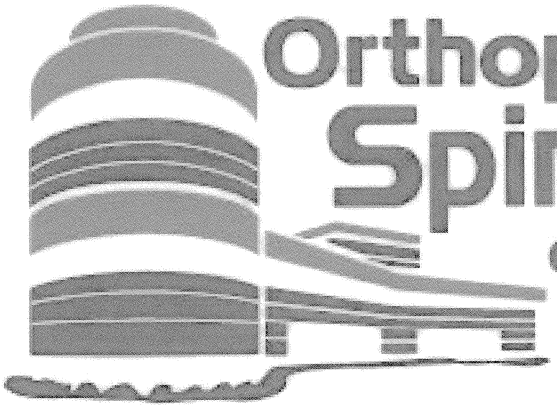


Orthopedic SpineCare of Long Island

T: (631) 847-0200 F: (631) 847-3525
Orthospinecareli.com
206 E. Jericho Turnpike, Huntington Stations, NY 11746

New Patient Packet

No Fault Insurance

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: _____

Orthopedic SpineCare of Long Island

Arnold M. Schwartz , MD
Paul R. Alongi, MD
Waqaas A. Quraishi, MD
Robert J. McCord, RPA-C

206 East Jericho Turnpike, Huntington Station, NY 11746 www.scolimd.com t (631) 847-0200 f (631) 847-3525

No Fault Insurance

Patient's Name: _____ Date of Accident: _____

In consideration of services rendered or to be rendered to the above patient, I hereby authorize payment directly to the above named physician of any and all first party No-Fault automobile insurance benefits to which I may otherwise be entitled for services rendered by the provider.

I understand that I am responsible to file the No-Fault ***"Application of Benefits" (AOB)*** with my insurance carrier, and if I fail to file an application for benefits under the New York State no-Fault Insurance Law, I understand that if the provider does not receive payment from the insurer, I am personally responsible for any outstanding balance of the provider's charges.

Patient Signature: _____ Date: _____

_____
Relationship to Patient (Self-Guardian-Other):

Insurance Information:

Insured: _____ Policy#: _____

Claim#: _____ Date of Accident: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Phone#: _____

Personal Injury Attorney:

Name of Firm: _____ Contact Person: _____

Address: _____ City/State/Zip: _____

Phone#: _____ Fax#: _____

Email: _____

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

PAGE 3

PATIENT: Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (Assignment of Benefits). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ (IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)

ASSIGNMENT OF NO-FAULT BENEFITS

I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT STATUTE) OF THE INSURANCE LAW. THE ASSIGNEE HEREBY CERTIFIES THAT THEY HAVE NOT RECEIVED ANY PAYMENT FROM OR ON BEHALF OF THE ASSIGNOR AND SHALL NOT PURSUE PAYMENT DIRECTLY FROM THE ASSIGNOR FOR SERVICES PROVIDED BY SAID ASSIGNEE FOR INJURIES SUSTAINED DUE TO THE MOTOR VEHICLE ACCIDENT, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS AGREEMENT MAY BE REVOKED BY THE ASSIGNEE WHEN BENEFITS ARE NOT PAYABLE BASED UPON THE ASSIGNOR'S LACK OF COVERAGE AND/OR VIOLATION OF A POLICY CONDITION DUE TO THE ACTIONS OR CONDUCT OF THE ASSIGNOR

PRINT NAME _____ SIGNED _____ DATE

PATIENT (Assignor) PATIENT

PRINT NAME _____ SIGNED _____ DATE

PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

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

DATE	PROVIDER'S SIGNATURE	IRS/TIN IDENTIFICATION NO.	WCB RATING CODE IF NONE, SPECIALTY

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

PLEASE SIGN #21 ONLY

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

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

I, _____ (Print patient's name), ("Assignor") hereby assign to **Orthopedic Spine Care of Long Island** (Print hospital or health care provider name), ("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

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

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

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

_____ (Print name of Patient)

_____ (Signature of Patient)

_____

_____ (Date of signature)

_____ (Address of Patient)

Orthopedic Spine Care of Long Island (Print name of Provider)

_____ (Signature of Provider)

206 East Jericho Turnpike

_____ (Date of signature)

Huntington Station, NY 11746 (Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

1. YOUR NAME	2. PHONE NOS. HOME BUSINESS	
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☒

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

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

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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:
Orthopedic Spine Care of Long Island 206 East Jericho Turnpike, Huntington Station, NY 11746

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.**

Orthopedic SpineCare of Long Island
MRI - CAT SCAN
PAIN MANAGEMENT
SPINE SURGERY & COMPREHENSIVE CARE

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.

Signature of Patient (or responsible party if minor) Date

Print Name

BP: _____ Pulse: _____ Date: _____

PATIENT REGISTRATION FORM

Age: _____ Height: _____ Weight_____

Patient Name: _____

Doctor Requesting Consult: _____
Name/Address: _____

Is there someone you would like to send a report of your visit to?

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**	
Accupunture		**Surgery**	
Epidural Steriods		**Pain Management**	
Other			

Past Health History: Please check any of the following:

___	asthma	___	kidney disease	___	liver disease
___	angina	___	arthritis	___	heart disease
___	diabetes	___	hepatitis	___	high blood pressure
___	stroke	___	tuberculosis	___	stomach ulcers
___	cancer	___	thyroid	___	lung disease
___	anemia	___	blood clots	___	seizures
___	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 incudes 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 ___ time ___unable to work

___on disability ___unemployed ___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)

Orthopedic SpineCare of Long Island
www.scolimd.com
T (631) 847-0200
F (631) 847-3525
206 E. Jericho Turnpike, Huntington Station, NY 11746

Patient Name:		Date:	

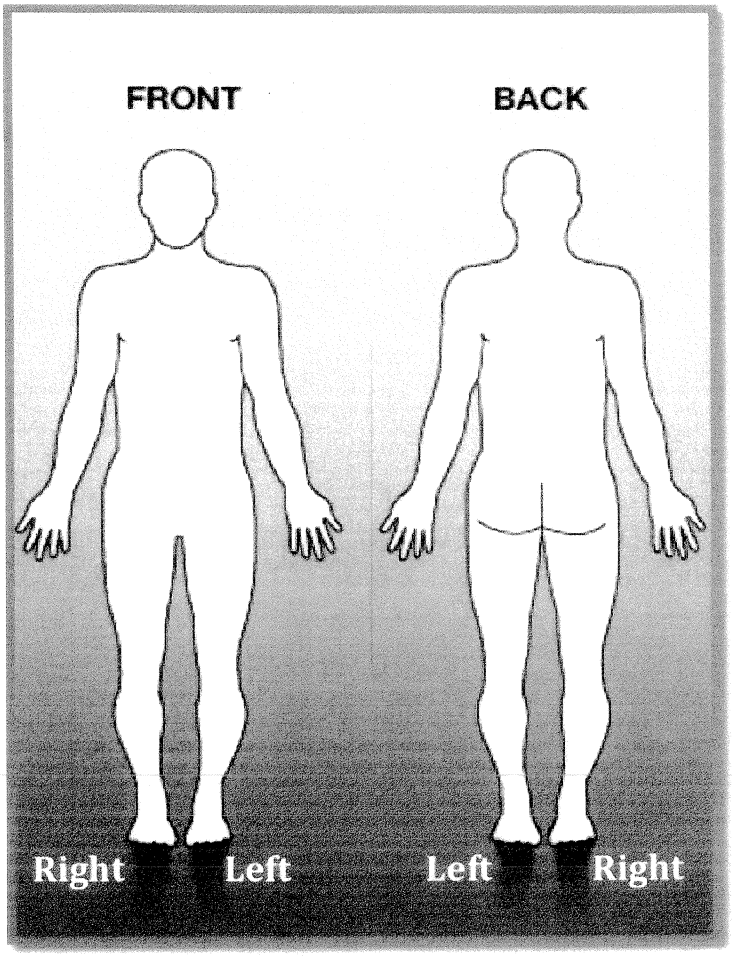
Where Is Your Pain Located Now?

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

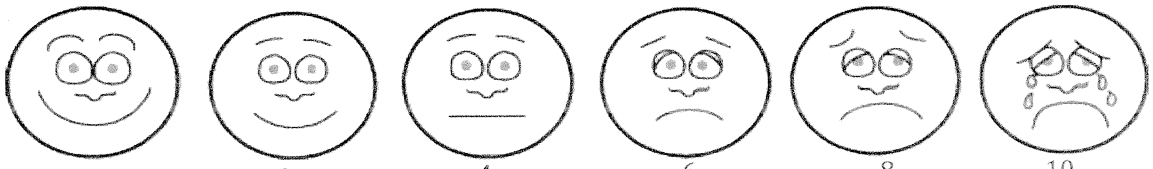
Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	0000	=======	XXXX	////

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

Orthopedic
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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