University Pain Medicine Center
Interventional Pain & Spine Specialists

University Pain & Spine Center
Interventional Pain & Spine Specialists

New York Pain Medicine Associate
Interventional Pain & Spine Specialists

University Pain Medicine Center
University Pain & Spine Center
New York Pain Medicine Associate
University Center for Vein Disorders
Corp. Mailing Address: 59 Veronica Avenue
Somerset, NJ 08873
732-873-6868
732-873-6869
Info@UPMCPain.com
UPSCNJ.com/

1. Patient Demographic Information (Información Personal del Paciente)

First Name (Nombre) : **Geeta**

Last Name (Apellido): **Bhagat**

Social Security # (# de Seguro Social):

Date of Birth (Fecha de Nacimiento):

Birth Sex (Género):

Preferred Language (Lenguaje de Preferencia):

Mobile Phone (Número de Celular):

Home Phone (# de Tel de casa):

Email: **gbc80180@yahoo.com**

Home Address (Dirección):

Apartment/Unit # (Número de Apto o Unidad):

City (Ciudad):

State (Estado):

Zip Code (Codigo Postal):

Emergency Contact Name (Contacto de Emergencia):

Emergency Contact Phone Number (# de Tel del Contacto de Emergencia):

Emergency Contact Relation (Relación al Contacto de Emergencia):

2. Employment (Empleo)

Current Employment Status (Estado actual del empleador):

Name of Employer / Nombre del Empleador:

Employer Phone Number / Número de Teléfono del Empleador:

Employer City / Ciudad del Empleador:

Employer State / Estado del Empleador:

3. Who referred you to our office? (¿Quién lo refirió a nuestra oficina?)

4. Attorney Information:

Attorney Name:

Attorney Phone Number:

Attorney City:

Attorney State:

5. What category is most appropriate for why you're being seen here today? (¿Qué categoría es la más apropiada para el motivo por el cual nos visita hoy?)

Medical History

6. Pharmacy Information - Información de su Farmacia:

   Name of your Preferred Pharmacy (Nombre de su Farmacia Preferida):

   Address of Pharmacy (If known) - (Dirección de la Farmacia - Si la sabe):

   City of Pharmacy (Ciudad de la Farmacia): | State of Pharmacy (Estado): | Zip Code of Pharmacy (If known) - (Código Postal de la Farmacia):

   Pharmacy Phone Number (If known) - (Número de Teléfono de la Farmacia (Si lo sabe):

7. Primary Care Doctor Information **If you don't have a Primary doctor, provide the name of the last doctor you saw** (Información sobre su doctor Primario **Si no tiene un doctor primario, proporcione el nombre del último doctor que consultó**)

   PCP Name | PCP City | PCP State

   PCP Phone Number | PCP Fax Number

8. Have you ever been treated by an Orthopedic/ Spine/ or Pain Management Doctor before? (¿Alguna vez ha sido tratado por un médico Ortopedista, de Columna o Especialista en Manejo del Dolor?)

9. Please provide the Orthopedic/ Spine/ or Pain Management Doctor's Information (Proporcione la información del Médico Especialista en Ortopedia, Columna o Tratamiento del Dolor)

	Name of Doctor - Nombre del Doctor	Phone Number - Número de Telefono	Fax Number - Número de Fax

10. Have you had any previous X-rays, Cat Scans, or MRIs? (¿Ha tenido alguna radiografía como tomografía computarizada o resonancia magnética previamente?)

Past Medical History

11. MEDICAL HISTORY - (HISTORIAL CLINICO)

    Height (Altura): | Weight (Peso):

    Cardiovascular History: Please check the boxes for any condition(s) you have experienced or are experiencing / Historial cardiovascular: (Marque las casillas correspondientes de cualquier afección que haya experimentado o esté experimentando):

    Respiratory History: Please check the boxes for any condition(s) you have experienced or are experiencing (Historial respiratorio: marque las casillas correspondientes a cualquier afección que haya experimentado o esté experimentando):

    Endocrinological Diseases: Please check the boxes for any condition(s) you have experienced or are experiencing (Enfermedades endocrinológicas: marque las casillas correspondientes a cualquier afección que haya experimentado o esté experimentando):

    Communicable Diseases: Please check the boxes for any condition(s) you have experienced or are experiencing (Enfermedades transmisibles: marque las casillas correspondientes a cualquier afección que haya experimentado o esté experimentando):

Other Condition(s): Please check the boxes for any condition(s) you have experienced or are experiencing (Otras condiciones: Marque las casillas correspondientes a cualquier condición que haya experimentado o esté experimentando):

Do you have any history of Cancer? (¿Tiene usted antecedentes de cáncer?)

Do you have a history of vascular or vein issues, such as varicose veins or cold feet? / (¿Tiene antecedentes de problemas vasculares o venosos, como venas varicosas o pies fríos?)

If you have any other medical history or conditions not listed above, or if you selected “Other” in any of the categories, please explain below. / (Si tiene algún otro antecedente médico o condición que no se haya mencionado anteriormente, o si seleccionó "Otro" en alguna de las categorías, por favor explíquelo a continuación.)

12. Musculoskeletal History (Historial Musculoesquelética)

History of Fractures? (¿Historial de Fracturas?)

History of Orthopedic Surgery? (¿Historial de ortopédica Cirugías?)

History of Arthritis (Historial de Artritis)

Neck or Back Issues? (¿Problemas de cuello o espalda?):

Hand/Shoulder Issues? (¿Problemas en la mano y el hombro?):

Knee Issues? (¿Problemas de Rodilla?):

Foot/Ankle Issues? (¿Problemas en el Pie o el Tobillo?):

If "Yes", Please specify where and onset? (En caso de ser afirmativo, especifique dónde y cuándo comenzó):

13. Allergies (medicines, cosmetics, environment, foods) Alergias (medicamentos, cosméticos, medio ambiente, alimentos):

Do you have any allergies (medicines, cosmetics, environment, foods)? If 'yes', please describe (¿Tiene alguna alergia (a medicamentos, cosméticos, al medio ambiente, a alimentos)? Si la respuesta es "sí", descríbala).

If 'yes', please describe (Si la respuesta es "sí", descríbala).

14. Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathic(s) and specify the date you started using it and the dosage. (Enumere todos los medicamentos actuales (recetados, de venta libre, vitaminas, hierbas, homeopáticos) y especifique la fecha en que comenzó a usarlos y la dosis):

15. Social History (Historia Social)

What is your smoking status? (¿Cuál es su estatus como fumador?)

Do you drink alcohol? (¿Bebes alcohol?)

Do you use recreational drugs? (¿Consume drogas recreativas?)

If 'yes', what? (Si es afirmativo, ¿qué?)

Are you involved in any recreational activities (Sports/Exercising) (¿Participa en alguna actividad recreativa (Deporte/Ejercicio)?):

If yes, What are you involved in? (Si es así, ¿En qué estás involucrado/a?)

BLOOD FLOW SYMPTOM ASSESSMENT

16. Symptom Awareness:

Do you notice your legs feel fatigued, tired, achy, or swell?

Do you notice your legs feel fatigued, tired, achy, or swell more during evenings?

Do you have visible varicose or spider veins?

Do you notice that your socks leave an impression on your skin at the end of the day?

Have you lost hair growth in the bottom half of your legs?

Have you experienced restless legs or cramping?

Have you seen another medical provider for this condition?

Provider Name

Provider Phone Number

Provider Address:

17. Impact on Daily Life:

In the last four weeks, have your leg symptoms interrupted Sleep:

In the last four weeks, have your leg symptoms interrupted Activities that require walking or sitting:

In the last four weeks, have your leg symptoms interrupted traveling:

18. Medical Attention:

Have you consulted a physician for these symptoms yet?

Accident/Injury Information (Información sobre accidentes y lesiones)

19. Problem List / Current Complaints (Lista de problemas / Quejas actuales):

    Why are you here today? (¿Por qué estás aquí hoy?)

    What is your main Complaint? (Please note, which side of the body RIGHT or LEFT) (¿Cuál es su principal queja? (Por favor, indique qué lado del cuerpo es el DERECHO o el IZQUIERDO).

    Secondary Complaint? (¿Queja Secundaria?)

    Rate your pain/Discomfort from 0-10 (0 = No Pain / 10 = Unbearable Pain) - (Califique su Dolor/Malestar de 0 a 10 (0 = Sin Dolor / 10 = Dolor Insoportable).

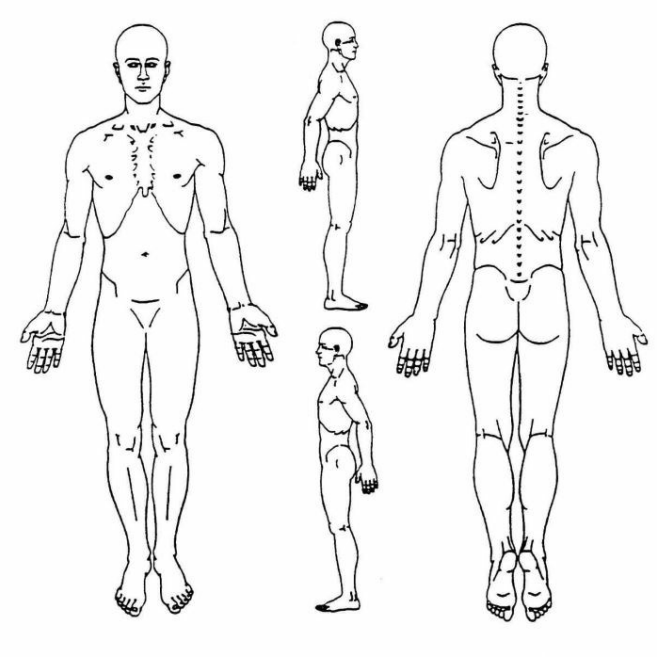
20. Describe any treatment you have received for this issue: (Describa cualquier tratamiento que haya recibido para este problema):

21. Previous care for this injury (Cuidados previos para esta lesión)

    Have you already seen a physician or other health specialist for this issue? (¿Ya has consultado a un médico u otro especialista de la salud por este problema?):

    If 'yes,' please provide their Name, Phone number (En caso afirmativo, proporcione su Nombre y Número de Teléfono):

22. Please mark the location of your pain on the diagram below. Circle the primary area of pain. If the pain radiates to other areas, draw a line to indicate where it travels. (Por favor, marque la ubicación de su dolor en el diagrama a continuación. Circule el área principal del dolor. Si el dolor se irradia a otras áreas, dibuje una línea para indicar hacia dónde se extiende.)



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CONSENT FOR MEDICAL SERVICES & FINANCIAL RESPONSIBILITY

I, ***Geeta Bhagat , understand and agree that my below affixed signature*** authorizes medical treatment and outlines my patient responsibilities regarding insurance billing and payment for services rendered by University Pain Medicine Center (UPMC), University Pain & Spine Center (UPSC), New York Pain Medicine Associate, PLLC (NYPMA), STEMMEE Surgical Center, and their affiliated providers and staff (hereinafter referred to as "Providers").

Consent for Medical Services: I voluntarily consent to undergo medical evaluations, diagnostic procedures, and treatments that are deemed necessary by my treating provider(s). I understand that I may decline or revoke consent for treatment at any time. I acknowledge that the Providers do not offer emergency medical services and that in the event of a medical emergency, I should seek care at the nearest hospital emergency department.

Prescription and Insurance Authorization: I authorize the Providers to access and review my prescription history and medication records for treatment and verification purposes. I affirm that the insurance information I provide is accurate and up to date. I agree to notify the practice promptly of any changes in my health insurance coverage or benefits.

Financial Responsibility: I agree to pay all required co-payments at the time of service, as well as any charges related to unmet deductibles or co-insurance. I am responsible for any unpaid costs due to inactive coverage or incorrect insurance information, payable within 60 days of notification. If my insurance provider sends payment directly to me, I will forward it to the Providers immediately. Any unpaid balance after 60 days may accrue interest up to 3% per annum, and if unpaid beyond 120 days, the Providers may initiate collections or legal actions.

Informed Consent: I confirm that I have had the opportunity to discuss the proposed treatment plan with my provider, including the **risks, benefits, and alternatives**, and that all questions have been answered to my satisfaction. I consent to proceed with care based on this understanding.

By signing below, I confirm that I fully understand and agree to the terms outlined herein, including the designation of my Authorized Representative, assignment of benefits, and granting of access to my insurance information.

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ASSIGNMENT OF BENEFITS

I, ***Geeta Bhagat,*** the undersigned patient or legally authorized representative, hereby **designate University Pain Medicine Center (UPMC), University Pain & Spine Center (UPSC), New York Pain Medicine Associate, PLLC (NYPMA), STEMMEE Surgical Center**, and their affiliated providers, facilities, administrative agents, attorneys, and billing representatives (collectively referred to as "Providers") as my **Authorized Representative** for all purposes related to the coordination, administration, and enforcement of my health insurance benefits and medical claims.

This designation includes, but is not limited to, the following rights, powers, and privileges:

Assignment of Benefits: I assign to the Providers all rights and benefits under my insurance policy or health plan, including ERISA-governed plans, for services rendered. This includes the right to, bill, collect, appeal, litigate, or arbitrate denied or underpaid claims in my name or theirs.

Direct Payment Authorization: I authorize my insurance carrier or any responsible third-party payor to remit all payments directly to the Providers. If payment is sent to me in error, I agree to endorse and forward those funds immediately to the Providers.

Insurance Access & Disclosure: I grant the Providers full access to my insurance policy, coverage terms, eligibility information, and claims records. This includes rights to obtain, review, and submit all documents necessary for prior authorizations, appeals, benefit disputes, and reimbursement enforcement. MY CARRIER SHALL NOT INTERFERE/DELAY THE FUFILLMENT OR ISSUANCE OF ANY SUCH REQUESTS MADE BY THE PROVIDERS.

HIPAA Authorization: I authorize the release of my protected health information (PHI) to the Providers and their designated agents, including legal counsel, for treatment, billing, and administrative purposes related to any claim or coverage matter.

Authority to Act: I grant the Providers permission to initiate and pursue **appeals, grievances, arbitration, and legal action** on my behalf for any disputed, delayed, or denied medical claims, and to recover any interest or penalties owed under federal or state law.

Term: This agreement is effective immediately and remains valid unless revoked in writing. It applies to all past, current, and future services provided by the Providers.

_____ _____

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USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)/HIPAA RELEASE

I, *Geeta Bhagat* , authorize and agree that **The Healthcare Providers, Entities, and Individuals listed below are hereby granted permission to request and receive disclosures of Protected Health Information (PHI):**

- University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), New York Pain Medicine Associate, PLLC (NYPMA) , STEMMEE Surgical Center, affiliated providers, and staff (collectively Referred to as, " Healthcare Providers")
- **The below-listed individuals: Designated representatives/friends/or family (Must include their First and Last Name):**

  _____

- Any other parties directly involved in my care, such as other medical providers working with my healthcare providers, vendors of medical supplies to be used for billing/collection purposes, any designees of my Healthcare Providers, and/or any other entity, carrier, employer, or representative financing/providing medical insurance coverage for care by my Healthcare Providers.

Revocation: I may revoke this authorization at any time by submitting a written request to my Provider's Privacy Officer at 59 Veronica Avenue, Somerset, NJ 08873. Revocation will not affect actions taken before the request is received.

Notice of Privacy Practices: I acknowledge receipt of Premier's Notice of Privacy Practices, which may change. I may request updates by calling 732-873-6868.

Authorization Duration: This authorization remains valid for three years from my last date of service with Providers. I understand that if my PHI is shared with entities not bound by HIPAA, it may no longer be protected by federal privacy laws.

Consent for Use: I understand that signing this authorization is not required to receive treatment and that I may request restrictions on the use of my PHI for treatment, payment, or operations. While Providers are not required to agree to these restrictions, any agreed limits are binding.

By signing below, I consent to the use and disclosure of my PHI for the purposes described above.

_____ _____

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MEDICAL RECORDS/PROTECTED HEALTH INFORMATION (PHI) RELEASE

I, ***Geeta Bhagat*** hereby authorize University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), New York Pain Medicine Associate(NYPMA), affiliated providers, and staff (collectively referred to as, " Healthcare Providers") to :

- **Request and Receive my Protected Health Information (PHI):** I grant permission for the above-named medical practices, their physicians, staff, representatives, or designees to access, request, receive, and review copies of my PHI from any healthcare provider, physician, or facility.
  - **Definition of PHI:**
    Protected Health Information (PHI) includes any information about my health status, medical condition, treatment, or payment for healthcare services that can be linked to me as an individual. This includes but is not limited to, medical records, lab results, billing information, and other data that healthcare providers use to treat me or manage my care.
- **Hold Harmless Agreement:** I release and hold harmless the entity providing my PHI or medical records from any claims or damages resulting from the release of this information, should the requesting entity mismanage my PHI.
- **Notice of Privacy Practices:** I acknowledge that I may be provided with a copy of the above-named entities' Notice of Privacy Practices or PHI handling policies upon request.

Termination of Authorization: I understand and agree that this authorization shall remain in effect indefinitely and does not expire. However, I may revoke it at any time by providing a written request to any of the above-listed entities. Such revocation will not affect any actions taken before the receipt of the revocation.

By signing below, I confirm that I have read, understand, and agree to the terms stated above

_____ _____
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APPOINTMENT POLICY AGREEMENT

I, Geeta Bhagat acknowledge and agree to University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), New York Pain Medicine Center(NYPMA) affiliated providers, and staff (collectively Referred to as, "The Practice") appointment no-show and cancellation policy. I understand that if I need to cancel or reschedule my appointment, I must do so at least 24 business hours in advance. Business hours are Monday through Friday, 9:00 a.m. - 5:00 p.m. (excluding federally recognized holidays).

No-Show and Cancellation Fees: If I fail to cancel any medical appointment scheduled with The Practice at least 24 business hours before the scheduled visit time, or if I do not attend without providing verbal notification, I will be considered a no-show. A non-refundable fee of $85 will be charged to my account or any credit card on file for each occurrence. I understand that I am responsible for paying all fees associated with violations of this policy.

Fee Exemptions: I understand that if I am legally or contractually exempt from no-show or cancellation fees due to insurance policy provisions or government mandates, I must notify The Practice in writing and provide proof of this exemption. In such cases, I will not incur a financial obligation for missed appointments.

Discharge and Release of Liability: I understand that if I have more than two cancellations or no-shows within a six-month period, my non-compliance with scheduled visits will serve as my notification to terminate the patient-provider relationship with The Practice. I acknowledge that failure to comply with this policy constitutes my voluntary discharge from The Practice's care. As a result, I will be discharged from The Practice and will no longer be considered a patient of The Practice, its physicians, or designee(s). By signing below, I agree that my discharge from care due to non-compliance with this agreement releases The Practice, including its physicians, employees, and agents, from any liability and any right to civil litigation, including claims of malpractice, negligence, or other civil claims, arising directly or indirectly from my discharge.

By signing below, I confirm that I have read, understood, and agree to the terms outlined in this policy, including the no-show and cancellation fees, discharge conditions, release from liability, and voluntary discharge acknowledgment.

_____ _____

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DIGITAL COMMUNICATION CONSENT

I, Geeta hereby grant consent to University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), New York Pain Medicine Center(NYPMA), STEMMEE Surgical Center, their affiliated providers, and staff hereafter referred to as "the Clinic," to contact me via digital communication methods including but not limited to voice calls, SMS (text messages), automated reminders, email, and any other source deemed necessary by the Clinic, for the purpose of communicating information related to my upcoming medical appointments or associated information requiring communication between all parties involved.

By signing this consent form, I acknowledge and agree to the following terms:

1. The Clinic may send digital communications in various formats and with various contents, including but not limited to appointment reminders, pre-appointment instructions, post-appointment follow-ups, and general healthcare-related information.
2. I confirm that I am the owner or an authorized user of the mobile phone number and/or email address provided below. I undertake to notify the Clinic immediately if I am no longer the owner or authorized user of the provided contact information.
3. I understand and agree that I am solely responsible for any message and data charges associated with receiving digital communications from the Clinic.
4. I acknowledge that I have the right to opt out of receiving digital communications from the Clinic at any time. I can do so by replying to any message with the word "STOP" or by notifying the Clinic in writing of my decision to opt out of digital communications.

_____ _____

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Out-of-Network Disclosure and Financial Consent

This Agreement ("Agreement") is entered into on this day between: *Party A:* ***University Pain Medicine Center (UPMC), University Pain & Spine Center(UPSC), New York Pain Medicine Associates (NYPMA),STEMMEE Surgical Center, affiliated providers, and staff*** *(collectively Referred to as, "Medical Providers") &* ***Party B: Geeta Bhagat***

Agreement Terms: *This agreement is made in accordance with federal protections under the No Surprises Act (NSA), effective January 1, 2022.*

1. Provider Insurance Participation Status: Party B acknowledges that the Medical Providers do not participate with their current health insurance plan and are considered out-of-network. Party B confirms that they:

- Have been notified that the Medical Providers are non-participating.
- Were offered the option to use in-network providers and voluntarily chose to proceed with these Medical Providers.
- Understand that this selection may result in higher out-of-pocket costs and affect overall insurance premiums.

2. Financial Responsibility: Party B agrees and understands that:

- Claims for services will be processed under out-of-network benefits, subject to applicable deductibles, co-payments, and coinsurance.
- They are responsible for the difference between the provider's billed charges and any allowed amount under their insurance plan.
- The final patient responsibility is subject to their specific insurance policy and may include non-covered services.

3. Good Faith Estimate (GFE) – NSA Compliance: Party B has been informed of their right to receive a Good Faith Estimate, which:

- Reflects the anticipated cost of care for non-emergency services.
- Is provided in writing (paper or electronic) prior to treatment, upon scheduling or upon request.
- Details both the estimated provider charge and the allowed amount that may be reimbursed by the insurer.

If the GFE is not provided as required, or the final bill exceeds the GFE by more than $400, Party B retains the right to use the Patient-Provider Dispute Resolution process under the No Surprises Act.

4. Acknowledgment of Written Estimates: Party B acknowledges that:

- They have received, in writing, the estimated total cost related to their care with the selected Out-of-

Network Provider(s).

- They have received, in writing, the estimated amount their insurer may cover under their Out-of-Network Benefit.

By signing this Agreement, Party B affirms that they have been informed of the out-of-network status of the Medical Providers, they understand their potential financial responsibility and they further voluntarily consent to receive non-emergency healthcare services under these terms from the Medical Providers covered under this agreement.

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INSURANCE REIMBURSEMENT/ LETTER OF PROTECTION

This Agreement is entered into by Geeta Bhagat and University Pain Medicine Center (UPMC), University Pain & Spine Center (UPSC), New York Pain Medicine Associates (NYPMA), STEMMEE Surgical Center, and all affiliated providers and staff (collectively, "Medical Providers").

1. Insurance Reimbursement Checks

- I understand and acknowledge that any insurance reimbursement checks issued to me for services rendered by the Medical Providers are the sole property of the Medical Providers. I agree to promptly endorse and remit any such payments to the Medical Providers within five (5) calendar days of receipt.
- If I fail to do so, I understand the Medical Providers may initiate collection procedures, including but not limited to third-party collections, litigation, and recovery of court costs and attorney's fees. I further acknowledge that interest may accrue on unpaid amounts at a rate not to exceed 3% per annum, pursuant to New Jersey law.

2. No-Fault, Personal Injury, and Workers' Compensation Claims / Letter of Protection

For services rendered in connection with a No-Fault (Auto), Personal Injury (PI), or Workers' Compensation (WC) claim:

- I authorize direct payment to the Medical Providers or their designated billing agents.
- If I have not filed a claim, I authorize the Medical Providers to file on my behalf.
- If my claim is denied or unpaid for any reason, I accept full financial responsibility for all charges related to my treatment.
- I authorize the Medical Providers to continue care at their discretion, with my verbal or continued written consent.
- In the event I receive a legal settlement, judgment, or award related to the injury for which I was treated:
- I agree that all amounts due to the Medical Providers shall be paid in full directly from settlement proceeds prior to any other disbursements.
- I instruct my attorney and/or insurance carrier to honor this obligation and issue direct payment to the Medical Providers for any outstanding balances.
- If my award is insufficient to cover the full amount due, I understand the balance may be reduced, written off, or further negotiated solely at the discretion of the Medical Providers.
- This provision shall serve as a Letter of Protection (LOP), enforceable against any party in possession of, or with control over, funds awarded to me for my care.

3. Governing Law

This Agreement shall be governed and enforced under the laws of the State of New Jersey, without regard to conflict of law principles.

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Do's & Don'ts for No-Fault / PIP /WC Patients

It is crucial to emphasize the importance of adhering to the Do's and steering clear of the Don'ts outlined below to ensure your health, protect your insurance benefits, and safeguard your legal rights.

DO's :

- **Attend All Appointments:** Consistent visits document your injury and show medical necessity.
- **Begin Treatment Promptly:** Starting care soon after your accident supports your health and helps establish your claim.
- **Communicate Early:** If you need to reschedule, contact us as soon as reasonably possible so your care remains consistent and adequately documented.
- **Follow Your Treatment Plan:** Any care recommended by your provider must begin within 24-48 hours of the initial visit. This not only helps your recovery but also strengthens your case.
- **Bring Updated Information:** Provide current insurance cards, claim numbers, and attorney information so your records and billing remain accurate.
- **Keep Your Attorney Informed:** Your attorney relies on your treatment records and progress to advocate for you effectively.

DON'Ts :

- **Don't Miss Independent Medical Exams (IMEs):** If your insurer requests an IME, you are required to attend. Missing an IME may result in suspension or denial of benefits. If the scheduled time/place is unreasonable, please notify your attorney and our office immediately so we can address the issue.
- **Don't Skip or Delay Care Without Reason:** Gaps in treatment may raise questions with insurers. If you must miss visits due to illness, emergencies, or other valid reasons, notify us so we can document it properly.
- **Don't Stop Treatment on Your Own:** Always consult with your provider before discontinuing care. Ending care prematurely may impact your recovery and could affect your claim.
- **Don't Ignore Provider Instructions:** Not completing prescribed therapy, exams, or imaging can weaken both your medical progress and your legal case.
- **Don't Wait to Share Updates:** Let us know right away if your insurance, attorney, or contact details change to avoid delays in your care or claims processing.

My signature below acknowledges my understanding of the above information, and I also agree to keep the provider informed of all care and issues that may arise, which could prevent me from following the above Do's, as it relates to the "Do's & Don'ts for No-Fault / PIP /WC Patients."

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Signature	Date

University Pain Medicine Center
Interventional Pain & Spine Specialists

University Pain & Spine Center
Interventional Pain & Spine Specialists

New York Pain Medicine Associate
Interventional Pain & Spine Specialists

University Pain Medicine Center
University Pain & Spine Center
New York Pain Medicine Associate
University Center for Vein Disorders
Corp. Mailing Address: 59 Veronica Avenue
Somerset, NJ 08873
732-873-6868
732-873-6869
Info@UPMCPain.com
UPSCNJ.com/

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an innetwork facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're Protected from Balance Billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-ofnetwork provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing.

You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what they would typically pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact No Surprises Help Desk from the Centeres for Medicare & Medicaid Services (CMS): 1-800-985-3059. You may also visit https://www.cms.gov/medical-bill-rights/help/submit-a-complaint for more information about your rights under federal Law.