NYC & NJ Practices of

NEW YORK CITY SPINE PLLC

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- Ph: 212-506-0232 / 973-998-9651 Fx: 212-265-0739 / 973-998-9653

DATE: _____

PATIENT INFORMATION

Patient name: _____ **Mr.** ☐ **Ms.** ■ **Mrs.** ☐

Home address: _____ **Cell#:** _____

City, State: _____ **Zip Code:** _____ **Home Phone:** _____

Date of Birth: _____ **Age:** _____ **SS#:** _____

Occupation: _____ **Employer Name:** _____

Employer's address: _____ **Zip Code:** _____ **Phone:** _____

Email address: _____

REFERRAL SOURCE

Referred by: ☐ **Internet** ☐ **Physician** ☐ **Friend** ☐ **Other** ☐ _____

Is this a second surgical opinion? Yes ☐ **No** ☐

Referring Physician: _____**Address:** _____ **Phone:** _____

PRIMARY INSURANCE

Policy Holder name: _____ **SS#:** _____ **DOB:** _____

Insurance Company: _____ **Phone:** _____

Insurance address: _____

Certificate number: _____ **Group:** _____ **Plan:** _____

COMPENSATION/NO FAULT INFORMATION (Work Related or Motor Vehicle Accident)

Carrier Name: _____ **Phone:** _____

Carrier address: _____ **Contact Person:** _____

WCB Case #: _____ **Carrier Case #:** _____

Date of Accident: _____ **Place:** _____ **Comp** ☐ **or** **No Fault** ☐

Comments/Details: _____

MEDICAL HISTORY

(To be filled out by the patient)

Please note the reason for today's visit:

_____

_____

Date of Injury/Problem began: _____ Side of body affected: R ☐ L ☐

Medications: _____

Allergies: _____

Please check off any of the following areas you have/had problems or conditions you have had:

☐ Bleeding Problem	☐ GI Problem	☐ Neurologic	☐ Skin
☐ Cancer: _____	☐ Goiter	☐ Psychiatric Illness	☐ Stomach Ulcer
☐ Cardiac Disease	☐ Gout	☐ Respiratory Illness	☐ Thyroid Disease
☐ Diabetes	☐ Hypertension	☐ Rheumatic Fever	☐ Tuberculosis
☐ Eyes/Ears/Nose/Throat	☐ Kidney Disease	☐ Rheumatoid Arthritis	☐ Vascular Disease

☐ Other: _____

List prior surgeries of any kind including dates and complications:

_____

_____

Please describe, with dates, any serious injuries:

_____

_____

Please provide any additional medical information relevant to your current problem:

_____

_____

List any Family Medical History: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you smoke: ☐ Y ☐ N How much: _____

Do you drink: ☐ Y ☐ N How much: _____

Do you use any recreational drugs: ☐ Y ☐ N Which ones? _____

Primary Care Physician: _____

Address: _____ Phone: _____

_____

Physician Signature

PAIN DIAGRAM

Today's Date _____ Name: _____Age: _____ Gender: _____

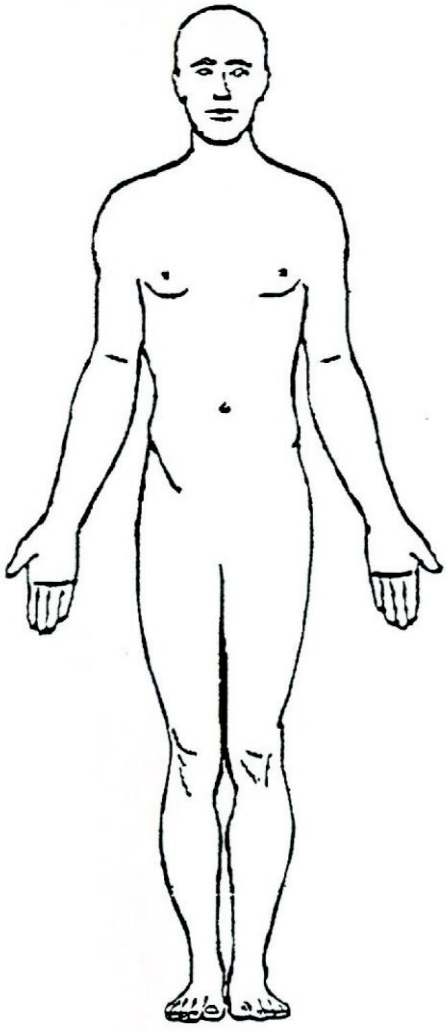
Height: _____ Weight: _____ Pulse: _____ Blood Type: _____

What side do you favor: ☐ RIGHT HANDED ☐ LEFT HANDED

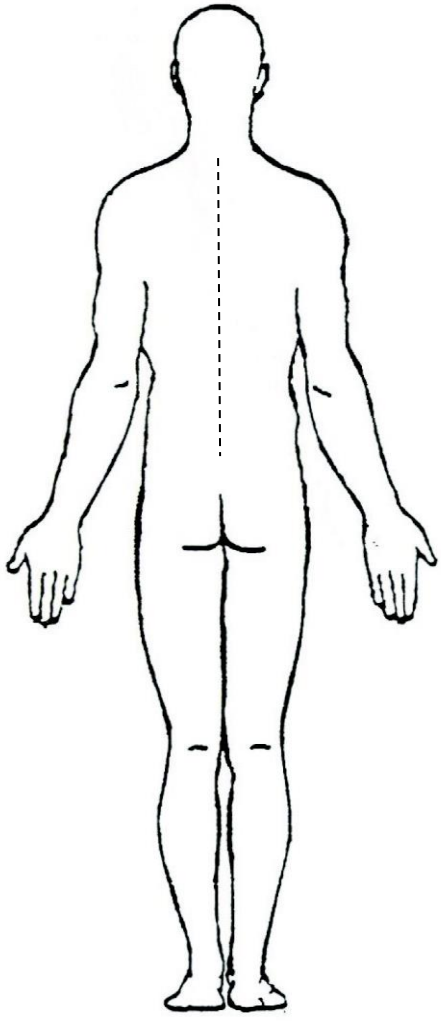
INSTRUCTIONS: Please fill out the pain drawing according to where you are hurt or feel pain. Use the appropriate key symbols to indicate the location of your pain.

KEY: /// STABBING | XXX BURNING | 000 PINS & NEEDLES | === NUMBNESS | ++++ ACHING | * OTHER**

RIGHT



LEFT



RIGHT

What treatment have you had for your pain? Please be specific:

☐ Physical therapy (when, how long, where): _____

☐ Chiropractor (when, how long, with whom): _____

☐ Acupuncture (when, how long, with whom): _____

☐ Injections (when, with whom):_____

☐ Surgery (when, with whom): _____

☐ Other: _____

_____

Patient Signature

INSURANCE/PAYMENT

We, at **New York City Spine Surgery, PLLC**, are committed to providing you with the best possible service. If you have insurance, we will help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our policies.

You should be knowledgeable of your health insurance benefits. Do not assume that we know what your benefits are. You insurance contract is between you and the insurance company unless you have been advised by our staff that your Physician is a participant. If this is not the case, then we are not a part of your contract, nor are we bound by its rules. Non- Covered Services. All Services/Supplies deemed NON- COVERED as noted in your carrier coverage manual are the sole financial responsibility of the: patient. These items include but are not limited to Supplies, Equipment, Bandages, Splints and Braces. Any charges that are above the Reasonable and Customary are also the sole responsibility of the patient.

Payment/co-payment for services is due at the time services are rendered unless payment arrangements have been negotiated with your insurance carrier. Upon payment we will help you process your insurance claim for your reimbursement.

If your carrier requires a REFERRAL one must be presented at the time of service. By law a patient may not be treated without a referral from the primary care physician to authorize all services, including X-rays and Supplies.

PATIENT AUTHORIZATIONS

Claims Authorization - I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance: carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization shall be bidding upon me, my dependents, and our heirs, executors and administrators.

Assignment of Benefits - Private and Federal (Medicare) - I authorize payments of medical and surgical benefits, including Medicare benefits, to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I understand that any services deemed "Non-Covered" by my carrier are my sole financial responsibility, as outlined in my coverage manual. Prompt and complete payment of said services is also my sole responsibility.

Credit Card Authorization - I authorize, when requested by me over the phone, use of my credit card for outstanding charges.

Litigation Disclaimer -It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X ray in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

Patient's Signature: _____ Print: _____ Date: _____

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NEW YORK CITY SPINE PLLC

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures *Will Be Made Only With Your Consent*, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and· protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive c o n f i d e n t i a l c o m mu n i c a t i o n s f r o m u s by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

This notice was published and becomes effective on/or before April 14. 2003.

I acknowledge by signing below that I have READ & CAN REQUEST COPY of the Notice of Privacy of New York City Spine, I also further acknowledge that I have had an opportunity to ask questions about this policy.

Patient Signature: _____

Patient Name: _____

Date: _____

If this acknowledgment is not signed by the patient, LEGAL GUARDIAN can sign below:

Name of person signing: _____

Relationship to patient: _____

Signature: _____

Date: _____