Tri-Borough NY Medical Practice, PC

Remitance: 185 Kingsland Street, Nutley NJ 07110

Phone:855-699-6246 **Fax:** 718-766-9763

SIGN IN SHEET

Trea﷯ng Physician: _____ Date: _____

Office Loca﷯on: _____Medical Assistant: _____

	NAME (PLEASE PRINT)	APPT TIME:	REASON FOR VISIT	REFERRED BY	INSURANCE	*OUTCOME **FOR OFFICE STAFF ONLY***
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

16						

PATIENT INTAKE FORM

Please fill in all the information as accurately as possible. The information provided will assist in formulating a complete health profile. All answers are confidential.

PATIENT INFORMATION

First Name: _____ Last Name: _____
Date of Birth: _____ **Gender**: ☐ Male ☐ Female ☐ Other Social Security #: _____
Street Address: _____City: _____ State:_____ ZIP Code: _____
Home Phone: _____ Mobile Phone: _____E-Mail: _____
Preferred Language: _____

Emergency Contact Name : _____
Relationship_____ Phone # _____

Reason for visit:

◊ MVA ◊ Workers Comp ◊ HEALTH ◊ other_____

Date of onset Injury: _____ Brief Nature of Injury: _____

_____

Referred by:_____

INSURANCE INFORMAITON

INFORMATION	PRIMARY	SECONDARY
POLICY HOLDER NAME		
NAME OF CARRIER		
CLAIM ADDRESS		
ID/CLAIM/CARRIER CASE#		
GROUP /POLICY /WCB#		
CLAIM HANDLER if MVA or WC		
PHONE NUMBER		

Employer Name: _____ Phone:_____
Address:_____ City:_____ State:_____ Zip Code: _____

Attorney Name:_____ Phone: _____
Address: _____ City: _____ State:_____ Zip Code: _____

PATIENT AUTHORIZATION

I hereby authorize Tri-Borough NY Medical Practice PC to bill my carrier for services rendered on my behalf. I understand Tri-Borough NY Medical Practice PC is not a participating provider with my carrier, and I may receive payment directly from my carrier for services rendered in which I am then responsible for said payment.

_____ _____ _____
Patient Signature Print Name Date

Dale _____
Cel/Home# *I*
Pdent Name
(Pfaase Pdnl)
Patient
Signature

Pulse
I

w-1

Date of Birth */_____/* Age _ F M Height ___/ _...,.Weight
Who requested lhat you vfs(t Ids office? Altomey

DacCor

(Name)

Self-Refemd Primary Care Physfclan:

What Is lhe main l88SOft far this vlsll? Pain Numbness Weakness Oller ____(Chief Complaint)

Whatbodvaa l la Involved? **n on)**

Neclc	Shoulder	R Elbow L	R Hand L	**R** PeMs ✦	**R** Knee ✦	R Foot L	**R** L
Mid	Arm	R Wdst L	**R** Finger L	**R** Hip L	**R** snide L	**R** Toe L	

How longhas Chis pmb!em been present? Days Weeks Months

Check lhe box whfcll best ffls how your problem started. Then answer lie one queslon below the box□ chaclced. Use as much space to lhe dght as needed.

NO INJURY (Onset was: Gradual or SUdden) ANSWER:
Whr do ,all lhtnk It started?
INJURY -(tMI[.AUTO OR WORK)
Date _____, Where and How did I Happen?
INJURY AT WORK
Date _____, Where and How did It Happen?
WORK RELATED• (BUT NO INJURY)
Dale _____, Where and How did It Happen?
AUTO ACCIDENT - Date/ De1aUs -
Driver/ Passellpr taken to ER?

fllasa sftada ,,,,, ,,,,,,,,,,
ac,a and """ wb1« ,,,,,,, , 1p UH!
The pain Is CcnstantComes and goes (luteaadlead)(IJmdolt)
lmre!UY of pain MBd Madende Severe EJllremely Sevese Score 1110_ QuaDls of Iba pain? Sllarp Dull Stabbtng 11vOllllllng Ad\fng Bw1lfng Other: Asaodaled ....? Swa1119 Numllness Weakness
8fnca my p,abCem 8'arC8d. Ills: Geltfng bellm' Getlftg ·,–
Uncllmtpd Does)'Ola' pain walce ,ou up lorn sleep?

Yes No
What makes yaur s,mptams mmtfl?Adlli1y Rest Emn:lse WmkSllfngWaDdng WNch

make)QI feel belles? Rest SlllfRg Adlvly E8dse Heat fee Olher Whal med effmts have)'llU taken or been pcasatbed fot 1111s paoblem?

Back

Front

L

Check \1llfch tnJatrnents)GI have Clled: M&dicaUon Y N(hoWlmtg) Steroid lrtdOn Y N (Whattype)

Aoapuncture Y N(hawllma) Pl ,slcal 1lharapy Y N (how long)

Address

BP /

Temp

Back Lower						R

L R

R

REVIEW OF SYSTEMS: Do ,ou have now, or have you ever had, any of the foUowfng heallh problems?

1) MIS Have you had am pmbtem wfth this same Pain corldlfon fn Iba past?

y N (mpfaln Have you had pr!ar Back Pain Ned< PBln Joint Swelllnglpa1n Pdar Fracture Arthrftls

2) ARE YOU **ALLEBG.11.** TO ANY MEDICATIONS? y N Ifyes. please Ost

3) ARE YOU A DIME11C? y N TJU:AlMBre IIISldlll **OI'BIMSGS** Diet None
(Please checlc aR lllat apply. or mark None If no pastmedlcal None
4)CON Wefgtltlosa: Lass ofappetite : Awes' : cancer
S)EYE Gfasses : Cantactlenses : Dau!te\Wan : cararact
8) ENI' Headng Loss : Hoaneaess : Rl'9fnllftEans ;
7) CV ffigh llllooclpnmura ; Caranary artaycllsease : ff88lt alBdc ; CHF ; llaod CflD: rncnmadadasteicA
8) RESP Aslhma: Ccn'9II: C0PD : Sma1c8r ; Pnemnmda : Shartof Braalll : 1B : Seep Apnea
9) 81 Sfanacb ldcer : Reaux : COiiis : Hepd1is : lloadlnStoal

11) 81(Slmllcets : Raab : Lumps: Eaema ; Lupus
12) NEU 8ebutas : Strake : 8afance Pralleem : Headu::bes
13) PSY Depressfon: Nesvausness : SleepdisaRfer : hepApn,a

14) HEA1 Easy breeding : eas, bndslng ; Anemia ; Sicfl:fa CeacfiseaS8

PAST MEDICAL IGSTORY
UST MEDICAL PROBLEMS:
WHAT MEDICATIONS DO YOU TAKE? None Please 11st with dasage:

ARE YOU TAKING. OR HAVE YOU EVER TAKEN. BLOOD THINNERS? y N l,as. (type)
PAST HOSPITALIZATIONS (Not for surgery) None
PAST SURGICAL HISTORY: What operations have yau had? Whan?

None Have you ever had a,eactfon ID anesihesla? y N

FAMILY HISTORY: Haw an. dlract relathes had any of the foUowlng clsonfels? If SO, which relatlve?
Air/ ffmatabllla wllb Uta same Pain condlloa ,au are being seen for 1oe1aJ? V N
SOCIAL HISTORY:
DfabeCes y N _tfghBIDadPresSUN y N _Hemtdisease Y N _Altldls V N

Do,auusetabacm? Y N Palcllperclaf _Howtoaa,__YeanAlcahafum? Y N Kawotan? DaBr Olher_lw!ek
Madlal Hlsta,y: M S D W Haw many peapkt Ive wfth ,au?
Occupallo------ Student Emptoyer.

Ale you curreatlJ wmtcfng? y N If no. boW long haw you been offWOik?

Tri-Borough NY Medical Practice, PC

185 Kingsland Street, Nutley NJ 07110
Phone: 855-699-6246
Fax: 718-766-9763

Jacob Peacock, M.D.

Interventional Pain Management Specialist
Diplomate American Board of Anesthesiology and Pain Medicine

You are scheduled for the following procedure (s) to help reduce your pain:

___Cervical Epidural Steroid Injection - Neck and Arm Pain	Date: _____
___Thoracic Epidural Steroid Injection - Mid Back Pain	Date: _____
___Lumbar Epidural Steroid Injection - Low Back and Leg Pain	Date: _____
___Cervical Medial Branch Blocks (facet) - Neck Pain	Date: _____
___Lumbar Medial Branch Blocks (facets) - Low Back Pain	Date: _____
___Cervical Radio Frequency Ablation of Medial Branches	Date: _____
___Lumbar Radio Frequency Ablation of Medial Branches	Date: _____
___Cervical Percutaneous Discectomy	Date: _____
___Lumbar Percutaneous Discectomy	Date: _____

Surgical Centers:

___Global Surgery Center - 680 Kinderkamack Rd, Ste 100 Oradell, NJ 07649-1600
___New York Queens Surgery Center - 46-03 31st Avenue Astoria, NY 11103
___Uptown Surgery Center - 930 East Tremont Avenue Bronx, NY 10460

You must **PREPARE** for your **PROCEDURE** by doing the following:

1. Do not **EAT** or **DRINK** after **MIDNIGHT** before your procedure. This includes water, gum or candy.
2. Take your prescription medications on the day of the procedure with a sip of water. Medications for the heart, blood pressure, asthma, seizures or anxiety should be taken with a small sip of water.
3. Discontinue **ASPIRIN** 7 days prior to the procedure.
4. Discontinue **ANTI-INFLAMMATORY** medications 2-3 days prior to the procedure. This includes ibuprofen, naproxen, diclofenac, Motrin, Advil, Aleve, meloxicam, etc.
5. **DIABETIC PATIENTS** - If you are on any injectable medications such as insulin, or oral diabetic medications, contact your medical doctor for proper management prior to these injections. Please check your glucose level at home before you come in for your procedure. We will also perform a glucose finger stick to check your sugar level prior to your procedure.
6. If you are on blood thinners such as Plavix (clopidogrel), Xaralto, Eliquis, Coumadin (warfarin), or others, you will need special instructions and medical clearance to safely discontinue.
7. Leave all valuables at home, this includes any and all jewelry.

Tri-Borough NY Medical Practice, PC

185 Kingsland Street, Nutley NJ 07110
Phone: 855-699-6246
Fax: 718-766-9763

Jacob Peacock, M.D.

Interventional Pain Management Specialist
Diplomate American Board of Anesthesiology and Pain Medicine

Está programado para los siguientes procedimientos para ayudar a reducir su dolor:

___Inyección epidural cervical de esteroides - Dolor de cuello y brazo Fecha: _____
___Inyección epidural torácica de esteroides - Dolor de espalda media Fecha: _____
___Inyección epidural lumbar de esteroides - Dolor lumbar y de piernas Fecha: _____
___Bloqueos de la rama cervical medial - Dolor de cuello Fecha: _____
___Bloqueos de la rama medial lumbar - Lumbalgia Fecha: _____
___Ablación cervical por radiofrecuencia de ramas mediales Fecha: _____
___Ablación por radiofrecuencia lumbar de ramas mediales Fecha: _____
___Discectomía percutánea cervical Fecha: _____
___Discectomía percutánea lumbar Fecha: _____

Centros Quirúrgicos:

___Global Surgery Center - 680 Kinderkamack Rd, Ste 100 Oradell, NJ 07649-1600
___New York Queens Surgery Center - 46-03 31st Avenue Astoria, NY 11103
___Uptown Surgery Center - 930 East Tremont Avenue Bronx, NY 10460

Debe **PREPARARSE** para su **PROCEDIMIENTO** haciendo lo siguiente:

1. No **COMA** ni **BEBA** después de la **MEDIANOCHE** antes de su procedimiento. Esto incluye agua, chicle o dulces.
2. Tome sus medicamentos recetados el día del procedimiento con un sorbo de agua. Los medicamentos para el corazón, la presión arterial, el asma, las convulsiones o la ansiedad deben tomarse con un pequeño sorbo de agua.
3. Suspenda la **ASPIRINA** 7 días antes del procedimiento.
4. Suspenda los medicamentos **ANTIINFLAMATORIOS** 2-3 días antes del procedimiento. Esto incluye ibuprofeno, naproxeno, diclofenaco, Motrin, Advil, Aleve, meloxicam, etc.
5. **PACIENTES DIABÉTICOS**: si está tomando algún medicamento inyectable, como insulina o medicamentos orales para la diabetes, comuníquese con su médico para recibir un tratamiento adecuado antes de estas inyecciones. Verifique su nivel de glucosa en casa antes de acudir a su procedimiento. También le realizaremos una punción de glucosa en el dedo para comprobar su nivel de azúcar antes de su procedimiento.
6. Si está tomando anticoagulantes como Plavix (clopidogrel), Xaralto, Eliquis, Coumadin (warfarina) u otros, necesitará instrucciones especiales y autorización médica para suspenderlos de manera segura.
7. Deje todos los objetos de valor en casa, esto incluye todas y cada una de las joyas.

GLOBAL SURGICAL SERVICES PC

254 Palisades Ave #118

Garfield, NJ, 07026

EIN #: 41-2634161

NEW YORK MOTOR VEHICLE NO FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to Global Surgical Services, PC, ("Assignee")

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.
(please print)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Patient:

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	

Provider: **Global Surgical Services, PC**
254 Palisades Ave #118, Garfield, NJ, 07026

Robert Drazic DO
Jonathan Silver PA
Jean Pierra PA
Andrew Pollack PA
Joseph Nagy PA
Ribi Priyev PA

Jacob Peacock MD Christopher Bilbao DO Osewa Olatokunbo NP Amna Rauf PA
Denis Clarke PA
Aaron Shiu DO

Michael Zilles MD Christine Chung NP
Carlotta Ross
Distin PA Adrian St Ange PA Yakov Yakova PA

(Print Provider Name)	(Provider Signature)	(Date)

Bronx Medical Practice PC.

PO BOX 30, NUTLEY, NJ 07110

EIN #: 83-2555474

NEW YORK MOTOR VEHICLE NO FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to Brooklyn Medical Practice PC., ("Assignee")

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.
(please print)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Patient:

_____ _____

(Print name of Patient) **(Signature of Patient)**

_____ _____

(Date of signature)

_____

(Address of Patient)

Provider: **Brooklyn Medical Practice PC**

Robert Drazic DO Jonathan Silver PA Jean Pierra PA Andrew Pollack PA Joseph Nagy PA Ribi Priyev PA

Jacob Peacock MD Christopher Bilbao DO Osewa Olatokunbo NP Amna Rauf PA Denis Clarke PA Aaron Shiu DO

Michael Zilles MD Christine Chung NP Carlotta Ross Distin PA Adrian St Ange PA Yakov Yakova

(Print Provider Name)	(Provider Signature)	(Date)

Bronx Medical Practice PC.

PO BOX 30, NUTLEY, NJ 07110

Please print:

MEDICAL LIEN

Attorney's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Patient's Name: _____

Address: _____

_____

City/State/Zip: _____

_____

Phone #: _____

DOA: _____ **CLAIM#:** _____ **CARRIER:** _____

I do hereby authorize Brooklyn Medical Practice PC to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself regarding the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly Brooklyn Medical Practice sums in the amount of □ **$6,000/$8,000 Left /Right Knee Arthroscopy** □ **$8,000/$10,000 Left / Right Shoulder Arthroscopy** as may be due endowing him for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect Brooklyn Medical Practice. I hereby further give a lien on my case to Brooklyn Medical Practice against any and all proceeds of any settlement, judgment o r verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Brooklyn Medical Practice or all the medical bills submitted by him for services rendered to me and, that this agreement is made solely for Brooklyn Medical Practice additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify any subsequent attorney of this lien and notify you the name, address, telephone number of my new attorney.

This lien agreement will be effective if the assignment becomes null and void through patients' violation of any policy condition and/ or the policy is deemed void ab initial and/ or is voided at any time before payment is made and /or when policy is exhausted and/or if the accident is found to be staged and/or if the undersigned patient committed fraud in procuring this policy or commits fraud at any time before the payment for the services is made.

Patient's Signature: _____ **Date:** _____

This agreement cannot be changed, altered or modified without written consent of the medical provider.

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Brooklyn Medical Practice PC. prior to the payment of any part of such settlement, judgment, award, or verdict to the Patient named above.

I agree to notify you if I discontinue the patient in pursuit of their claim. I agree to provide you status of their claim upon your written request.

Attorney's Signature: **Date:**

Physician Disclosure of Financial Interest - Tri-Borough NY Medical Practice PC

Thank you for the opportunity to provide your orthopedic and pain management needs. We at Tri-Borough NY Medical Practice PC are committed to assuring your complete satisfaction. Dr. Leonid Shapiro is the 100% owner of Tri-Borough NY Medical Practice PC.

New York and New Jersey Law require that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred so that you may address any concerns you may have directly with your physician.

Dr. LEONID SHAPIRO is the 100% owner of Tri-Borough NY Medical Practice PC.

During your treatment and scheduling you may be referred to South Nassau Orthopedic Surgery & Sports Medicine, Hudson Premier Healthcare Partners LLP, Bronx Medical PC, Anestat PC, Interventional Pain Spine & Orthopedic PA, South Bronx Medical, NYC Medical Practice PC and Brooklyn Medical Practice PC. depending on your scheduling needs and plan of care.

The purpose of the disclosure notice is to inform you, the patient, that Dr. Leonid Shapiro MD, , has a financial interest in South Nassau Orthopedic Surgery & Sports Medicine, Hudson Premier Healthcare Partners LLP, Bronx Medical PC, Anestat PC, Interventional Pain Spine & Orthopedic PC, South Bronx Medical, NYC Medical Practice PC and Brooklyn Medical Practice PC.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate surgery center.

You will not be treated differently by your physician if you choose to obtain health care services at another medical provider. We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician.

By signing this Disclosure of Physicians Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has a financial interest in the above-listed surgery centers.

_____

Print Name of Patient Type or Print Name of Parent or Guardian (If applicable)

_____

Signature of Patient Signature of Parent or Guardian (if applicable)

_____

Date

Below is a listing of operative ancillary service providers in which our physicians may have a financial interest:

Tri-Borough NY Medical Practice PC
South Nassau Orthopedic Surgery & Sports Medicine;
Hudson Premier Healthcare Partners LLP; Anestat PC; Bronx Medical PC;
Interventional Pain Spine & Orthopedic PA*;*
South Bronx Medical*;*
NYC Medical Practice PC
and Brooklyn Medical Practice PC

TRI-BOROUGH NY MEDICAL PRACTICE,

PC

185 KINGSLAND STREET, NUTLEY NJ 07110
EIN #: 85-2620371

NEW YORK MOTOR VEHICLE NO FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to TRI-BOROUGH NY MEDICAL PRACTICE, PC, ("Assignee")

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on_____, notwithstanding any other agreement to the contrary.
(please print)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Patient:

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

Provider: **TRI-BOROUGH NY MEDICAL PRACTICE PC**
185 KINGSLAND ST, NUTLEY NJ 07110

Robert Drazic DO Jonathan Silver PA Jean Pierra PA Andrew Pollack PA Joseph Nagy PA Ribi Priyev PA

Jacob Peacock MD Christopher Bilbao DO Osewa Olatokunbo NP Amna Rauf PA Denis Clarke PA Aaron Shiu DO

Michael Zilles MD Christine Chung NP Carlotta Ross Distin PA Adrian St Ange PA

Yakov Yakova **PA**

(Print Provider Name)	(Provider Signature)	(Date)

Please print:

TRI-BOROUGH NY MEDICAL PRACTICE, PC

185 KINGSLAND STREET,
NUTLEY NJ 07110
T: 855-699-7246 F:718-766-9763

MEDICAL LIEN

Attorney's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Patient's Name: _____

Address: _____

_____

City/State/Zip: _____

_____

Phone #: _____

DOA: _____ **CLAIM#:** _____ **CARRIER:** _____

I do hereby authorize TRI-BOROUGH NY MEDICAL PRACTICE PC to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself regarding the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly TRI-BOROUGH NY MEDICAL PRACTICE P C specific sums in the amount of: □ **$6,000/$8,000-L/R Knee Arthroscopy** □ **$8,000/ $10,000-L/R Shoulder Arthroscopy** as may be due endowing him for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect TRI-BOROUGH NY MEDICAL PRACTICE PC. I hereby further give a lien on my case to TRI-BOROUGH NY MEDICAL PRACTICE PC against all proceeds of any settlement, judgment o r verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to TRI-BOROUGH NY MEDICAL PRACTICE PC for all the medical bills submitted by him for services rendered to me and, that this agreement is made solely for TRI-BOROUGH NY MEDICAL PRACTICE PC additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree that if I change attorneys, this agreement will remain enforce and in effect and that I will notify any subsequent attorney of this lien and notify you the name, address, telephone number of my new attorney.

This lien agreement will be effective if the assignment becomes null and void through patients' violation of any policy condition and/ or the policy is deemed void ab initio and/ or is voided at any time before payment is made and /or when policy is exhausted and/or if the accident is found to be staged and/or if the undersigned patient committed fraud in procuring this policy or commits fraud at any time before the payment for the services is made.

Patient's Signature: _____ **Date:** _____

This agreement cannot be changed, altered, or modified without written consent of the medical provider.

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect TRI-BOROUGH NY MEDICAL PRACTICE PC prior to the payment of any part of such settlement, judgment, award, or verdict to the Patient named above.

I agree to notify you if I discontinue the patient in pursuit of their claim. I agree to provide you status of their claim upon your written request.

Attorney's Signature: _____ **Date:** _____

Physician Disclosure of Financial Interest - Tri-Borough NY Medical Practice PC

Thank you for the opportunity to provide your orthopedic and pain management needs. We at Tri-Borough NY Medical Practice PC are committed to assuring your complete satisfaction. Dr. Leonid Shapiro is the 100% owner of Tri-Borough NY Medical Practice PC.

New York and New Jersey Law require that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred so that you may address any concerns you may have directly with your physician.

Dr. LEONID SHAPIRO is the 100% owner of Tri-Borough NY Medical Practice PC.

During your treatment and scheduling you may be referred to South Nassau Orthopedic Surgery & Sports Medicine, Hudson Premier Healthcare Partners LLP, Bronx Medical PC, Anestat PC and Interventional Pain Spine & Orthopedic PA depending on your scheduling needs and plan of care.

The purpose of the disclosure notice is to inform you, the patient, that Dr. Leonid Shapiro MD, , has a financial interest in South Nassau Orthopedic Surgery & Sports Medicine, Hudson Premier Healthcare Partners LLP, Bronx Medical PC, Anestat PC and Interventional Pain Spine & Orthopedic PA.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate surgery center.

You will not be treated differently by your physician if you choose to obtain health care services at another medical provider. We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician.

By signing this Disclosure of Physicians Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has a financial interest in the above-listed surgery centers.

_____

Print Name of Patient Type or Print Name of Parent or Guardian (If applicable)

_____

Signature of Patient Signature of Parent or Guardian (if applicable)

_____

Date

Below is a list of operative ancillary service providers in which our physicians may have a financial interest:

Tri-Borough NY Medical Practice PC
South Nassau Orthopedic Surgery & Sports Medicine;
Hudson Premier Healthcare Partners LLP; Anestat PC; Bronx Medical PC; and
Interventional Pain Spine & Orthopedic PA
NYC Medical

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name | Date of Birth | Patient Identification 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. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. 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 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

NF2 confirmation on file / Status of negative IME _Pain & Ortho _ EUO Status_ Funds Availability _ Claim status_ All Billing inquiry, PIP Ledger

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

For the following to be included, indicate the specific information to be disclosed and initial below.

Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs	
☐ Clinical records from mental health programs*	
☐ HIV/AIDS-related Information	

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW | DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE	SIGNATURE	DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

185 KINGSLAND STREET, NUTLEY NJ 07110

T: 855-699-7246 F:718-766-9763

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your Insurance

- **All patients are required to provide up to date insurance information that would cover services from the initial date of treatment. If during the course of treatment insurance has changes you must notify the practice immediately.**

- **NY/ NJ NO FAULT:** We will bill directly the carrier you have provided for services rendered. Any copays, deductible and coinsurance will be your responsibility. In the event you are not covered or your claim is denied for whatever reason you will be held responsible for payment of services.

- **WORKERS COMPENSATION:** We will bill directly the carrier you have provided as well as the workers compensation board. In the event that your claim has not been established, denied or closed you will be responsible for such payment.

- **HMO/PPO/MEDICARE/MEDICAID:**Please be aware that TRI-BOROUGH NY MEDICAL PRACTICE PC and its providers do NOT participate with any carriers. As a courtesy we will bill your health insurance on your behalf only if you have out of network coverage. Please note that you will be responsible for any deductible, copay and coinsurance that may be applied.

- **MISSED / CANCELLED APPOINTMENTS:** Please note that time and coordination between our office, the surgical center, transportation and providers are done in order to provide a service to you. We ask that every attempt is made by you the patient to keep your scheduled appointments. We do understand that emergency may arise and consideration will be given for those circumstances. Thank you.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name: _____

Address:_____

City_____State:_____Zip:_____

Signature: _____

185 KINGSLAND STREET, NUTLEY NJ 07110

T: 855-699-7246 F:718-766-9763

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how.my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____
Relationship to Patient:_____
Signature:_____
Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____
Reason:_____
Initials:_____

GLOBAL SURGERY CENTER

680 kinderkamack rd. Oradell NJ 07649

Phone (973) 327-1800 Fax (201)645-5633

Notice of Lien

Patient Name:

Date ofInjury:

I do hereby authorize GLOBAL SURGERY CENTER to furnish my attorney, with a full report of the procedure(s) I underwent as a result of my accident referenced above.

I hereby authorize and direct my attorney, to pay directly to the GLOBAL SURGERY CENTER such sums as may be due and owing them for medical services rendered me both by reason of this accident and reason of any other bills that are due the center, And to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate the center. I hereby further give lien on my case to the center against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated of injuries in connection therewith.

I understand that I am directly and fully responsible to said center for all medical bills submitted by them for service rendered me and that this agreement is made solely for said center's additional protection and in consideration ofthem awaiting payment I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify the center of any change or addition of attorney(s) used by me in connection with this accident. I have instructed my attorney to the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the center. I have been advised that if my attorney does not wish to cooperate in protecting the center's interest, the center will not await payment, but may declare the entire balance due and payable.

Patients Signature: _____ Date: _____

Attorney, for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said center named above and agree that payment is to be made directly to the said center. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and cost

Attorneys Signature: _____ Date: _____

New York Surgery Center Queens, LLC

46-04 31st Avenue

Queens, NY 11103

Lien & Assignment of Benefits

PATIENT NAME: _____ **DOA:** _____

ADDRESS: _____

LIEN AMOUNT: $ 15,000.00

The undersigned, as assignor, in consideration of the medical and/or surgical services rendered to the undersigned at New York Surgery Center Queens, LLC, and other good and valuable consideration, does hereby assign, transfer, and act over to New York Surgery Center Queens, LLC, and assigns any and all benefits occurring to the undersigned either from Medicare, Medicaid, No-Fault Insurance, or any other health insurance policy and/or plan, as a result of the treatment rendered to the undersigned at New York Surgery Center Queens, LLC.

The undersigned further agrees to make all applications necessarily required to obtain benefits referred to herein above and to cooperate with New York Surgery Center Queens, LLC and its agents, in obtaining thereof.

The undersigned further covenants and represents to New York Surgery Center Queens, LLC that there is presently in effect the following policy of health insurance and that he or she is not aware of the termination or cancellation thereof.

All reimbursement checks from your insurance company must be presented to New York Surgery Center Queens, LLC for negotiation within 24 hours of receipt. I understand that if this does not happen, I am personally responsible for payment to the company's charge.

I authorize that from all monies collected on settlement of a lawsuit, all monies that are due to New York Surgery Center Queens, LLC be forwarded to them prior to disbursement.

_____ _____

Signature of Patient Signature of Attorney

Law Office: _____

PROCEDURE CONSENT FORMS

T: 855-699-7246 F: 718-766-9763

Informed Consent for Treatment

Patient Name: _____ Date of Birth: _____

I understand and acknowledge that during the start of my treatment today that the following procedures may be required:

_____EMG/ NCV TESTING

_____Epidural: Cervical, Thoracic, Lumbar, Facet Joints and Radio Frequency Ambulation (RAF) with use of local anesthesia.

_____Trigger Point Injection

_____Diagnostic Discography, Surgical Discectomy, Rhizotomy

_____Orthopedic surgical procedure: Arthroscopy, Repairs

_____Joint Injection _____

I acknowledge and understand that prior to any procedure being performed more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask specific questions and have those questions answered. The procedure will proceed only when a verbal consent and this written consent have been obtained.

RISKS

I understand that the practice of medicine is not an exact science and acknowledge that I have not received any guarantees, assurances, or promises concerning the results of the procedure(s). I understand that as a result of the performance of the procedure(s) there is a moderate risk that I may suffer allergic reaction or suffer infection.

The potential benefits and likelihood of success with treatment are very good. I understand and acknowledge that there are alternatives to treatment such as (but not limited to) prescribed, over the counter (OTC) medications and not seeking treatment (i.e. living with the condition (s). If the procedure is rejected, the future prognosis is unknown at this time.

I acknowledge and understand that during the course of my treatment, conditions may develop which may necessitate to the performance of additional procedures, which are unforeseen, or not known to be needed at the time this consent is obtained and that my treating physician will not be held responsible for any unforeseen circumstances.

I acknowledge and understand that this request for and consent to surgical and/or diagnostic procedures shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the physician, and for all other medical personnel otherwise involved in the course of treatment.

By signing below, I have read this form and had this form read and/or explained to me and that I fully understand this form, and I have been given ample opportunity to ask questions, and any questions I have asked have been answered or explained in a satisfactory manner. In signing, I understand the relative risks, potential benefits and alternatives for treatment and I voluntarily consent to allow Dr. _____ or any physician designated or selected by them and all other personnel that may otherwise be involved in performing such procedures, to perform the procedures described or referred to herein.

_____ _____

Signature of Patient or Person Signing on Behalf of Patient Date

_____ _____

Signature of Witness Date

TRI-BOROUGH NY MEDICAL PRACTICE, PC

185 KINGSLAND STREET, NUTLEY NJ 07110
T:855-699-7246 F: 718-766-9763

Patient Name: _____Date of Procedure: _____

PRE PROCEDURE INSTRUCTIONS:

1. Do **NOT** eat or drink anything for at least 6 hours, before the scheduled procedure.
2. Take your normal scheduled medication in the morning of the procedure with a sip of water
3. Do **NOT** take diabetic medication (insulin, metformin, etc) or diuretics (water pills) in the morning of your scheduled procedure
4. **STOP** Aspirin and Plavix 5 days before your scheduled procedure.
5. **STOP** any NSAIDS (ibuprofen, Advil, Aleve, Diclofenac, Celebrex, etc), 3 days before your procedure.
6. Medical Clearance if required must be provided no more than 30 days or no later than 24 hours from your scheduled date.

********* As a result of Covid-19 all patients will require antigen testing via nasal or saliva swab. This must be completed no more than 5 days prior to your scheduled date. Patients are required to provide results no later than 24hrs from the date of your scheduled procedure************

For a site nearest you please speak with the front desk staff at your therapy office or call the scheduling office directly at 855-699-7246.

Thank you for your understanding and cooperation.

TEST SITE LOCATION:

_____
_____
_____

185 KINGSLAND STREET, NUTLEY NJ 07110

T: 855-699-7246 F:718-766-9763

Summary of Our Notice of Privacy Practices

Effective Date: June I, 2003

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review the full Notice of Privacy Practices (NPP), which is available on request. If you have any questions about this notice, please contact the privacy Officer.

Who will follow this notice?

- The above-named medical practice

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or healthcare operations purposes described in this notice.

Our pledge regarding health information:

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this healthcare practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;and
- Follow the terms of the notice that is currently in effect.

How we may use and disclose health information about you:

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to.get reimbursed for your care, and to operate our organization

There are also various other ways in which we may use or disclose your information:

- To allow oversight of the quality of the healthcare we provide
- To allow workers' compensation claims
- As required by subpoena in lawsuits and disputes
- Various uses as required by law or to avert a serious threat to health or

safety The full details for all these uses are contained in the full NPP.

185 KINGSLAND STREET, NUTLEY NJ 07110

T: 855-699-7246 F:718-766-9763

Your rights regarding health information about you:

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper Copy of this Notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from the Administrator listed above.

Changes to this notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand comer, the effective date. In addition, each time you register for treatment or healthcare services, we will offer you a copy of the current notice in effect.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the Administrator listed above. All complaints must be submitted in writing. You will not be penalized for filing complaint.

Other uses of health information:

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of care that we provided to you.

185 KINGSLAND STREET, NUTLEY NJ 07110
T: 855-699-7246 F:718-766-9763

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Bergen Orthopedic and Sports Medicine

495 ALLWOOD RD # 4108 CLIFTON NJ 07102

EIN #: 39-2328877

NEW YORK MOTOR VEHICLE NO FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I,_____, ("Assignor") hereby assign to Bergen Orthopedic and Sports Medicine, ("Assignee")

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, notwithstanding any other agreement to the contrary.
(please print)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

Patient:

_____ _____

(Print name of Patient) **(Signature of Patient)**

_____ _____

(Date of signature)

_____

(Address of Patient)

Provider: **Bergen Orthopedic and Sports Medicine.**

495 ALLWOOD RD # 4108 CLIFTON NJ 07102

Robert Drazic DO Jonathan Silver PA Jean Pierra PA Andrew Pollack PA Joseph Nagy PA Ribi Priyev PA

Jacob Peacock MD Christopher Bilbao DO Osewa Olatokunbo NP Amna Rauf PA Denis Clarke PA Aaron Shiu DO

Michael Zilles MD Christine Chung NP Carlotta Ross Distin PA Adrian St

Ange PA **Yakov** **Yakova PA**

(Print Provider Name)	(Provider Signature)	(Date)

Bergen Orthopedic and Sports Medicine

495 ALLWOOD RD # 4108 CLIFTON NJ 07102

Please print:

MEDICAL LIEN

Attorney's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____

Patient's Name: _____

Address: _____

_____

City/State/Zip: _____

_____

Phone #: _____

DOA: _____ **CLAIM#:** _____ **CARRIER:** _____

I do hereby authorize Bergen Orthopedic and Sports Medicine to furnish you, my attorney, with a full report of their examination, diagnosis, treatment, prognosis, etc. of myself regarding the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly Bergen Orthopedic and Sports Medicine sums in the amount of □ **$6,000/$8,000 Left /Right Knee Arthroscopy** □ **$8,000/$10,000 Left / Right Shoulder Arthroscopy** as may be due endowing him for medical services rendered to me both by reason of this incident and by reason of another settlement, judgment or verdict as may be necessary to adequately protect Bergen Orthopedic and Sports Medicine. I hereby further give a lien on my case to Bergen Orthopedic and Sports Medicine against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to Bergen Orthopedic and Sports Medicine or all the medical bills submitted by him for services rendered to me and, that this agreement is made solely for Bergen Orthopedic and Sports Medicine additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify any subsequent attorney of this lien and notify you the name, address, telephone number of my new attorney.

This lien agreement will be effective if the assignment becomes null and void through patients' violation of any policy condition and/ or the policy is deemed void ab initial and/ or is voided at any time before payment is made and /or when policy is exhausted and/or if the accident is found to be staged and/or if the undersigned patient committed fraud in procuring this policy or commits fraud at any time before the payment for the services is made.

Patient's Signature: _____ **Date:** _____

This agreement cannot be changed, altered or modified without written consent of the medical provider.

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect Bergen Orthopedic and Sports Medicine prior to the payment of any part of such settlement, judgment, award, or verdict to the Patient named above.

I agree to notify you if I discontinue the patient in pursuit of their claim. I agree to provide you status of their claim upon your written request.

Attorney's Signature: **Date:**

Physician Disclosure of Financial Interest - Tri-Borough NY Medical Practice PC

Thank you for the opportunity to provide your orthopedic and pain management needs. We at Tri-Borough NY Medical Practice PC are committed to assuring your complete satisfaction. Dr. Leonid Shapiro is the 100% owner of Tri-Borough NY Medical Practice PC.

New York and New Jersey Law require that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred so that you may address any concerns you may have directly with your physician.

Dr. LEONID SHAPIRO is the 100% owner of Tri-Borough NY Medical Practice PC.

During your treatment and scheduling you may be referred to South Nassau Orthopedic Surgery & Sports Medicine, Hudson Premier Healthcare Partners LLP, Bronx Medical PC, Anestat PC, Interventional Pain Spine & Orthopedic PA, South Bronx Medical, NYC Medical Practice PC, Brooklyn Medical Practice PC, NJ Orthopedic and Sports Medicine, Westchester Ave Medical PC and Bergen Orthopedic And Sports Medicine. depending on your scheduling needs and plan of care.

The purpose of the disclosure notice is to inform you, the patient, that Dr. Leonid Shapiro MD, , has a financial interest in South Nassau Orthopedic Surgery & Sports Medicine, Hudson Premier Healthcare Partners LLP, Bronx Medical PC, Anestat PC, Interventional Pain Spine & Orthopedic PC, South Bronx Medical, NYC Medical Practice PC, Brooklyn Medical Practice PC, NJ Orthopedic and Sports Medicine, Westchester Ave Medical PC and Bergen Orthopedic And Sports Medicine and Global Surgical Services PC.

You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate surgery center.

You will not be treated differently by your physician if you choose to obtain health care services at another medical provider. We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician.

By signing this Disclosure of Physicians Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has a financial interest in the above-listed surgery centers.

_____

Print Name of Patient Type or Print Name of Parent or Guardian (If applicable)

_____

Signature of Patient Signature of Parent or Guardian (if applicable)

_____

Date

Below is a listing of operative ancillary service providers in which our physicians may have a financial interest:

Tri-Borough NY Medical Practice PC
South Nassau Orthopedic Surgery & Sports Medicine;
Hudson Premier Healthcare Partners LLP; Anestat PC;
Bronx Medical PC; South Bronx Medical;
Interventional Pain Spine & Orthopedic PA*;*
NYC Medical Practice PC, Brooklyn Medical Practice PC;
NJ Orthopedic and Sports Medicine;
Westchester Ave Medical PC and Bergen Orthopedic and Sports Medicine.
Global Surgical Services PC