

## NJPNI PATIENT RETAINER AND HIPAA POLICY STATEMENT

### Assignment of (Insurance) Benefits (AOB) – Appointment as Legal Authorized Representative

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to New Jersey Pediatric Neuroscience Institute (**NJPNI**) (the “Provider”) and their affiliated law firms (the “Law Firms”), (collectively hereinafter, “My Authorized Representatives”), and I appoint them as my authorized representative with the power to:

- ✓ File and process medical claims, appeals and grievances with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan ***naming me as plaintiff in such lawsuits and actions if necessary*** (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan
- ✓ Use a photocopy of my signature to be used to process insurance claims

I certify that the health insurance information that I provided to the Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. This AOB will remain in effect until I revoke it in writing.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from the Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

### ERISA Authorization

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is \_\_\_\_\_@\_\_\_\_\_. I understand I can revoke this authorization in writing at any time.

### Other Matters

This letter shall also confirm our mutual understanding that The Law Firms may represent other present or future clients on a basis adverse to you so long as we have not been engaged by you in the matter in which we are representing the other client. You agree that you will not assert our representation of you as a basis for disqualifying us from representing another client in any particular matter vis-à-vis yourself or any other party.

131 Madison Ave, 3<sup>rd</sup> Floor  
Morristown, NJ 07960  
P: 973-326-9000  
F: 973-326-9001



385 Prospect Ave, 2<sup>nd</sup> Floor  
Hackensack, NJ 07601  
P: 201-996-9300  
F: 973-326-9001

No Guarantee

Because of the uncertainty of legal proceedings, the interpretation and changes in the law and many unknown factors, NJPNI and its lawyers cannot and do not warrant, predict or guarantee results or the final outcome of any matter. Any expressions by us concerning the potential outcome of legal matters are expressions of our best professional judgment.

Out-of-Network Disclosure/Patient Acknowledgment of Responsibility

You understand that the Provider is an out-of-network provider and that, consequently, you are responsible for the difference between charges and payments made by your health plan and any coinsurance and deductible required by your health plan. The Provider cannot waive any such patient responsibility. However, in consideration for your executing this Agreement and allowing us to litigate against your health plan on your behalf, the Provider agrees to pursue any such balance owed against the health plan and not the patient. However, if at the end of such litigation, there remains a balance owed, then you will be responsible for that balance. Any recover of funds made in connection with any ligation or arbitration we file against your health plan will be paid to the Provider and not to you. You specifically agree that such recovery is owed to the Provider and not to you. NJPNI always attempts to advocate for you the patient and for fair reimbursement. In the event it is necessary to collect on any outstanding balances, you agree to pay all costs of collection, legal expenses and attorney’s fees in connection with the collection of any outstanding patient as well as interest on the outstanding balance at annual interest rate of 18%.

HIPAA Privacy Notice

I am aware of the HIPAA privacy notice for NJPNI. The HIPAA documents binder is in the waiting room and is available for your reading. HIPAA describes how NJPNI attempts to ensure the safety of my protected health information. HIPAA also explains my rights and NJPNI responsibilities to my privacy. I understand that if I want to limit access to my protected health information, I can list my requests below. I also understand that any questions that I have regarding my privacy can be answered by the Practice Administrator. By signing this acknowledgement form, I agree to the NJPNI HIPAA privacy policy as stated here and in their plan.

Please list all individuals/ family members who we have permission to communicate with in regards to healthcare and billing information. Also please list if there are any restrictions to release of information.

Name/ relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/ relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/ Parent signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Note: A photocopy of this Authorization/Patient Retainer shall be as effective and valid as the original.

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## Insurance/Payment Information

### **Does NJPNI participate with my insurance?**

NJPNI is contracted with several, but not all, insurance plans. If this does not include your insurance policy, there may be other options for your benefits and coverage.

### **Out of Network Options**

In some instances, your insurance company may not be able to provide you with a **board certified pediatric neurosurgeon** that is in-network with your plan AND available within a certain radius of your home (usually 30-50 miles). When this happens, your insurance company may grant an **out of network gap exception**. If a board certified in-network provider capable of providing pediatric neurosurgical services is **not** available within a certain radius of your home, this exception may be granted. This process can **ONLY** be started by a parent or an in-network referring provider by calling the number listed on the back of the insurance card and stating they would like to obtain an out of network gap exception. The surgeons at NJPNI are all board certified in pediatric neurosurgery. If your doctor directly refers you to see a board certified pediatric neurosurgeon, be sure to indicate this to your insurance company to obtain the exception and see the best provider for your child. Out of network gap exceptions are **not** approved indefinitely. If an out of network gap exception is approved, the exception is only valid for a specific period of time. An extension may be requested as needed for continuity of care, which our office will process for you. The claim for your visit at our office will process at the in-network level of eligible expenses.

### **Hospital Consultations and Emergencies**

If you were seen by one of our providers in an emergency or in the hospital, our office will attempt to obtain authorization with your insurance company for continuity of care. If approved, the claim for your follow up visits at our office will process at the in-network level of eligible expenses and at time of service, the patient will be responsible for their regular copay or co-insurance. If your child has received or requires surgery, certain procedures allow for a 90 day period of post-operative visits to be covered in full under the cost of the surgery.

### **Payment Plans**

NJPNI offers a payment plan option to patients who are unable to pay for their office visit in full. Please ask a billing or front desk representative for details.

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## Payment

**Please indicate how you will be paying for your visit today (Circle one):**

**CREDIT CARD**

**CASH**

**CHECK**

**PAYMENT PLAN**

(Previously discussed with billing department)

Payment is expected at the time of service. If for some reason payment is not collected at the time of service, without prior agreement with the billing manager, your credit card on file will be charged. We will not charge any amount above the charged fee for your office visit. You will be notified of this charge with a receipt in the mail. If you agree to this authorization, please sign below and return this form to the receptionist.

**Patient's name:** \_\_\_\_\_

**Guardian's signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Billing Zip code:** \_\_\_\_\_

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# Patient's Authorization Form to Appeal Insurance Claim Decision

Today's Date: \_\_\_\_\_

Patient/Member Name: \_\_\_\_\_

Patient Insurance ID#: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

I hereby authorize NJ Pediatric Neuroscience Institute, LLC to appeal any insurance claim with  
\_\_\_\_\_ (Name of Insurance Company)

on my behalf, as my Designated Representative. As part of the appeal, I hereby authorize my carrier to communicate with NJ Pediatric Neuroscience Institute, LLC in all aspects of the appeal. I understand that these communications may contain the following, all medical and financial information about my treatment relating to my examination.

I understand this information is privilege and confidential and will only be released as specified in the authorization, or as required or permitted by law. This authorization is valid for a period of one year.

\_\_\_\_\_  
Signature of Member or Legal Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Title

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