your TYPICAL or AVERAGE pain?

no pain	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">10</td> </tr> </table>										0	1	2	3	4	5	6	7	8	9	10	worst possible pain
0	1	2	3	4	5	6	7	8	9	10												

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">10</td> </tr> </table>										0	1	2	3	4	5	6	7	8	9	10	worst possible pain
0	1	2	3	4	5	6	7	8	9	10												

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">0</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">1</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">2</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">3</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">4</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">5</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">6</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">7</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">8</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">9</td> <td style="border-top: 1px solid black; border-bottom: 1px solid black; width: 10%; text-align: center;">10</td> </tr> </table>										0	1	2	3	4	5	6	7	8	9	10	worst possible pain
0	1	2	3	4	5	6	7	8	9	10												

What percentage of your awake hours is your pain at its worst? _____%

NAME _____ AGE _____ DATE _____ SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)



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 claims 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, , by marking (or) and signing below, agree to:

representation by 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.

* 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.

release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, 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)

 **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: _____

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.

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.