THE SPINE & PAIN INSTITUTE of NEW YORK

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Date _____

Last Name _____ **First Name:** _____ **SS#** _____

Birth Date: _____/_____/_____ **Age** _____ **Sex:** ☐ **F** ☐ **M** **Marital Status:** ☐ **M** ☐ **S** ☐ **D** ☐ **W**

Home Address_____ **Apt** _____ **City:** _____ **State:** _____ **Zip** _____

****** Does the above address, match the address on your State Identification Card?** ☐ **Yes** ☐ **No *******

Home Phone (_____) _____ **Mobile Phone: (_____)** _____

Email Address: _____

Employment: ☐ **Full Time** ☐ **Part Time** ☐ **Unemployed** ☐ **Self Employed** ☐ **Retired**

Employer: _____ **Occupation:** _____

Please check off each that may apply to you:

Preferred Language: ☐ **English** ☐ **Spanish** ☐ **Chinese** ☐ **French** ☐ **Arabic** ☐ **German** ☐ **Russian** ☐ **Italian** ☐**Other:**_____

Race (Please select one): ☐ **White** ☐ **Black** ☐ **Native American** ☐ **Asian** ☐ **other** ☐**Unknown/ Refuse to answer**

NO FAULT INFORMATION:

No Fault Carrier: _____ **Date of Accident:** _____

Claim #:_____ **Phone:** _____

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

Adjustor's Name: _____ **Phone:** _____

WORKER'S COMPENSATION INFORMATION:

Worker's Compensation Carrier: _____ **Date of Accident:** _____

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

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

Phone: _____ **Adjustor's Name:** _____ **Phone:** _____

PERSONAL PRIVATE INSURANCE (Only to be used if NF or WC benefits are denied or exhausted):

Insurance Name: _____ **Plan Type: PPO** ☐ **POS** ☐ **EPO** ☐ **HMO** ☐ **Not Sure**

Policy Holder's Name: _____ **Relation:** _____ **Policy Holder's DOB:** _____

Policy #_____ **Group #:**_____ **Phone: (_____)** _____

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

********Private Insurance will NOT be used without your consent********

The given information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that in the event that insurance benefits are paid directly to me, I will forward payment to The Spine and Pain Institute of New York with the understanding that if to do so within 90 days, it may be determined that the services of collection fees and costs associated with the collection of said past due balance(s) is mine. I also authorize The Spine and Pain Institute of New York or insurance company to release any information required to process my claims.

_____ _____

Patient/ Guardian Signature ***Date***

Release of Information

I hereby authorize the physician to release any information acquired in the course of my treatment, to my primary and/or referring physician and my insurance company (ies).

_____ _____

Patient/ Guardian Signature ***Date***

EMERGENCY CONTACT: **Name:** _____ Relation: _____ **Phone: (_____)** _____

REFERRING PHYSICIAN:

Doctor's Name: _____ **Phone: (_____)** _____

Reason for your visit today? _____

PRIMARY /FAMILY PHYSICIAN:

Doctor's Name: _____ **Phone: (_____)** _____

PREFERRED PHARMACY: The Spine & Pain of NY e-prescribes non-narcotic medications as mandated by federal laws. In order to comply, we need accurate pharmacy information. All controlled substances must be obtained at the same pharmacy, where possible, and **must** be filled in **The State of NY.** Should you need to change pharmacies arise, our office must be informed ahead of time. Please provide your pharmacy's information where you expect to fill any prescriptions written by the practitioners at The Spine & Pain Institute of NY.

1. Pharmacy Name: _____ **Phone: (_____)** _____

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

2. Mail Away Pharmacy: ___**Linden Care** ___ **Express Scripts** ___ **Optum Rx** __**Other**

Pain Management Questionnaire

1. Where is the location of you pain?

2. When did your pain begin?

3. On a scale of 0 (no pain) to 10 (the worst pain imaginable) where would you rate your pain?

Currently _____ **At its worst**_____

Assignment of Benefits

As a courtesy to the patient and their families, Spine and Pain Consultant, PLLC does submit claim to many third party payers. I request that payment of authorized Medicare or private benefits to be made to Spine and Pain Consultant, PLLC for any covered services furnished by Spine and Pain Consultant, PLLC if my insurance carrier pays me directly; I agree to forward all funds to Spine and Pain Consultant PLLC within 10 business days.

Disclosure of Information

I understand that my medical records and billing information are made and retained by Spine and Pain Consultant, PLLC and are accessible to Spine and Pain Consultant, PLLC personnel, who may use disclosed medical information for Spine and Pain Consultant, PLLC operations and functions and to any other health care personnel, involved in my continuum of care for this admission.

Release of Records

I authorized Spine and Pain Consultant, PLLC to release to any governmental health care program and its agents, or to any private insurance company or its agents any information needed to determine my benefits payable for Spine and Pain Consultant, PLLC.

I hereby authorize my attending physician to release all medical records pertaining to my healthcare information to Spine and Pain Consultant, PLLC.

Acknowledgement of Notice of Private Practice

A complete description of how my medical information will be used and disclosed by Spine and Pain Consultant, PLLC has been Spine and Pain Consultant, PLLC's NOTICE OF PRIVATE PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this consent form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Private Practices.

Consent for Care Treatment

I, the undersigned, do hereby agree and given consent to Spine and Pain Consultant, PLLC to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

_____

Patient Name Date of Birth

_____

Patient Signature (or Parent/ Guardian or Representative) Date

_____

Relationship to Patient

_____

Witness Date

This authorization permits The Spine & Pain Institute of NY to disclose identifiable health information about you. List any relatives/ personal representatives who are authorized access to your medical records/ treatment plans:

_____ _____

_____ _____

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 _____ I authorize _____

Initials — Name of individual health care provider

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

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ 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.

_____ 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.**

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.

THE SPINE & PAIN INSTITUTE of NEW YORK

Email and Text policy

I, _____, hereby voluntarily provide my email and cell telephone number to The Spine and Pain Institute of New York.

I agree to permit The Spine & Pain Institute of New York, PLLC and their authorized representative to communicate with me by email and text message with respect to confirming my follow up/procedure appointments, medical claims submitted to my insurance company as well as any balances not covered by insurance, coinsurance, deductibles or any other balance deemed patient responsibility.

To be clear, I am consenting to communication by email as required by 15 USC 7001 and related state regulations and statutes. I understand that I have the option to receive any communication on paper or non-electronic form. In such case, I will notify the practice in writing of this request. I understand that my consent is continuous. However, I understand further that I may terminate my consent to email communication in writing to The Spine and Pain Institute of New York. There are no hardware or software requirements needed to receive email communication from The Spine and Pain Institute of New York or their authorized representatives other than an active email account obtained from a vendor that provides such email accounts.

The Spine and Pain Institute of New York will not sell, share, or rent your email address or any other personal information collected on this consent.

Email address: _____

Cell phone #: _____

Patient Signature: _____

Date:_____

I_____ hereby give The Spine & Pain Institute of New York and all its affiliate entities permission to leave messages regarding:

- Medical Information _____
- Billing Information _____

On my answering machine at the following numbers:

- _____
- _____

_____

Patient Signature