



# New Patient Packet

## Medicare

# ***Orthopedic Spine Care of Long Island***

## **REGISTRATION**

### **PATIENT INFORMATION**

**Marital Status:** ☐ Single ☐ Married ☐ Widowed

**Sex:** ☐ Male ☐ Female

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

SS #: \_\_\_\_\_

Address: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Pharmacy Phone#: \_\_\_\_\_

Primary Care DR: \_\_\_\_\_

Referring DR: \_\_\_\_\_

Phone#: \_\_\_\_\_

Phone#: \_\_\_\_\_

### **INSURANCE INFORMATION**

**Primary Insurance:** \_\_\_\_\_

**ID#:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**ID#:** \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_

### **Accident Information:**

Is condition due to an accident? ☐ Yes ☐ No Date: \_\_\_\_\_

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other: \_\_\_\_\_

I hereby authorize the physician(s) of Orthopedic Spine Care of Long Island, PC, to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependent for purposes of review, investigation or evaluation of claims. In case of denial or termination of benefits, I, the undersigned, understand that I am responsible for payment in full for services rendered. I authorize payment of medical benefits to the physician(s).

**Patient or Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

**OCA Official Form No.: 960**

**[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: <b>Orthopedic Spine Care of Long Island      206 East Jericho Turnpike, Huntington Station, NY 11746</b>
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**

### 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: <input type="checkbox"/> At request of individual <input type="checkbox"/> 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.

A. Notifier:

B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for D. \_\_\_\_\_ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. \_\_\_\_\_ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. \_\_\_\_\_ listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- ☐ **OPTION 1.** I want the D. \_\_\_\_\_ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- ☐ **OPTION 2.** I want the D. \_\_\_\_\_ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**
- ☐ **OPTION 3.** I don't want the D. \_\_\_\_\_ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:

J. Date:

**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: [AltFormatRequest@cms.hhs.gov](mailto:AltFormatRequest@cms.hhs.gov).**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



#### Out-Of-Network Office Visit Fees

Consult Appointment:	\$300
X-ray (per body part):	\$200
Follow-Up Appointment:	\$150

Initial:

## Financial Policy/Guarantor Agreement

Orthopedic Spine Care of Long Island (OSCLI) is dedicated to providing the best possible care for you and your family. Below you will find our detailed financial policies. By signing below, you agree to abide by the terms of this agreement.

**In-Network Plans:** Payment is due at the time of service unless payment arrangements have been made in advance with your insurance carrier and confirmed in writing. You are responsible for paying all copays, coinsurance, and deductibles required by your insurance carrier. Additionally, you promise to pay for all services not covered by your insurance carrier.

OSCLI will file insurance claims on your behalf. You must notify OSCLI immediately of any changes to your health insurance. Any charges denied due to incorrect insurance information can become your financial responsibility. If we later receive a check from your insurer, and your account has been paid in full, OSCLI will refund any excess payment to you.

**Out-of-Network Plans:** If we do not participate with your insurance, you are responsible to pay our fees indicated above at the time of service. You are also responsible for all coinsurance fees and deductibles according to your health insurance provider. As a service to you, OSCLI will file insurance claims for you on an unassigned basis. Your insurance company may send payment directly to you; we request that you forward these checks directly to us. You are responsible to pay OSCLI the balance due on your account using the funds paid to you by your insurance carrier as a result of the services rendered by OSCLI. If you cash the insurance check and fail to pay OSCLI the balance owed, OSCLI may commence a lawsuit against you. You agree to pay all attorney fees incurred by OSCLI for such a lawsuit.

**Authorization to Release Records:** I hereby authorize OSCLI to release my medical records to my insurance carriers, government agencies, or to whomever is responsible for my medical care for the purpose of payment for services, and pre-certification and authorization of services requested.

**Payment:** We accept cash, check, Visa, MasterCard, Discover, and American Express. There is a 3% service fee for all credit card charges of \$300 or more. All balances of \$500 or less must be paid in full. Our return check fee is a minimum of \$25. A three-month auto-payment plan can be arranged for balances over \$500. Any account balance not paid, can be sent to an outside agency for collection. If you wish to set-up a payment plan or your insurance has changed, please contact our New Patient Coordinator at 631-847-0200 x137.

**Denial of Payment:** In the event your insurance carrier does not make the appropriate payment or denies payment of your claim, you authorize OSCLI to pursue an appeal on your behalf; however, OSCLI does not obligate itself to pursue such appeal and may instead seek payment from you.

We reserve the right to charge fees for services not typically covered by insurance companies such as copying of medical records and the completion of disability forms.

I have read and understand OSCLI's financial policy above, and I agree to be bound by the terms of this agreement. I also understand and agree that such terms may be amended by OSCLI from time to time.

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Signature of Patient (or responsible party if minor)

Date

---

Print Name

4/2017

BP: \_\_\_\_\_

Pulse: \_\_\_\_\_

Date: \_\_\_\_\_

## **PATIENT REGISTRATION FORM**

Age: \_\_\_\_\_

Height: \_\_\_\_\_

Weight \_\_\_\_\_

Patient Name: \_\_\_\_\_

Doctor Requesting Consult: \_\_\_\_\_

Name/Address: \_\_\_\_\_

Who would you like us to send a report of your visit to?

Additional Reports to:

Referring Provider: \_\_\_\_\_

Name/Address: \_\_\_\_\_

Name/Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **History of Present Illness:**

**Chief Complaint: (Reason for being seen) List detailed symptoms, location and description of pain.**

**Example: I am having pain in my lower back with radiation down to my knees.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1) When did the present episode of pain (weakness, etc.) begin? \_\_\_\_\_

2) What, where and how did this episode start? \_\_\_\_\_

3) Have you ever had anything like this before? If yes, when? How? \_\_\_\_\_

### **Neck/Upper Back**

Have you experienced arm and hand numbness/weakness? Yes No

Based on a total of 100%, What percentage of your pain is in your \_\_\_\_\_% neck vs. \_\_\_\_\_% arms.

### **Mid/Lower Back**

Have you experienced leg numbness/weakness? Yes No

Based on a total of 100%, What percentage of your pain is in your \_\_\_\_\_% back vs. \_\_\_\_\_% legs.

1) What makes the pain worse?

_____ sitting	_____ standing	_____ walking
_____ bending forward	_____ bending backward	_____ coughing

2) What reduces the pain?

_____ sitting	_____ standing	_____ walking
_____ medications	_____ exercise	_____ lying down

## Past Medical Treatment:

Have you been treated by another doctor for this injury or complaint? Yes No

If Yes, please list the doctors name and location

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Have you had any diagnostic test performed for this problem?

Test	Date (s)	Test	Date (s)
X-Rays		Bone Scan	
MRI		Discogram	
Myelogram		CAT Scan	
Dexascan		Other	

## What other treatments have you tried for your problem/complaint?

Treatment	Date (s)	Treatment	Date (s)
Physical Therapy		Chiropractic	
Accupuncture		Surgery	
Epidural Steriods		Pain Management	
Other			

## Past Health History: Please check any of the following:

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> asthma      | <input type="checkbox"/> kidney disease | <input type="checkbox"/> liver disease       |
| <input type="checkbox"/> angina      | <input type="checkbox"/> arthritis      | <input type="checkbox"/> heart disease       |
| <input type="checkbox"/> diabetes    | <input type="checkbox"/> hepatitis      | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> stroke      | <input type="checkbox"/> tuberculosis   | <input type="checkbox"/> stomach ulcers      |
| <input type="checkbox"/> cancer      | <input type="checkbox"/> thyroid        | <input type="checkbox"/> lung disease        |
| <input type="checkbox"/> anemia      | <input type="checkbox"/> blood clots    | <input type="checkbox"/> seizures            |
| <input type="checkbox"/> Other _____ |   |  |

## Surgeries, Hospitalization, Serious Injuries

Have you ever had **SPINAL SURGERY**? Please list dates, procedure and surgeon.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list other **SURGERIES** that you have had. Please include dates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all the **MEDICATIONS** you are now taking. (This includes all prescription, over the counter and herbal medications.)

Do you have **ALLERGIES** to ANY medication?    Yes       No

If yes, please list: \_\_\_\_\_

Do you have an **ALLERGY** to latex?    Yes       No

Do you have an **ALLERGY** to shellfish, iodine or x-ray contrast?    Yes       No

**Family History:** Please Check any of the below which apply to your family history

Type	Yes	No	Specify Relationship and Dates
Arthritis			
Cancer			
Heart Disease			
Osteoarthritis			
Back Problems			
Diabetes/Thyroid			
Neurologic Disease			
Scoliosis			
High Blood Pressure			

**Work History**

Occupation: \_\_\_\_\_

Employer Name/Address \_\_\_\_\_

Are you presently working?    Yes       No

\_\_\_ full time

\_\_\_ on disability

\_\_\_ time

\_\_\_ unemployed

\_\_\_ unable to work

\_\_\_ retired

How many days of work have you missed in the past year due to your spine problem? \_\_\_\_\_



## Social History

- Education: (Grade School      Middle School      High School      College      Graduate Student)
- Marital Status: (Single      Married      Widow      Divorced)
- Do you have children?    \_\_\_Yes      \_\_\_No      If yes, how many children?\_\_\_\_\_
- Do you smoke?    \_\_\_Yes      \_\_\_No      If yes,\_\_\_\_\_Pack(s)/day. How many years?\_\_\_\_\_
- Do you drink alcoholic beverages? \_\_\_Yes    \_\_\_No      How much?\_\_\_\_\_
- Do you now, or have you ever, taken illicit intravenous drugs? \_\_\_Yes      \_\_\_No

**Review of Systems:** (Please check all symptoms you have experienced in the past 2 months.)

A. General:      \_\_\_fever/chills                      \_\_\_weight loss                      \_\_\_other:\_\_\_\_\_

B. Eyes:            \_\_\_vision loss                            \_\_\_glasses/contacts                            \_\_\_other:\_\_\_\_\_

C. ENT:            \_\_\_hearing loss                 \_\_\_dentures                 \_\_\_other:\_\_\_\_\_

D. Cardiac:      \_\_\_chest pain                      \_\_\_palpitations                      \_\_\_other:\_\_\_\_\_

E. Respiratory:      \_\_\_shortness of breath                  \_\_\_cough  
                             \_\_\_wheezing                                  \_\_\_other:\_\_\_\_\_

F. GI:                   \_\_\_bowel dysfunction (incontinence)                   \_\_\_nausea/vomiting  
                             \_\_\_rectal bleeding   \_\_\_other:\_\_\_\_\_

G. GU:           \_\_\_bladder dysfunction (incontinence)                         \_\_\_frequency  
                    \_\_\_painful voiding   \_\_\_other:\_\_\_\_\_

H. Musculoskeletal:    \_\_\_joint pain                                 \_\_\_joint swelling  
                                 \_\_\_morning stiffness                                 \_\_\_other:\_\_\_\_\_

I. Skin:            \_\_\_rashes                                 \_\_\_lesions  
                        \_\_\_itching                                 \_\_\_other:\_\_\_\_\_

J. Neuro:           \_\_\_balance difficulties                                 \_\_\_seizure  
                        \_\_\_headache   \_\_\_other:\_\_\_\_\_

K. Psych:           \_\_\_depression                                 \_\_\_anxiety  
                        \_\_\_mania   \_\_\_other:\_\_\_\_\_

L. Hematologic/Lymphatic: \_\_\_bleeding tendency  
 \_\_\_bruising  
 \_\_\_swollen glands  
 \_\_\_other:\_\_\_\_\_

M. Allergies/Immunologic: \_\_\_decreased immunity                      \_\_\_frequent infection  
                              \_\_\_other:\_\_\_\_\_

**My signature signifies that I have read, answered and understand the above information to be true and accurate.**

**Patient/Guardian signature:** \_\_\_\_\_

**Physician use Only: (Comments/Notes)**

**Patient  
Name:**

**Date:**

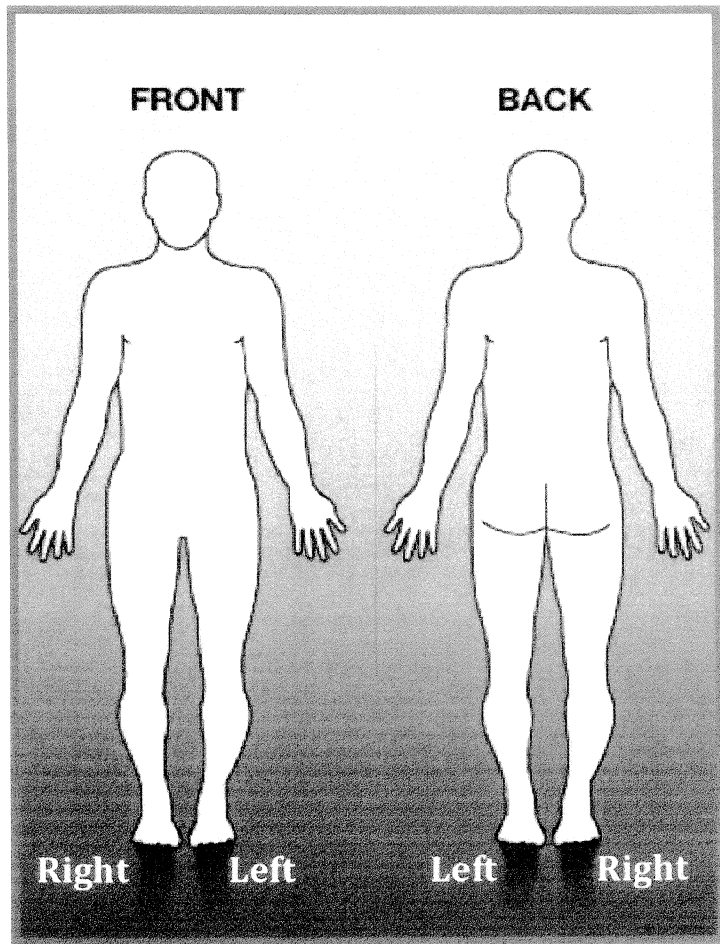
### Where Is Your Pain Located Now?

Mark **ALL** areas on the body where you feel the described sensations. Please use appropriate symbols. Include **ALL** affected areas.

Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	0000	=====	XXXX	////

**Indicate Pain in the  
Following Areas:**

- Neck
- Shoulder
- Back
- Elbow
- Hip
- Knee
- Ankle



**Please Circle Appropriate Level:**



0  
NO HURT



2  
HURTS  
LITTLE BIT



4  
HURTS  
LITTLE MORE



6  
HURTS  
EVEN MORE



8  
HURTS  
WHOLE LOT



10  
HURTS  
WORST

## **Patient Contract for Using Opioid Pain Medication in Pain**

This is an agreement between \_\_\_\_\_ (the patient) and Orthopedic Spine Care of Long Island (OSCLI) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of pain.

### **Opioid and Controlled Substances Agreement and Informed Consent:**

Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to morphine (e.g. MS Contin, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), Hydromorphone (dilaudid), Hydrocodone (e.g. Vicodin, Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinel), etc.

### **Side Effects & Risks:**

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

### **Caution:**

Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stable dose of these medications are obtained. Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary. If decision is made to terminate opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercise to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea...)

### **The following conditions must be followed and agreed upon as long as the patient is receiving treatment at OSCLI. Noncompliance with any one of these conditions may result in discharge from the practice.**

1. OSCLI must be the only source for the medications that were reviewed above. The patient may not obtain these medicines from any other source or physician except when it is explicitly allowed and approved by your OSCLI provider.
2. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.
3. The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by an OSCLI physician.

4. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to the OSCLI provider. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify OSCLI.

5. **Lost or stolen prescriptions or medications will NOT be replaced.** It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to OSCLI.

6. To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommended appointments.

7. **Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays. If there is a need to change any narcotic prescription a new appointment will be made.**

8. OSCLI has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.

9. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at OSCLI.

10. **The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.**

11. The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law.

12. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.

13. **Patient agrees that any use of illicit substances ( Marijuana, Cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test it will result in discharge.** The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician.

I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from OSCLI.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

---

Patient Signature

Date

---

Doctor Signature

Date