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 South Nassau Orthopedic Surgery & Sports Medicine PC to bill my carrier for services rendered on my behalf. I understand South Nassau Orthopedic Surgery & Sports Medicine 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

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS
To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S DATE OF BIRTH

LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION

I, _____, hereby authorize my treating health provider,
Claimant's Name

_____, to disclose the following described health information:
Health Provider's Name

_____

_____

_____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

☐ New York State Workers' Compensation Board

☐ My current/former employer _____

☐ Workers' compensation insurance carrier(s) _____

☐ Third-party administrator _____

☐ My attorney/licensed representative _____

☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)

☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

_____ _____ _____
Printed Name of Claimant or Legal Representative | Signature of Claimant or Legal Representative | Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant _____ and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate) _____

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request.
DO NOT SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.

Physician Disclosure of Financial Interest -South Nassau Orthopedic Surgery & Sports Medicine PC

Thank you for the opportunity to provide your orthopedic and pain management needs. We at South Nassau Orthopedic Surgery & Sports Medicine PC are committed to assuring your complete satisfaction. Dr. Leonid Shapiro is the 100% owner of South Nassau Orthopedic Surgery & Sports Medicine PC.

New York Law requires 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 South Nassau Orthopedic Surgery & Sports Medicine PC.

During your treatment and scheduling you may be referred to Tri-Borough NY Medical Practice PC or Interventional Pain Spine & Orthopedic 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, as 100 percent owner of the above-named PCs. has a financial interest in both South Nassau Orthopedic Surgery & Sports Medicine PC, Tri-Borough NY Medical Practice PC and Interventional Pain Spine & Orthopedic 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;
Bronx Medical PC; and Interventional Pain Spine & Orthopedic PC

OCA Official Form No.: 960

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 _____ (Initials) I authorize _____ (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: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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.

X _____ Date: _____

Signature of patient or representative authorized by law.

* 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.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CLAIM ADMIN CLAIM NUMBER (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	CLAIMANT'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the health care provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation insurer/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your health care provider to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or insurer may not be required to pay the provider's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of their bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with their employer or its insurance carrier settling their case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or insurer of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of their bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that they may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the insurer of liability for medical treatment is approved.

South Nassau Orthopedic Surgery & Sports Medicine PC

Service Location: 64 South Central Ave,Valley Stream NY 11580
Business: 185 Kingsland Street, Nutley NJ 07110
T: 516-825-1101 F: 516-568-2840

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 South Nassua Orthopedic Surgery & Sports Medicine, 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: _____

South Nassau Orthopedic Surgery & Sports Medicine PC

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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:_____

South Nassau Orthopedic Surgery & Sports Medicine PC

Service Location: 64 South Central Ave, Valley Stream NY 11580
Business: 185 Kingsland Street, Nutley NJ 07110
T: 516-825-1101 F: 516-568-2840

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.

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.

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.

South Nassau

ORTHOPEDIC SURGERY AND SPORTS MEDICINE, P.C.

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ ACCT#: _____

HOME TEL#: ( ) _____ - _____ CELL #: ( ) _____ - _____

- Have you ever had an MRI? YES / NO
- Have you ever had any x-rays performed with our medical office? YES / NO
- Please provide your HEIGHT: _____ and WEIGHT: _____
- Do you have any allergies to medications? YES / NO
  (If yes, please provide the names of the medications): _____
- Do you have any food allergies? YES / NO
  (If yes, please provide the names of those foods): _____
- Do you have an allergy to latex or latex products? YES / NO

ATTENTION MRI PATIENTS AND ACCOMPANYING FAMILY MEMBERS:

The MRI room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan and even be dangerous, so please answer the following questions carefully. This is particularly important with regards to prior surgery on the part of the body being scanned.

- Have you ever had an operation or surgical procedures of any kind? YES / NO
- If yes, please list all surgical procedures and dates: _____
- What does your doctor think is wrong? _____
- PACEMAKER, wires or defibrillator? YES / NO
- Brain/ aneurysm clip? YES / NO
- Ear implant or **HEARING AID** (must be removed prior to MRI)? YES / NO
- Infusion pump or medication pump of any kind? YES / NO
- Do you have kidney disease? YES / NO
  (IF yes, what is your creatinine level: _____ Date: _____)
- Have you ever been a machinist, welder or metal worker? YES / NO

CONTINUED ON REVERSE SIDE

- Have you ever been hit in the face or eye with a piece of metal? (including shavings, slivers, bullets or BB's) **YES / NO**
- Have you ever had a piece of metal removed from your eye? **YES / NO**
- Are you pregnant or breastfeeding? **YES / NO**
- Do you have claustrophobia (fear of enclosed spaces)? **YES / NO**

Please indicate if you have any of the following items in or on your body:

- Eye implant? **YES / NO**
- Electrical stimulator for nerves or bone? **YES / NO**
- Bullets, BB's or pellets? **YES / NO**
- Metal or shrapnel or metal fragments? **YES / NO**
- Magnet implant (anywhere in the body)? **YES / NO**
- Skin patch for medication? **YES / NO**
- Coil, filter or wire in a blood vessel? **YES / NO**
- Orthopedic hardware (plates, screws, pins, rods, wires)? **YES / NO**
- Artificial limb or joint? **YES / NO**
- Penile prosthesis? **YES / NO**
- Shunt? **YES / NO**
- False teeth, retainers or magnetic braces? **YES / NO**
- Surgical clips, staples, wires, mesh or sutures? **YES / NO**
- Intrauterine device (IUD)? **YES / NO**
- Tissue expander for future implants? **YES / NO**

The normal function of the MRI unit generates electrical currents which may create a sensation of warmth, either in the sides of the imaging unit or in the surrounding coil. If you experience any focal warmth that leads to discomfort, please notify the technologist immediately.

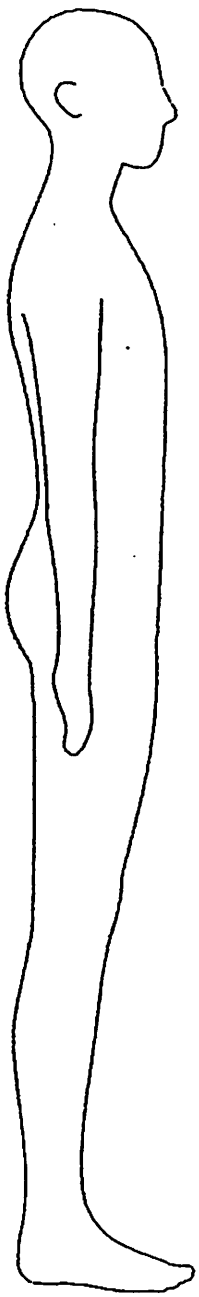
I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of patient (or guardian): _____ Date: _____

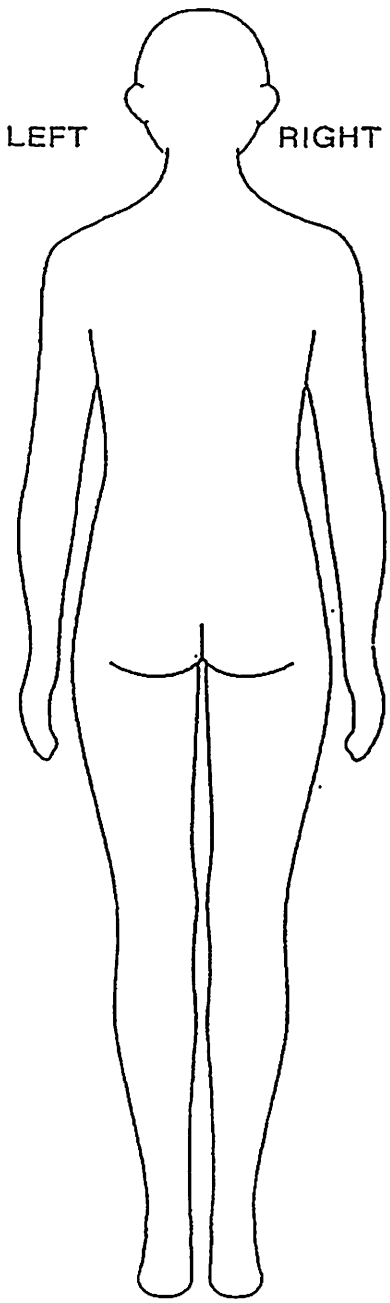
Reviewer #1: _____ Reviewer #2: _____

CONTINUED ON REVERSE SIDE

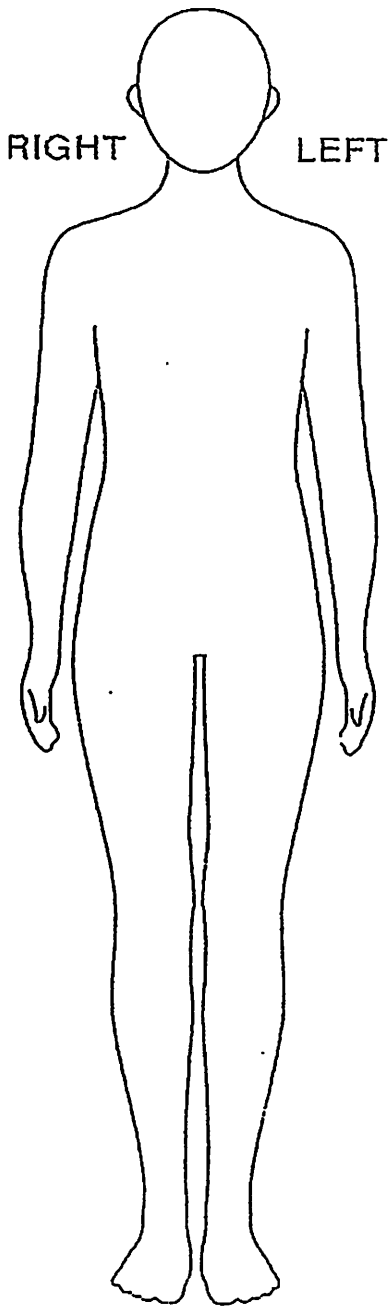
RIGHT SIDE



BACK



FRONT



Signature: _____ Date: _____