For all services (regardless of date of service) rendered at Coastal Spine
OUT-OF-NETWORK ADVANCE PATIENT NOTICE FORM

You are seeking services from Coastal Spine, P.C. Coastal Spine, P.C. is out-of-network with your insurance company.

By placing my signature on this waiver form below, I acknowledge the following:

- I am aware that Coastal Spine, P.C., is out-of-network and does not participate with my insurance company.
- I understand that the amount or estimated amount that Coastal Spine, P.C. will bill for the services to be provided is available upon my request. If requested, Coastal Spine, P.C. will provide me with the Current Procedural Terminology (CPT) codes and charges associated with the services that I am expected to receive, absent unforeseen medical circumstances that may arise.
- I understand that I am financially responsible for the costs applicable to my health care services in excess of my copayment, deductible, or coinsurance. Additionally, I may be responsible for any costs in excess of those allowed by my health benefits plan.
- It is advised that I contact my insurance carrier before obtaining services: i) for further consultation on costs and ii) to obtain prior authorization if needed.
- I understand that associated services may also be out-of-network. If I am to receive anesthesiology, laboratory, pathology, radiology, or assistant surgeon services, I was provided with the contact information for those providers. I understand that I should contact my insurance carrier to determine the related costs and the network status of these additional providers.
- I am now knowingly, voluntarily, and specifically selecting Coastal Spine, P.C. as my provider on an out-of-network basis.

You may receive checks and explanations of benefits directly. If you have an insurance company that process checks and correspondence to the member, you will be required to comply with the guidelines below. If those guidelines are not met, you will be responsible for payment in full of Coastal Spine, P.C.'s fees, and Coastal Spine, P.C. reserves the right to forward all outstanding account balances to an outside collection agency. Once the account is transferred to the collection agency the total account balance **WILL BE THE PATIENT'S RESPONSIBILITY. If the patient defaults on payment and the matter is deferred to a collection agency the patient shall be liable for and any all legal/attorney fees and costs.**

- All checks AND correspondence MUST be forwarded to our office within **10 days of receipt. If you receive Explanations of Benefits without checks they also must be forwarded,** including denials, so that we may investigate. We must receive the detailed pages.
- It is the patient's responsibility to request replacement explanations of benefits if they have been misplaced. Coastal Spine, P.C. cannot process payments without Explanations of Benefits. The patient may also need to request their policy documentation from insurance.
- If Coastal Spine, P.C. does not receive insurance checks and all Explanations of Benefits from you, you will be responsible for payment of the TOTAL outstanding account balance. Our agreement to accept your deductible amount and not bill you for the coinsurance is contingent upon your compliance with the terms and conditions stated above.
- The patient is ultimately responsible for any and all unpaid or denied services regardless of deductible and co-insurance agreements stated above as noted in the **Assignment of Benefits and Financial Responsibility** form in the required New Patient packet. If your insurance company refuses to pay for services for any reason, the patient understands that they are personally responsible for any unpaid charges which would void the deductible and co-insurance agreement.
- The patient is **required** to assist in the appeal process and may be asked to provide an authorized signature to consent to appeal on your behalf. No assistance may result in full balance billing.
- Failure to comply with this procedure will result in cancellation of future appointments with our physicians or therapists and prescriptions.

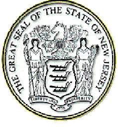
Please enter your signature below stating that you understand and will comply with the above agreement.

Print Name:______________________________ **Patient Signature:** ____________________________________ **Date:** ___________________

**Please note, that you may receive follow up calls from the billing department or notes within your monthly statements as reminders for needing information from you.

Thank you!

Coastal Spine Billing Office



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, [PRINT NAME], by marking [√] (or [x]) 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:_____________
Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative

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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.

Contact Information of Personal Representative

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

PRINT NAME: ____

ADDRESS:____

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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.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY FORM

Assignment of Benefits and Claims

I hereby assign and transfer to Coastal Spine, P.C. and/or its physicians all of my rights, title and benefits payable by my insurance carrier and/or benefits plan for services performed by Coastal Spine, P.C. and/or its physicians.

I hereby authorize Coastal Spine, P.C. and/or the physicians to submit claims to my insurance carrier or intermediary for all services rendered by Coastal Spine, P.C. and/or its physicians and to exercise any appeals and other rights under my policy or benefits plan on my behalf.

I authorize and assign to Coastal Spine, P.C. and its physicians the right to file suit and to obtain counsel and enter into legal or other actions on my behalf and/or in my name, including arbitration/dispute resolution processes, for any claims against my insurance carrier, PIP carrier, Workers' Compensation carrier, plan administrator, payor or third party.

I authorize Coastal Spine, P.C. and/or its physicians to appoint an attorney to represent me directly for the collection of PIP benefits, Workers' Compensation benefits and all other insurance benefits through the carriers themselves, plan administrator, payor or third party. I authorize Coastal Spine, P.C. and/or its physicians to obtain an attorney to represent me directly in appealing a claim to the appropriate state or Federal Agency for all state and federal plans.

I authorize Coastal Spine, P.C. and/or the physicians to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I direct my insurance carrier, or its intermediaries, to issue a payment check directly to Coastal Spine, P.C..

If my insurance carrier will not directly pay Coastal Spine, P.C. and/or its physicians, I authorize and direct the insurance company to send all checks and copies of Explanation of Benefit forms in connection with the services of onset date of service to present to my home address and/or the billing company and/or the attorney representing Coastal Spine, P.C. and/or the physicians so that we may forward checks to Coastal Spine, P.C., 4000 Church Rd, Mt Laurel, NJ 08054. All such checks must be made out to me and Coastal Spine, P.C. jointly.

If my insurance carrier requires a referral prior to commencement of treatment, I agree to obtain this prior to any examination or treatments.

Financial Responsibility

I understand that I am responsible for co-payments, deductible payments, and other charges not covered by my health care benefits. It is my responsibility to notify Coastal Spine, P.C. of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Coastal Spine, P.C. of the health insurance company if the submitted claims or any part of them are denied for payment.

In the event that I receive direct payment from my carriers or benefits plan of any amounts due to Coastal Spine, P.C. and/or its physicians for services rendered, I agree to forward immediately to Coastal Spine, P.C. any checks made payable to me. I agree to notify Coastal Spine, P.C. upon receipt of such check and to endorse the checks appropriately "Pay to the Order of Coastal Spine, P.C.." and immediately mail the check and any Explanation of Benefits to Coastal Spine, P.C., 4000 Church Rd, Mt Laurel, NJ 08054, keeping copies of the check and Explanation of Benefits for my record.

I have read and understand the terms and conditions of the ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY outlined above and accept full responsibility for this account. I understand my signature below creates a valid contract between the patient and the provider.

PRINTED PATIENT NAME: ______________________________________

AUTHORIZED SIGNATURE: _____________________________________ DATE: ___________________________

WITNESS: ____

NAME OF PERSON PROVIDING AUTHORIZATION (if different from patient): ___________________________________