

No Fault Insurance



206 E. Jericho Turnpike, Huntington Station, NY 11746



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Patient Personal Information

Date:

Marital Status: Single Married Widowed

Sex: Male Female

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Email Address: _____

Pharmacy: _____

Employer: _____

SS #: _____

Address: _____

Primary Care Physician: _____

Phone: _____

Address/Phone: _____

Referring Doctor: _____

Primary Insurance Company:

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: _____ SSN#: _____

Identification #: _____ Group ID: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Company:

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Date of Birth: _____ SSN#: _____

Identification #: _____ Group ID: _____

Relationship to Patient: _____ Employer: _____

Accident Information:

Is condition due to an accident? Yes No Date: _____

Type of Accident: Auto Work Home Other: _____

Assignment and Release:

I hereby authorize the physician(s) of Orthopedic Spine Care of Long Island, PC, to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of claims.

I authorize payment of medical benefits to the physician(s).

Patient or Authorized Signature: _____

Physician's Signature: _____

In case of denial or termination of benefits, I the undersigned, understand that I am responsible for payment in full for services rendered.

Patient or Authorized Signature: _____ **Date:** _____



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No Fault Insurance

Patient's Name: _____

Date of Accident: _____

In consideration of services rendered or to be rendered to the above patient, I hereby authorize payment directly to the above named physician of any and all first party No-Fault automobile insurance benefits to which I may otherwise be entitled for services rendered by the provider.

In the event the providers charges are outstanding and I fail to file an application for benefits under the New York State No-Fault Insurance Law, I hereby authorize the provider to file such claim in my behalf so that the provider may realize payment of its charges. I understand that if the provider does not receive payment from the insurer, I am personally responsible for the payment of the providers charges.

Signature: _____

Relationship to Patient: _____

Date: _____

Insurance Information

Insured: _____

Policy Number: _____

CLM#: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Contact Person: _____

Please Note: Effective February 1, 1974, each insurance company which offers insurance policies to satisfy the minimum requirements of No-Fault law shall offer policies with a family deductible up to \$200. The deductible is the portion of the covered medical expenses which an insured person must pay before the insurance carrier would be expected to make payment. The patient or the patient's family should be aware of whether or not the policy holders had chosen a deductible option for medical expenses on the auto insurance policy.



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

Medical Record from (insert date) _____ to (insert date) _____

Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

Other: _____ Include: *(Indicate by Initialing)*

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: <input type="checkbox"/> At request of individual <input type="checkbox"/> Other:	11. Date or event on which this authorization will expire:
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12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:
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All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Signature of patient or representative authorized by law. Date: _____

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa, Mastercard, Discover and American Express
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim. If we later receive a check from your insurer, and your account is paid in full, we will refund any overpayment to you.
3. We have made prior arrangements with some insurance companies and other health plans to accept an assignment of benefits. We will bill them directly, but you are required to pay your co-insurance and deductible at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. When you receive that payment you will be responsible to forward to us the difference between what was paid by you at the time the service was rendered and what was billed to your insurance carrier.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance.
7. If you miss an appointment without calling 24 hours in advance to cancel that appointment, you will be charged \$100, barring any unusual circumstances. This charge is allowed by your insurance carrier and will not be billed to them.

I have read and understand the practice’s financial policy and I agree to be bound by these terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor)

Date

Please print the name of the patient

BP: _____

Pulse: _____

Date: _____

PATIENT REGISTRATION FORM

Age: _____

Height: _____

Weight _____

Patient Name: _____

Doctor Requesting Consult: _____

Name/Address: _____

Is there someone you would like to send a report of your visit to?

Name/Address: _____

Name/Address: _____

History of Present Illness:

Chief Complaint: (Reason for being seen) List detailed symptoms, location and description of pain.

Example: I am having pain in my lower back with radiation down to my knees.

1) When did the present episode of pain (weakness, etc.) begin? _____

2) What, where and how did this episode start? _____

3) Have you ever had anything like this before? If yes, when? How? _____

Neck/Upper Back

Have you experienced arm and hand numbness/weakness? Yes No

Based on a total of 100%, What percentage of your pain is in your _____% neck vs. _____% arms.

Mid/Lower Back

Have you experienced leg numbness/weakness? Yes No

Based on a total of 100%, What percentage of your pain is in your _____% back vs. _____% legs.

1) What makes the pain worse?

___ sitting	___ standing	___ walking
___ bending forward	___ bending backward	___ coughing

2) What reduces the pain?

___ sitting	___ standing	___ walking
___ medications	___ exercise	___ lying down

Past Medical Treatment:

Have you been treated by another doctor for this injury or complaint? Yes No

If Yes, please list the doctors name and location

Name: _____

Address: _____

Have you had any diagnostic test performed for this problem?

Test	Date (s)	Test	Date (s)
X-Rays		Bone Scan	
MRI		Discogram	
Myelogram		CAT Scan	
Dexascan		Other	

What other treatments have you tried for your problem/complaint?

Treatment	Date (s)	Treatment	Date (s)
Physical Therapy		Chiropractic	
Accupuncture		Surgery	
Epidural Sterioids		Pain Management	
Other			

Past Health History: Please check any of the following:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> kidney disease | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> angina | <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease |
| <input type="checkbox"/> diabete | <input type="checkbox"/> hepatitis | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> stroke | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers |
| <input type="checkbox"/> cancer | <input type="checkbox"/> thyroid | <input type="checkbox"/> lung disease |
| <input type="checkbox"/> anemia | <input type="checkbox"/> blood clots | <input type="checkbox"/> seizures |
| <input type="checkbox"/> Other _____ | | |

Surgeries, Hospitalization, Serious Injuries

Have you ever had **SPINAL SURGERY**? Please list dates, procedure and surgeon.

Please list other **SURGERIES** that you have had. Please include dates.

Please list all the **MEDICATIONS** you are now taking. (This includes all prescription, over the counter and herbal medications.)

Do you have **ALLERGIES** to ANY medication? Yes No

If yes, please list: _____

Do you have an **ALLERGY** to latex? Yes No

Do you have an **ALLERGY** to shellfish, iodine or x-ray contrast? Yes No

Family History: Please Check any of the below which apply to your family history

Type	Yes	No	Specify Relationship and Dates
Arthritis			
Cancer			
Heart Disease			
Osteoarthritis			
Back Problems			
Diabetes/Thyroid			
Neurologic Disease			
Scoliosis			
High Blood Pressure			

Work History

Occupation: _____

Employer Name/Address _____

Are you presently working? Yes No

___full time ___time ___unable to work
___on disability ___unemployed ___retired

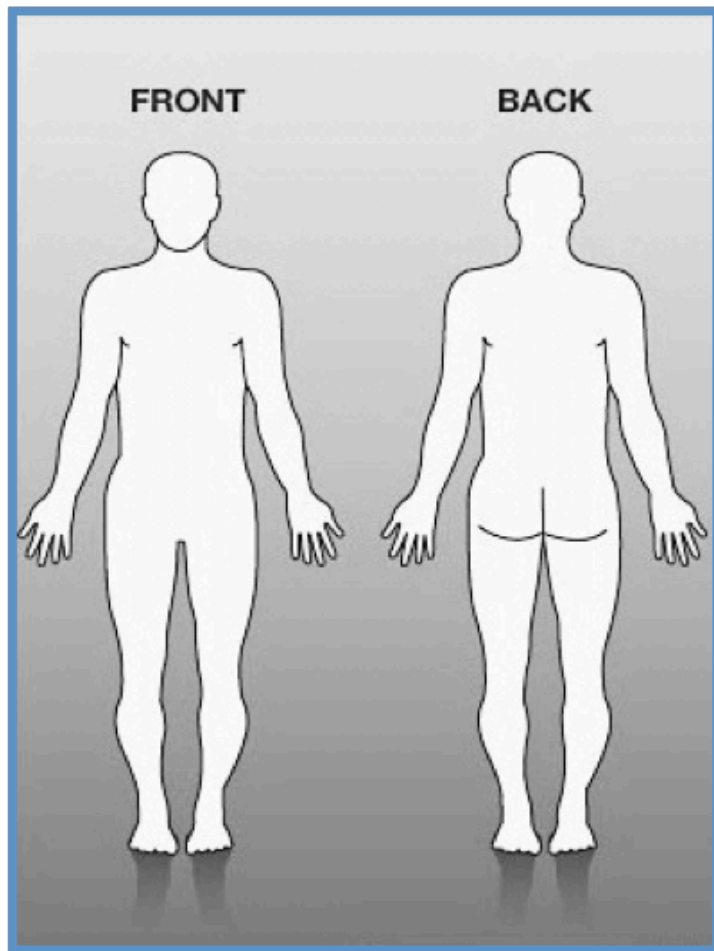
How many days of work have you missed in the past year due to your spine problem? _____

Patient Name:		Date:	
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Where Is Your Pain Located Now?

Mark the areas on the body where you feel the described sensations. Please use appropriate symbols. Mark the areas of radiation. Include all affected areas. Please draw in your face.

Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	0000	=====	xxxx	////



Please Initial Appropriate Level:



Patient Contract for Using Opioid Pain Medication in Pain

This is an agreement between _____ (the patient) and Orthopedic Spine Care of Long Island (OSCLI) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of pain.

Opioid and Controlled Substances Agreement and Informed Consent:

Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to morphine (e.g. MS Contin, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), Hydromorphone (dilaudid), Hydrocodone (e.g. Vicodin, Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinel), etc.

Side Effects & Risks:

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution:

Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stable dose of these medications are obtained. Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary. If decision is made to terminate opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercise to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea...)

The following conditions must be followed and agreed upon as long as the patient is receiving treatment at OSCLI. Noncompliance with any one of these conditions may result in discharge from the practice.

1. OSCLI must be the only source for the medications that were reviewed above. The patient may not obtain these medicines from any other source or physician except when it is explicitly allowed and approved by your OSCLI provider.
2. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.
3. The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by an OSCLI physician.

4. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to the OSCLI provider. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify OSCLI.

5. **Lost or stolen prescriptions or medications will NOT be replaced.** It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to OSCLI.

6. To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommended appointments.

7. **Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.**

8. OSCLI has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.

9. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at OSCLI.

10. **The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.**

11. The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law.

12. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.

13. **Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test it will result in discharge.** The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician.

I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from OSCLI.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient Signature

Date

Doctor Signature

Date