



CASTLE CONNOLLY
TOP DOCTORS



CASTLE CONNOLLY
2011-2020

TOP DOCTOR
2020



TOP DOCS
2011-2020

Robert A. Kayal, MD, FAAOS

*Board-Certified Orthopaedic Surgeon
Founder, President & CEO
Chairman, Department of
Orthopaedic Surgery*

Orthopaedic Surgeons

Edward C. Friedland, MD, FAAOS
E. Jeffrey Pope, MD, FAAOS
Amit Sood, MD, FAAOS
Edward A. Lin, MD, FAAOS
Aaron J. Greenberg, MD
Victor Ortiz, MD
Kevin S. Finnesey, MD, FAAOS
Paul Kovatis, MD

Foot & Ankle Surgeon

Chad W. Rappaport, DPM, FACFAS

Podiatrist

Theresa Ronna, DPM

Physiatrist

Steve M. Aydin, DO

Rheumatologists

Alan Zalkowitz, MD
Rajesh K. Pandey, MD
Irina Raklyar, MD, FACR

Primary Care Sports Medicine

Michael Loreti, MD

Physician Assistants

Michael G. Kayal, RPA-C
Dean P. Mellas, PA-C
James J. Verardi, PA-C
Roya Rahimi, PA-C, CNMT
Michael T. Booth, PA-C
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Vivek A. Desai, PA-C
Robert A. Villa, PA-C
Jesse Markowitz, PA-C
Erin Cieslak, PA-C
Joel Marrero, PA-C

Chiropractors

Mark Leichter, DC, CFMP
James D. Lupi, DC, CFMP
Gino S. Ramundo, DC
Giselle M. Savoia, DC
Harout Tchoulhakian, DC

Occupational Therapist
Mary Chris Bassman, OTR, CHT

Physical Therapists

Elvin G. Luyun, PT, DPT
Jon-Joseph P. Lozado, PT
Cherrilyn Garcia, PT, DPT
Dheeraja Byreddy, MPT
Alexander M. Estacio, PT
Aldou Cinco, PT
Anna Templo, PT, DPT
Krystle Ardiente, PT
Harjot Garry Singh, PTA

WELCOME TO KAYAL ORTHOPAEDIC CENTER, P.C.

PATIENT NAME:				TODAY'S DATE:	
E-MAIL ADDRESS: BRIEFLY DESCRIBE					
PATIENT'S REASON FOR TODAY'S VISIT					
DATE OF ONSET OR INJURY:					
IS TODAY'S VISIT RELATED TO A WORK OR OCCUPATION INJURY?	YES	NO	AUTHORIZATION #:		
IS TODAY'S VISIT RELATED TO A MOTOR VEHICLE ACCIDENT?	YES	NO	AUTHORIZATION #:		
IF SO, HAS THIS INJURY ALREADY BEEN REPORTED?	YES		NO		

**AN IMPORTANT MESSAGE TO OUR PATIENTS ABOUT YOUR INSURANCE
COVERAGE**

In the past few years, the number of different health insurance programs has increased at an amazing rate. Even within one company, there may be several programs with different benefits and requirements. There is absolutely NO WAY that we can possibly know or keep up to date with each program's provisions. Some programs require that you utilize a specific facility. Some require pre- authorization for services, while others do not. Some require a signed referral from your primary care physician prior to any consultations with a specialist. Finally, some programs may require a second opinion. It is your responsibility to know and advise us of your program's requirements in advance each and every time that we provide a service. We will do our best to comply with any requirements that you may have. Please understand that if we provide a service that is outside of your program, you will be responsible for the appropriate fees. These are NOT our regulations. They are your insurance company's rules, and unless you follow them carefully, your insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to be used if you have any questions concerning your coverage. With respect to bill collections, please understand that unless other written arrangements are made with Kayal Orthopaedic Center, P.C., I agree to pay your final bill within 30 days of receipt. If I do not pay what I owe, I understand that I will be in default and the Kayal Orthopaedic Center, P.C. may retain an attorney to collect the balance due to it. If the Kayal Orthopaedic Center, P.C. retains an attorney who is not a salaried employee, I agree to pay the Kayal Orthopaedic Center, P.C.'s reasonable attorney fees upon placement of the claim with the law firm.

SIGNATURE OF PATIENT OR GUARANTOR OF PAYMENT: x

PLEASE NOTIFY THE STAFF OF ANY CHANGES IN YOUR ADDRESS OR INSURANCE INFORMATION

PATIENT HISTORY

NAME:				TODAY'S DATE:	
-------	--	--	--	---------------	--

Franklin Lakes 784 Franklin Ave #250
Glen Rock 266 Harristown Rd #107
Westwood 260 Old Hook Rd #401

Paramus 185 Route 17 South #101
Paterson 680 Broadway

Garfield 96 Manner Ave
North Bergen 9226 John F. Kennedy Blvd
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AGE:		HEIGHT:		WEIGHT:	
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PAST MEDICAL HISTORY:	_____

PRIMARY CARE PHYSICIAN:		PHONE:	
PHARMACY NAME:		PHONE:	
PHARMACY ADDRESS:			

CURRENT MEDICATIONS

DRUG	DOSAGE	FREQUENCY

ALLERGIES (DRUG, FOOD, METALS, ETC.) E.g. Ibuprofen,
Penicillin, Shell Fish, Peanuts, Milk, Eggs, Wheat, Soy, Silver,
Nickle, Latex, Chemicals in Shampoo or Cosmetics, Sun,
Seasonal, Pets

ALLERGY TYPE	SIDE EFFECT / ADVERSE REACTION



Check here if you have ever had a skin reaction while wearing jewelry including body piercings. What type of metal jewelry? _____

SURGICAL HISTORY

SURGERY	DATE	DOCTOR & HOSPITAL

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SOCIAL HISTORY

MARITAL STATUS (CIRCLE)	SEX & AGES OF CHILDREN (IF ANY)	TOBACCO USAGE IF ANY & FREQUENCY	ALCOHOL USAGE IF ANY & FREQUENCY	ILLICIT DRUG USAGE IF ANY & FREQUENCY	SEXUALLY TRANSMITTED DISEASES (CIRCLE)
SINGLE MARRIED DIVORCED WIDOWED					HEPATITIS C? HIV?

PERTINENT FAMILY MEDICAL HISTORY
(i.e. CANCER, HEART DISEASE, DIABETES, ARTHRITIS, ETC.)

MOTHER	FATHER	SIBLINGS	CHILDREN	OTHER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF KAYAL ORTHOPAEDIC CENTER, P.C.'S NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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I, _____, acknowledge receipt of KAYAL ORTHOPAEDIC CENTER, P.C.'S (the "Provider") Notice of Privacy Practices effective February 16, 2006 and I consent to the Provider's use and disclosure of my health information and insurance/payment information which specifically identifies me or which can reasonably be used to identify me for treatment, payment and healthy care operations of the Provider and in accordance with the Notice of the Provider's Privacy Practices. I understand that while this consent is voluntary, if I refuse to sign this consent, the Provider can refuse to treat me.

I also consent to the restrictions contained in the Notice of Privacy Practices regarding all worker's compensation information. I understand that such information will not be disclosed to me without the written authorization of the applicable worker's compensation carrier/payor. In the event that such worker's compensation carrier/payor refuses to release any or all of such records, I hold the Practice and all of its shareholders, physicians, employees and agents harmless in connection with such refusal.

I understand that I have the right to request that the Provider restrict how my health and insurance/payment information is used or disclosed to carry out treatment, payment or healthcare operations.

I understand that I may revoke this consent at any time by notifying the Provider in writing, but if I revoke my consent, such revocation will not affect any actions that the Provider took before receiving my revocation.

Signature of patient or patient's representative	Date
Printed name of patient or patient's representative	
Relationship to patient	

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ASSIGNMENT OF BENEFITS FORM

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to the organization listed below for any equipment or services provided to me by the organization. I expressly assign all my rights in and to such insurance benefits directly to KAYAL ORTHOPAEDIC CENTER, P.C., and authorize KAYAL ORTHOPAEDIC CENTER, P.C. to endorse any and all drafts on my behalf, issued pursuant to this assignment, for the benefit of KAYAL ORTHOPAEDIC CENTER, P.C.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for product received. You should consult your insurance carrier as to the costs associated with your treatment.

In certain circumstances, insurance company may send check for services provided directly to the patient or the guarantor. In such cases, the patient and the guarantor agree to endorse and forward such a check to KAYAL ORTHOPAEDIC CENTER, P.C. If the patient deposits such a check into a personal account, the patient and guarantor agree to immediately send a check for the equivalent amount to KAYAL ORTHOPAEDIC CENTER, P.C.

PATIENT _____ NAME _____ (PRINT): _____

Patient Social Security Number: _____ Patient Date of Birth: _____

PARENT/GUARDIAN ONLY

YOUR NAME (PRINT): _____
 Your Social Security Number: _____ Your Date of Birth: _____
 Signature of Patient or Parent/Guardian: _____ Date: _____

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DISCLOSURE STATEMENT

I understand that KAYAL ORTHOPAEDIC CENTER, P.C. is an out-of-network provider, meaning that, you should contact your insurance carrier as to the out-of-network benefits you are entitled to under your policy. By accepting treatment, you are voluntarily accepting to be treated by an out-of-network provider. All co-payments and deductible payments are due in full at the time of service unless prior arrangements have been specifically made. All accounts over 60 days are subject to an additional charge. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including a reasonable attorney's fee.

Our providers are affiliated with the following facilities: The Valley Hospital; Patient Care Associates; Chilton Medical Center; Hackensack Medical Center, and HUMC Pascack Valley.

The amount or estimated amount of your treatment is available upon request during our office's regular business hours. You may also request the amount or estimated amount of fees that we will bill you for directly upon request along with the CPT codes associated with your treatment absent unforeseen medical circumstances that may arise. You should contact your insurance carrier for further information on the costs associated with your treatment.

I understand that I will be charged a fee of \$100.00 if I do not show up for an office visit or if I cancel my appointment less than 24 hours from the time of my scheduled appointment.

PATIENT _____ NAME _____ (PRINT): _____

Patient Social Security Number: _____ Patient Date of Birth: _____

PARENT/GUARDIAN ONLY

YOUR NAME (PRINT): _____

Your Social Security Number: _____ Your Date of Birth: _____

Signature of Patient or Parent/Guardian: _____ Date: _____

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IMPORTANT MESSAGE TO OUR PATIENTS

Recently some insurance companies decided to institute a policy that reimburses patients for services rendered by their physicians. In turn, the physician provider is then expected to bill and pursue the patient for the provided service. As such, in effort to avoid confusion and improper patient billing, if your insurance company reimburses you for services provided by the KAYAL ORTHOPAEDIC CENTER, PC, we ask that you simply:

- BRING IN ALL PAGES OF THE EXPLANATION OF BENEFITS MAILED TO YOU, ALONG WITH THE ATTACHED CHECK.
- ENDORSE THE CHECK AND BRING IT INTO OUR OFFICE. PLEASE DO NOT CASH THE CHECK AND THEN REIMBURSE THE KAYAL ORTHOPAEDIC CENTER, PC WITH A PERSONAL CHECK.
- CALL OUR BILLING DEPARTMENT IF YOU HAVE ANY QUESTIONS CONCERNING CHECKS THAT YOU MAY RECEIVE FROM YOUR INSURANCE COMPANY!

Failure to comply with this request will make you responsible for the full amount billed.

We are working in earnest to make this an easy process for both you and our billing staff. We truly appreciate your assistance in this important matter. Should you have any questions of concerns, please do not hesitate to contact me at the office.

Thank you for your cooperation in this

matter.

Sincerely

yours,

Billing Department

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IMPORTANT MESSAGE TO OUR PATIENTS NON-INVASIVE PAIN RELIEF

Biologics, or the use of specialized cells to stimulate the patient healing process, is fast becoming the future of orthopaedics. At Kayal Orthopaedic Center, our surgical team uses advanced biomaterials to relieve pain, reduce inflammation and restore joint mobility in a variety of orthopedic conditions.

Dr. Robert A. Kayal, MD has been using these non-operative injection treatments for over 14 years with great success. During your appointment, a Kayal Orthopaedic Center provider injects medication directly into the painful joint region. Unlike medications that are distributed throughout the body, injections provide localized, directed joint relief.

Viscoelastic supplementation, steroid supplementation and corticosteroid injections are advanced treatment options often used in conjunction with physical therapy and oral medication. There are two common injection types:

- **Corticosteroid injections** provide a fast-acting anti-inflammatory result, and injections may include a local anesthetic to numb the area until the steroid begins to work.
- **Viscoelastic supplementation injections** are made of a natural lubricant found in joint fluid. When injected it helps to absorb shock and allows joints to glide better. These medications may be used to manage osteoarthritis, accelerate soft-tissue healing and encourage tissue regeneration.

Please be advised that if you receive any of the above injections they will be performed under Ultrasound guidance, which is a new cutting edge technology. Ultrasound guidance has become extremely popular for not just diagnostic imaging, but now is being routinely used for needle guidance to ensure accurate needle placement.

Please be aware that this is a billable charge to your insurance company.

Print name: _____

Signature: _____ Date: _____

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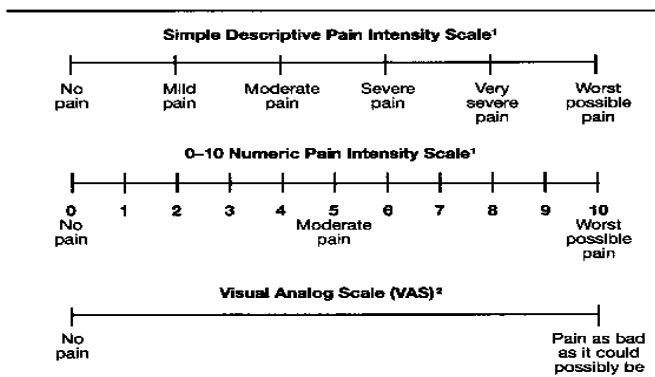
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Harjot Garry Singh, PTA

1. DESCRIBE PAIN:

-How long have you been in pain? _____

-What is pain level (from 1-10) _____



¹If used as a graphic rating scale, a 10 cm baseline is recommended.
²A 10-cm baseline is recommended for VAS scales.

-What are your symptoms? Please circle all that apply:

- difficulties walking
- going up and down stairs
- getting in/out of bed
- standing/sitting/bending over
- Other _____

2. WHAT CONSERVATIVE CARE WAS PERFORMED? Please circle all that apply:

- ice
- rest
- activity modification
- chiropractic
- physical therapy (with timing and duration),
- acupuncture
- pain and non-steroidal anti-inflammatory medication
- if so, which one & for how long and how often ?
- Advil/ibuprofen _____
- Tylenol/acetaminophen _____
- Aleve/naproxen sodium _____

Patient's Name (Please print)

Signature

Date

PATIENT DEMOGRAPHICS QUESTIONNAIRE

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Please note that we are requesting this *optional* information in an attempt to comply with Federal "Meaningful Use" guidelines, as released by The Office of the National Coordinator for Health Information Technology. More information regarding these guidelines is available at <http://healthit.hhs.gov>.

You are **NOT** obligated to respond in order to be treated.

If you do not wish to provide this information, please simply fill in your name and today's date and check the "Declining to Respond" choice.

NAME _____ TODAY'S DATE _____

Please check below as appropriate:

ETHNICITY	LANGUAGE(S) SPOKEN		
Caucasian Respond	English	Sign Language	Declining to
Black	Italian	Laotian	
Black Non-Hispanic	Spanish	Hindustani	
White Non-Hispanic	French	Hmong	
Hispanic	German	Punjabi	
Asian	Russian	Tagalog	
Asian Pacific Islander	Armenian	Vietnamese	
Pacific Islander	Chinese		
Subcontinent Asian American	Japanese Native		
American	Korean		
Native Hawaiian	Cambodian		
(Khmer) American Indian/Alaskan	Portuguese		
Other	Other		

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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

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.¹ 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.

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**CONSENT TO REPRESENTATION IN UM APPEALS AND
AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND
ARBITRATION OF CLAIMS**

¹If 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.

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

Relationship to Patient:

_____ I am the Patient
_____ |

_____ am the Personal
Representative (provide
contact information on
back)

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

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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!

REVOCAION 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

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: _____

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CONSENT FOR RADIOGRAPHIC EXAMS FOR WOMEN OF REPRODUCTIVE AGE

PATIENT'S NAME: _____

DATE OF BIRTH: _____ AGE: _____

X-Ray exams of the abdomen and pelvis exposing the uterus to radiation are:

- *Abdomen
- *Lumbar Spine
- *Sacrum
- *Hip(s)
- *Pelvis
- *Coccyx (Tail Bone)

Onset of last menstrual period: _____ Today's Date: _____

I am pregnant: YES _____ NO _____ I DON'T KNOW _____

I recognize that if I am pregnant and have radiation to the abdomen, there is a possibility of injury to the fetus. However, I do wish to this X-Ray examination completed today. I will not hold Kayal Orthopaedic Center, P.C. responsible for any potential harm to myself or my unborn child, By signing below I consent to the necessary

X-Ray procedure(s).

PATIENT NAME: _____ SIGNATURE: _____

CONSENT TO X-RAY A MINOR:

I am a parent or legal guardian of _____, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic X-rays of said minor. Kayal Orthopaedic Center, P.C. has requested the X-rays for further diagnostic purposes. At this time, I know of no other conditions which the taking of X-rays would further complicate.

Signed: _____ Date: _____

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HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: KAYAL ORTHOPAEDIC CENTER, P.C. to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to:

Please indicate the information or types of information to be disclosed (including dates if necessary):

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to KAYAL ORTHOPAEDIC CENTER, P.C.

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for drug and/or alcohol abuse, mental health, sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS). This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

Patient or Legal Representative: _____ Date: _____

Representative's authority to act on behalf of individual: _____

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James D. Lupi, DC, CFMP
Gino S. Ramundo, DC
Giselle M. Savoia, DC
Harout Tchoulhagian, DC

Occupational Therapist
Mary Chris Bassman, OTR, CHT

Physical Therapists
Elvin G. Luyun, PT, DPT
Jon-Joseph P. Lozado, PT
Cherrilyn Garcia, PT, DPT
Dheeraja Byreddy, MPT
Alexander M. Estacio, PT
Aldou Cinco, PT
Anna Templo, PT, DPT
Krystle Ardiente, PT
Harjot Garry Singh, PTA

Witness: _____

E-Mail Authorization

Patient's Name: _____

Date of Birth: _____

E-Mail: _____

Address: _____

By providing us with your email address, you are authorizing us to send you emails to update you on announcements and/or new technologies and services we offer here at Kayal Orthopaedic Center, PC.

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 Glen Rock 266 Harristown Rd #107
 Westwood 260 Old Hook Rd #401

Paramus 185 Route 17 South #101
 Paterson 680 Broadway

Garfield 96 Manner Ave
 North Bergen 9226 John F. Kennedy Blvd
 Stony Point, NY 11 Holt Dr



CASTLE CONNOLLY
TOP DOCTORS



CASTLE CONNOLLY
2011-2020



TOP DOCS
2011-2020

Robert A. Kayal, MD, FAAOS

*Board-Certified Orthopaedic Surgeon
Founder, President & CEO
Chairman, Department of
Orthopaedic Surgery*

Orthopaedic Surgeons

Edward C. Friedland, MD, FAAOS
E. Jeffrey Pope, MD, FAAOS
Amit Sood, MD, FAAOS
Edward A. Lin, MD, FAAOS
Aaron J. Greenberg, MD
Victor Ortiz, MD
Kevin S. Finnesey, MD, FAAOS
Paul Kovatis, MD

Foot & Ankle Surgeon

Chad W. Rappaport, DPM, FACFAS

Podiatrist

Theresa Ronna, DPM

Physiatrist

Steve M. Aydin, DO

Rheumatologists

Alan Zalkowitz, MD
Rajesh K. Pandey, MD
Irina Raklyar, MD, FACR

Primary Care Sports Medicine

Michael Loreti, MD

Physician Assistants

Michael G. Kayal, RPA-C
Dean P. Mellas, PA-C
James J. Verardi, PA-C
Roya Rahimi, PA-C, CNMT
Michael T. Booth, PA-C
Jennifer M. Castellanos, PA-C
Vivek A. Desai, PA-C
Robert A. Villa, PA-C
Jesse Markowitz, PA-C
Erin Cieslak, PA-C
Joel Marrero, PA-C

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