SSIP SPINE SPORTS & INTERVENTIONAL PAIN MEDICINE

Patient Registration

Appointment Date:

Patient Demographics

First Name:	Last Name:	DOB:	Age:

Sex: M ___ F ___	Social Security #:	Marital Status: S ___ M ___ O ___

Address:	City:	State:	Zip:

Home Phone:	Cell:	Work:

Email Address:	Can medical information be emailed to this address: Yes _____ No _____

Employer:	Occupation:

Emergency Contact

Name:	Phone Number:	Relationship:

Referral Source

How did you learn about us? Internet _____ Friend/Family _____ Physician _____ Attorney _____ Other _____

Please list the name and number of the referral source:

Major Medical Insurance (please provide private health insurance)

Insurance Company:	Phone Number:

ID Number:	Policy Holder:	Policy Holder's DOB:

Symptom Specifications

Please list your symptoms and complaints relating to your visit today:

Medical Treatment History

Are these symptoms related to an accident? Yes _____ No _____

Did you go to the hospital? Yes _____ No _____	If Yes, list name of hospital:
Were you: Out-patient _____ In Patient_____	Any XRAYS/MRI's or testing performed? If yes what type?
Have you seen any doctors for this injury and/or condition? Yes ____ No ____	If Yes, Name & Phone Number:

Medication Prescribed:

Pharmacy Information

Pharmacy:	Phone Number:	City:

Injury Questionnaire

Injury Specifications		
Date of Injury:	Accident Occurred in: City:	State:
Injury resulted from: Motor Vehicle Accident _____ Work Accident _____ Other _____(If other, Please specify)_____		
Do you have an attorney representing you for this injury? Yes _____ No _____		
Attorney Firm Name:	Telephone Number:	
Did you miss any time from work as a result of the injury? Yes ____ No _____	1st Date Missed:	Date of Return:

No Fault-Motor Vehicle Accident	
Insurance Company Name:	Insurance Phone Number:
Policy Holder Name:	Claim Representative:
Claim #	Policy #
Was the accident reported to the insurance company? Yes_____ No_____	
Was the accident reported to the police? Yes ____No ____ (If yes, provide the front desk with a copy of the police report.)	
Where you the: Driver _____ Passenger _____Pedestrian_____	
# of people in Vehicle:	Where was the vehicle hit? Front ____ Rear ____ Driver Side ____ Passenger Side _____
Were you working at the time of the accident? Yes _____ No _____	

Worker's Compensation-Work Accident	
Insurance Carrier:	Employer Name & Address (at the time of the accident):
Claim /Carrier Case #:	
WCB #:	
Claim/Case Manager:	Phone Number:
Was your injury reported to your employer? Yes _____ No _____	
Name & Phone Number of Supervisor Reported to:	

PREVIOUS MEDICAL HISTORY

Patient Name :_____

Do you have any medical illness? **Please circle**

Asthma Diabetes High blood pressure Hypothyroidism Hyperthyroidism

Heart disease (what kind)_____ Cancer (what kind)_____

Other illnesses:_____

Did you have any surgeries or operations in the past? ☐ Yes ☐ No

What kind of surgery ? _____ Date: _____

Do you have any **FAMILY HISTORY** ? ☐ Yes ☐ No

If so, please list:_____

Allergies (please list all known allergies): _____

Do you take any kind of **MEDICATION?** ☐ Yes ☐ No

Name of **MEDICATION, STRENGTH** and **reason for taking**:_____

_____

_____

Do you smoke? ☐ Yes ☐ No Do you drink alcoholic beverages? ☐ Yes ☐ No Do you use drugs? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If so, how many months?_____

Have you ever had an **INJURY or a PREVIOUS ACCIDENT?** ☐ Yes ☐ No

If yes, what body part was injured?_____

_____

How long ago?_____

What is your job title and responsibilities?

_____

What work-related tasks do you have difficulty with because of your injury?

_____

What daily activities are difficult for you to do since the injury/accident? Circle all that apply.

Sitting Standing Lifting Carrying Bending Walking Going up/down stairs Playing sports

Other:_____

Patient's Name:_____ **Date:** _____ / _____ / _____

Do you have any of these problems due to your injury?

☐Chest pain ☐Shortness of breath ☐Night sweats ☐Fever ☐Unintentional weight loss
☐Cough ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Pain during urination
☐Changes in bowel/bladder habits ☐Headaches ☐Dizziness ☐Nervousness ☐Anxiety
Difficulty sleeping: ☐due to Insomnia ☐ due to pain ☐due to nightmares

Where is your pain located?

Neck	Upper back	Lower back	Shoulder	Hip	Knee	Ankle
(/10)	(/10)	(/10)	(/10)	(/10)	(/10)	(/10)

Circle your least and greatest pain levels: **(None)** 0--1--2--3--4--5--6--7--8--9--10 **(Severe)**

NECK, SHOULDERS, and ARMS

Do you have neck pain? ☐ Yes ☐ No
If so, does the pain travel into either shoulder? ☐ Yes ☐ No
☐Right ☐Left ☐Both

In either ARM, do you have:
☐Pain ☐Numbness ☐Tingling ☐Pins & Needles ☐Weakness
☐Right Arm ☐Left Arm ☐Both

In either HAND, do you have
☐Pain ☐Numbness ☐Tingling ☐Pins & Needles ☐Weakness
☐Right Hand ☐Left Hand ☐Both

LOW BACK, LEGS, and FEET

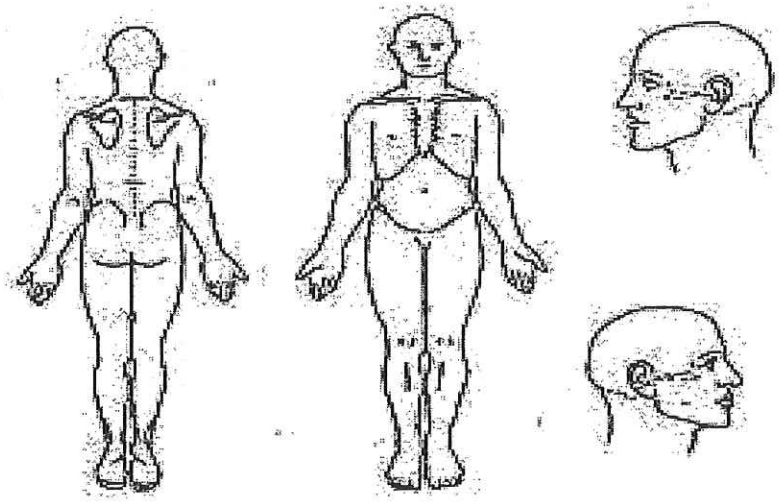
Do you have back pain? ☐ Yes No ☐
In either BUTTOCK, do you have: ☐Pain ☐Numbness ☐Tingling
☐Right ☐Left ☐Both

In either LEG, do you have:
☐Pain ☐Numbness ☐Tingling ☐Pins & Needles ☐Weakness
☐Right Leg ☐Left Leg ☐Both

In either FOOT, do you have:
☐Pain ☐Numbness ☐Tingling ☐Pins & Needles ☐Weakness
☐Right Foot ☐Left Foot ☐Both

PLEASE MARK YOUR AREA(S) OF PAIN IN THE FIGURES BELOW.

Left **Right** **Right** **Left**



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:
Spine Sports & Interventional Pain Medicine 186 Montague Street, 3rd floor, Brooklyn, NY 11201

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.

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.**

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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.
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Spine Sports & Interventional Pain Medicine 186 Montague Street, 3rd floor, Brooklyn, NY 11201

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- ☐ 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.
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Include: (*Indicate by Initialing*)

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(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:

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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.**

ASSIGNMENT OF BENEFITS AND PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

1. INDIVIDUAL FINANCIAL RESPONSIBILITY
    - I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
    - Co-payments are due at time of service.
    - If my plan requires a referral, I must obtain it prior to my visit.
    - In the event, that my health plan determines a service "non-payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
    - If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.
    - I will assume the responsibility to respond to any financial correspondence furnished by Spine Sports and Interventional Pain Medicine and the billing service, and I also agree to pay any outstanding/remaining difference(s), if my initial out-of-pocket payment is not sufficient to satisfy my account once my insurance company has been billed. I understand that my insurance carrier may pay me for services rendered, I must submit the check to Spine, Sports and Interventional Pain Medicine upon receipt.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT FOR ASSIGNMENT OF BENEFITS
    - I hereby authorize and direct payment of my medical benefits to Spine Sports and Interventional Pain Medicine on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS
    - I hereby authorize Spine Sports and Interventional Pain Medicine to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. MEDICARE REQUEST FOR PAYMENT
    - I request payment of authorized Medicare benefits to me or on my behalf for any services furnished to me by or in Spine Sports and Interventional Pain Medicine. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits of related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party — Date

_____ _____

Print of Patient, Authorized Representative or Responsible Party — Relationship to Patient

Spine Sports & Interventional Pain Medicine
186 Montague Street, 3rd Fl, Brooklyn, NY 11201

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the HIPAA Notice of Privacy Practices.

_____

Signature

_____

Printed Name

_____

Date

If representative's signature appears above, please list patient name and relationship to patient:

_____

Patient Name

_____

Relationship to Patient

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective January 2018

This Notice of Privacy Practices applies to the following organizations.

Spine Sports & Interventional Pain Medicine
186 Montague Street 3rd Fl. Brooklyn, NY 11201

Compliance Officer: Stefanie Sanso
ssanso@healthplusmgmt.com
516-294-4590 x 142