University Pain and Spine Center
INTERVENTIONAL PAIN & SPINE SPECIALISTS
59 Veronica Ave. Somerset, NJ 08873
Phone: 732-873-6868 Fax: 732-873-6869
upmcnj.com
DIDIER DEMESMIN, MD • BRENDAN O'DONOVAN, DO • SEJAL PATEL, MS, PA-C • SISSEY KURIAN, PA

Dr. Didier Demesmin and staff would like to welcome you to University Pain and Spine Center. We are pleased that you have chosen our office to treat your pain condition. Our goal is to provide you with the most comprehensive interventions available in pain treatment, offering superior clinical care and up to date minimally invasive procedures, all with the latest technology.

We offer a specialized approach to diagnosing and treating pain. An individualized plan of care for each patient is made with the mission of improving function, alleviating pain, and enhancing the quality of life.

Our main office address is 59 Veronica Avenue in Somerset, NJ. Our satellite offices are located at:

294 Applegarth Road, Suite G, Monroe, NJ.
1450 Parkside Ave, Ewing NJ
630 E Palisade Ave, Englewood Cliffs NJ
679 Montgomery St, Jersey City NJ
199 Broad St Bloomfield NJ

For the convenience of our patients, our offices have ample parking with a handicapped-accessible entrance.

We encourage your active participation in your care, we will discuss your plan of care with you, if you have any questions please don't hesitate to ask. We want you to be proactive and write down any questions you have so that when you come in for an office visit, we can discuss any concerns you may have.

We make a commitment to provide you with the best care.

Enclosed is a new patient information packet to be completed at your home so that you can avoid filling the forms out in the office. We ask that you bring the following items to your first visit:

- **Valid Photo ID**
- **Insurance Card or Insurance Information (if your injuries are related to a Motor Vehicle accident or Workman's Compensation case, please bring the insurance information and the adjuster's name and phone number)**
- **MRI Films and Reports, CT Scan Films and Reports, if there are any.**
- **EMG Report if there is any.**
- **If you have been seen by a Pain Management Specialist, please bring a list of the procedures that have been done or if possible, a copy of the office notes.**

Should you need to reschedule or cancel your appointment, please call us at least 24 hours prior to your appointment to avoid a $25 fee.

To learn more about University Pain and Spine Center
please visit our website at UPMCNJ.com
Thank you for choosing University Pain and Spine Center
Didier Demesmin, M.D. and Staff

University Pain and Spine Center

INTERVENTIONAL PAIN & SPINE SPECIALISTS

NEW PATIENT PAPERWORK

Your completed intake paperwork helps our providers get to know you and your medical history better.
We rely on its accuracy and completeness to provide you with the best care possible. If you have any questions or are unsure how to complete any section of this form, please ask our front desk.

Today's Date _____

Your Name: _____

Address: _____ City/State/Zip: _____

Phone Number: (C)_____(H)_____(OTHER)_____

Date Of Birth: _____ Gender: ☐ Male ☐ Female Other _____

Social Security Number: _____

Email: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Refuse to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Primary Language: ☐ English ☐ Spanish Other _____

Referral & Physician Relationship

Primary Care Physician:

Name: _____Address: _____ Phone: _____

Referring Care Physician:

Name: _____ Address: _____ Phone: _____

Attorney:

Name: _____ Address: _____ Phone: _____

How did you hear about us? _____

Pharmacy:

Name: _____ Address: _____ Phone: _____

E-Prescribing PBM Consent

I give consent to University Pain and Spine Center to request and use my prescription medication history from third party pharmacy benefit payors for treatment purposes.

Sign: _____ Date:_____

INSURANCE INFORMATION

Primary Insurance: _____ ID Number: _____ Group Number: _____
Insurance Policy Holder: Self/Spouse/Child/Other
Please provide the information below if you are not the policy holder.
Policy Holder Name: _____ Date of Birth: _____

Secondary insurance
Insurance: _____ ID Number: _____ Group Number: _____
Insurance Policy Holder: Self/Spouse/Child/Other
Please provide the information below if you are not the policy holder.
Policy Holder Name: _____ Date of Birth: _____

Motor Vehicle Accident
Insurance: _____ Claim Number: _____ Date of Accident: _____
Attorney: _____(P): _____ Address: _____
Adjuster Name: _____ (P):_____
Do you have access to your Declaration Page? ☐Yes ☐No
If yes, please provide a copy to the front desk.
Have you assigned your health care as primary? ☐Yes ☐No
Insurance Policy Holder: Self/Spouse/Child/Other
Please provide the information below if you are not the policy holder.
Policy Holder Name: _____ Date of Birth: _____

Were you ☐In your own car ☐Taxi ☐Bus ☐Pedestrian ☐Vehicle owned by someone else ☐Bicycle ☐Other_____
Were you ☐The Driver ☐The Passenger ☐In the Back Seat (Right or Left)
Were you struck from ☐Front ☐Behind ☐Left Side ☐Right Side
Were you wearing a seatbelt? ☐Yes ☐No
Did the police come and take a report? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No

If Yes, by ambulance? ☐Yes ☐No

Were you X-rayed Examined Released Admitted (Dates): _____

Have you ever been in an accident before? ☐Yes ☐No

If yes please provide date, type, any injuries: _____

Have you lost time from work because of this accident? ☐Yes ☐No

If yes, please provide dates missed from work: _____

Are you applying for Disability? ☐Yes ☐No

I certify that I, _____was injured in a motor vehicle accident that occurred on __ /__ /__. I am aware that it is punishable under the law to commit insurance fraud and that it is a breach of the doctor-patient relationship to knowingly mislead the doctor. I am also aware that filing a statement of claim containing any materially false information, or concealing for the purpose of misleading, information concerning any fact, material thereto, is a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

I hereby certify that all my statements on this application are true, accurate and complete.

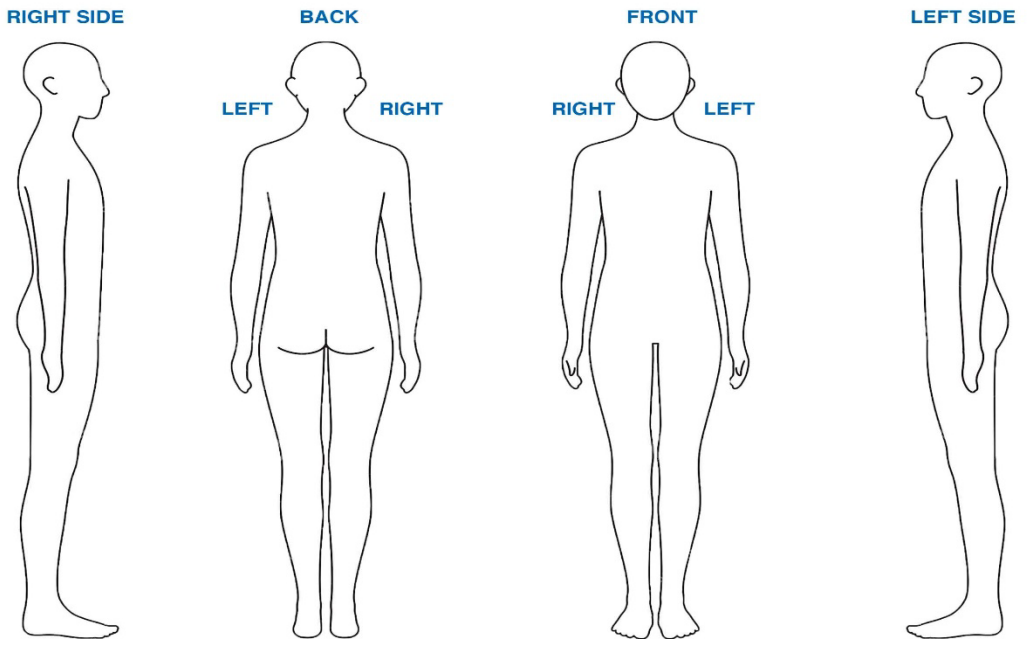
Signature: _____ Date: _____

Pain History

Location of Pain: ☐Low back ☐Buttock ☐Hip ☐Leg ☐Foot
☐Neck ☐Shoulder ☐Arm ☐Hand ☐Mid Back ☐Other:_____
How long ago did your pain start? _____

Use the diagram to indicate the location and type of pain. Mark the drawing with the following letters

N- Numbness
W- Weakness
S- Stabbing
B- Burning
P- Pins & Needles
A- Aching
C- Cramping



Please rate the intensity of your pain
0= No pain 1 2 3 4 5 6 7 8 9 10= the worst pain

Is your pain Constant? Yes or No
What time of day is your pain worse? ☐Morning ☐Afternoon ☐Evening ☐Night ☐Sleeping
What makes your pain worse? ☐Laying down ☐Sitting ☐Standing ☐Walking ☐Lifting ☐Other: _____
What makes your pain better? ☐Laying down ☐Sitting ☐Standing ☐Walking ☐Lifting ☐Ice ☐Heat
☐Massage ☐ Other: _____
Does your pain affect your daily activities? Yes or No
Have you ever had back or neck surgery? Yes or No
If yes, please list prior surgery and when: _____
Have you consulted any other physician? Yes or No If yes, who? _____
Have you ever had any recent diagnostic testing regarding your pain?
☐ X-rays ☐CAT Scan ☐MRI ☐EMT ☐EMG ☐Myelogram ☐Other: _____
Date: _____ Facility Name: _____

Conservative Treatments
Please check any treatments you have undergone for this problem. (All that apply)

- ☐ NSAIDS (Motrin, Aleve etc.)
- ☐ Anti- Depressants
- ☐ Oral Steroids
- ☐ Nerve Block
- ☐ Trigger Point Injections
- ☐ Chiropractor
- ☐ Ultrasound
- ☐ Acupuncture
- ☐ Tens Unit
- ☐ Massage
- ☐ Physical Therapy
- ☐ Relaxation
- ☐ Bed Rest
- ☐ Exercise

Current Medications/Supplements

Please list all medications you are currently taking.

Medication *Dose* *Frequency*

_____
_____
_____
_____
_____

Are you on Blood Thinners? Yes or No

Please check off any of the following that applies to you.

Constitutional	☐ Fever	☐ Weight loss	☐ Weight Gain	☐ General Weakness
Neurologic	☐ Headache	☐ Dizziness	☐ Memory Loss	☐ Numbness
Eyes	☐ Glasses	☐ Contacts	☐ Blurriness	☐ Double Vision
Ears/Throat	☐ Deafness	☐ Ringing	☐ Swallowing	☐ Hoarseness
Cardiac	☐ Chest pain	☐ Abnormal Beats	☐ Loss of Consciousness	
Pulmonary	☐ Cough/Cough blood	☐ Wheezing	☐ Shortness of Breath	
Intestinal	☐ Constipation	☐ Diarrhea	☐ Incontinence	
Urinary	☐ Frequency	☐ Burning	☐ Incontinence	☐ Bleeding
Muscle/Bone	☐ Pain	☐ Weakness	☐ Cane/Walker	☐ Bleeding
Endocrine	☐ Unexplained	☐ Weight Gain/loss	☐ Fatigability	
Circulatory	☐ Hypertension	☐ Stroke	☐ Aneurysm	
Skin	☐ Bruising	☐ Lesions	☐ Birth Marks	
Hematologic	☐ Bleeding	☐ Transfusion	☐ Blood Clots	
Psychiatric	☐ Depression	☐ Addiction	☐ Anxiety	☐ Anemia
Sleep	☐ Gasping for Breath	☐ Stop Breathing	☐ Insomnia	

Mark the following Conditions/Diseases that you have been treated for in the past:

Cardiovascular

- ☐ Cancer-Type_____
- ☐ Diabetes-Type_____
- ☐ HIV/AIDS

Head/Eyes/Ears/Nose/Throat

- ☐ Headaches
- ☐ Migraines
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Hepatic

- ☐ Hepatitis A (active/inactive/unsure)
- ☐ Hepatitis B (active/inactive/unsure)
- ☐ Hepatitis C (active/inactive/unsure)

Genitourinary/Nephrology

- ☐ Dialysis
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Urinary Incontinence

Hematologic

- ☐ Anemia
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Coronary Artery Disease

Gastrointestinal

- ☐ Bowel Incontinence
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding

Neuropsychological

- ☐ Alzheimer Disease
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Schizophrenia
- ☐ Seizures

Musculoskeletal

- ☐ Amputation
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Phantom Limb Pain
- ☐ Rheumatoid Arthritis

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Valley Fever
- ☐ Tuberculosis
- ☐ Other

_____

Past Surgical History

_____
_____
_____
_____

Allergies

Are you allergic to any of the following?

☐ IV Contrast ☐ Latex ☐ Seasonal ☐ Anesthesia ☐ Tape ☐ Iodine
☐ Medication _____

Family History

☐ Heart Attack ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Dementia ☐ Aneurysm ☐ Migraine ☐ Brain Tumor
☐ Breast Cancer ☐ Colon Cancer ☐ Other: _____

Mother ☐Alive ☐Deceased Age: ____ *Father* ☐Alive ☐Deceased Age: ____
Brother ☐Alive ☐Deceased Age: ____ *Sister* ☐Alive ☐Deceased Age: ____

MEDICAL HISTORY AND CONSENT FOR TREATMENT

I certify that the above information is accurate, complete, and true.
I authorize University Pain and Spine Center and any associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Initial Here_____

MEDICARE RELEASE

ALL MEDICARE PATIENTS MUST SIGN AFTER THE FOLLOWING STATEMENT

I request that payment under the medical insurance program be made on my behalf to University Pain and Spine Center for any services furnished me by its physician (s) and/or practitioners. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

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Notice of Assignment of Benefits to a Provider

An assignment of benefits is an arrangement by which a patent requests that his or her health insurance benefit payments be made directly to:

University Pain and Spine Center
59 Veronica Avenue
Somerset New Jersey 08873
732-873-6868

Insurance authorization and Assignment of Benefits

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to University Pain and Spine Center (hereafter referred to as UPSC), authorizing this transfer of payment from the Insured to the health healthcare provider.

I, _____

[print the full name of the undersigned]

herby absolutely authorize UPSC to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payments be sent directly to UPSC. I understand that all of the providers at UPSC are out of network with all insurance carriers with the exception of Medicare. It is the policy of this practice to bill my insurance carrier as a courtesy for reimbursement of expenses.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied UPSC with the up-to-date and correct insurance identification card(s) as well as supplied UPSC all necessary information regarding the guarantor of the Insurance policy(ies) and the necessary information regarding the subscriber(s) eligibility for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied which may result in denial of payment(s) to UPSC and resubmitted claims with corrected updated information that are still denied due to the fact that the corrected information was not supplied in a timely fashion to UPSC and I understand it will be my responsibility to pay UPSC for those medical services rendered to me or my dependent(s), I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that if my insurance carrier(s) does not issue payment or issues partial payment, UPSC has the right to appeal and if necessary to arbitrate any claims with the carrier. I am responsible for providing any documentation that is in my possession or within my ability to obtain that the carrier may require to UPMC for a successful arbitration.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney or agency for collection or taken to court, I agree to pay all collection fees, reasonable legal fees and court costs and other expenses incurred as a result of said collection or court date, all actions having venue of Somerset County, NJ, other venues notwithstanding. Further, I understand that there is a $30.00 fee for returned checks.

I understand that UPSC and its appointed attorneys or collection agencies reserve the right to report to commercial credit bureaus when an account becomes delinquent. All delinquent accounts are reported as a "collection account’” on the consumer credit report. The debit will remain as a collection account while on the credit bureau report; however, any subsequent payment activity is reported to the credit bureaus on a monthly basis. Payment in full will result in the collection account being reported to the commercial credit bureaus as satisfied.

I certify that the information I have reported about my insurance coverage is correct and I hereby authorize UPSC, the release of any information relating to any claims for benefits, in order to process any claims for benefits and to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

X _____

Sign (Patient od Other Person Authorized to Act for Patient — Date

_____

Print Name — Witness By

_____

Relationship to Patient — Signed (Witness) — Date

_____

Address — Print Name

_____

Address

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Receipt of Notice of Privacy Practices

In order to assist you in receiving your health information from University Pain and Spine Center (UPSC), please complete this form:

_____ (Initial) University Pain and Spine Center is permitted to share **any and all** medical information with the following individuals listed below, including test results, sensitive information and information disclosed during office visits.

_____(Initial) University Pain and Spine Center is permitted to share **any** medical information with the individuals listed below, including test results, sensitive information and information disclosed during office visits except:_____

IMPORTANT Permission given to call with test results, messages from doctor, billing, etc.:

Person(s) _____ Relationship, _____ Phone#· _____
Ok to leave a message? YES / NO
Person(s) _____ Relationship, _____ Phone# _____
Ok to leave a message? YES / NO

☐ Do not give any information to anyone else but myself.
Ok to leave a message? YES / NO

*I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

*I hereby acknowledge receipt of HIP AA notice of privacy practices from University Pain Medicine Center. If unable to obtain acknowledgement of receipt of HIPAA notice, please disclose reason and signature at the end of this document.

_____ _____
Signature of patient or *patient's representative* Date

_____ _____
Printed name of patient or patient's representative Date

APPOINTMENT Cancellation/NO-SHOW POLICY

UPMC requires notice of a cancelled appointment. We understand unexpected occurrences may happen and cause the need to cancel/reschedule your appointment so we ask that you let us know as soon as possible (at least a 24-bour notice) in order to run our office as efficiently as possible and need to utilize canceled appointments for other patients. There will be a $25 charge for missed office visits and a $50 charge for missed or canceled less than 24-hour notice for procedure visits.

_____ _____
Print Name Signature Date

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Dear Valued Patient,

Customer service is of utmost importance to our team. Our commitment is to provide the community with the highest quality patient care available. To be transparent, we want to inform you regarding our participatory status with your health plans. Due to our high standards of healthcare performance, **we do not currently participate with any commercial plan networks.** This means that our services will most likely be processed as "Out-of-Network".

Your out-of-network benefits may differ from the in-network benefits if you have a PPO (participating provider organization) plan. HMO (health maintenance organization) plans may not cover services rendered by out-of-network providers at all. It is important that you review your insurance benefits prior to beginning treatment. With our dedication to our patients, we voluntarily accept the insurance's allowed amount, when services are covered, for all commercial plans. This means we will adjust the amount that the insurance indicates is "not allowed" or "exceeds reasonable and customary" *(*in the sole opinion of tile insurance company*). It is always the difference between our billed charge and the allowed amount.

The part that you ***are*** responsible for is your copay, deductible, and coinsurance as per the insurance explanation of benefits (EOB) when the claim is processed. If your deductible has not yet been met, your insurance may not issue any payment and indicate that you are responsible for the entire allowed amount. If you are paid directly by the insurance, you will be responsible for turning over the payment and supplying a copy of the EOB. In the event that the cost sharing (deductible and coinsurance) portion of the balance(s) cannot be paid in full; our trained billing staff will personally assist you on developing and implementing a payment plan.

Sincerely,
University Pain and Spine Center

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59 Veronica Ave. Somerset, NJ 08873
Phone: 732-873-6868 Fax: 732-873-6869
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RECORDS RELEASE AUTHORIZATION REQUEST FORM

TO: _____
DOCTOR, Hospital, Or Facility
Address: _____ Phone/Fax:_____

TO: _____
DOCTOR, Hospital, Or Facility
Address: _____ Phone/Fax:_____

TO: _____
DOCTOR, Hospital, Or Facility
Address: _____ Phone/Fax:_____

I hereby authorize and request you to release my complete records in your possession, concerning my illness and/or treatment to University Pain and Spine Center:

Patient's Name (Please Print): _____
Date of Birth: _____
Patient Address: _____
Patient's Signature: _____
Date: _____
Witness:_____

University Pain and Spine Center
59 Veronica Ave Somerset, NJ 08873 Tel: 732.873.6868 Fax: 732.873.6869

Doctors Lien

To: Attorney/ Insurance	Doctor:
_____	_____
_____	_____
_____	_____
_____	_____

Re: Patient records and doctors lien:

I, _____hereby authorize the above doctor to furnish you, my attorney/insurance carrier, with a full report of the case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness which occurred/begun on _____.

I hereby give a lien to said doctor on any settlement, claim, judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums from such settlement, claim, judgement, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all medical bills that are in compliance with the fee schedule submitted by him for service rendered to me, and that this agreement is made solely for said doctor`s additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgement, or verdict by which I may eventually recover said fee.

Patient Signature: _____ Date: _____

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named doctor.

Attorney Signature: _____ Date:_____

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: _____

<Name>
<Address 1>
<Address 2>
<Address 3>

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to subject to criminal and civil penalties.

Your Name (First, Middle, Last)	Gender: Male ☐ / Female ☐		
List any aliases, maiden names or other names you use or have used in the past	Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Your Address (No. & Street, City/Municipality, State, County & Zip Code	Date of Birth	Social Security No. (if none, enter "none")	
Your Previous Address (If you lived at the above address for less than 2 years from the accident date)	Email:		

Date of Accident	Time of Accident AM ☐ PM ☐	Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Does anyone living in your residence own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____
Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury: _____

Were you treated by a doctor? Yes ☐ No ☐	Doctor's Name and Address
If you were treated in a hospital, were you an In-patient? ☐ Out-patient? ☐	Hospital's Name and Address

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $ _____._____	What is your average weekly wage or salary? $_____

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

Do Not Detach - HIPAA Authorization for Medical Information - Do Not Detach

I hereby authorize all medical providers to release my Protected Health Information to the bearer of this PIP application regarding medical treatment rendered to me for this accident as well as any prior or subsequent treatment pursuant to the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164 or any other statutory or regulatory authority. I understand my eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that if I wish to revoke this authorization I must revoke it in writing to the health information management department of the medical providers. I understand that the revocation will not apply to information that has already been released in response to this authorization and that once the above information is disclosed it may be re-disclosed by the recipient and may no longer be protected by state or federal privacy laws or regulations.

Signature: _____ Date: _____

Do Not Detach - Authorization for Wage Information - Do Not Detach

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.