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

Workers Compensation

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: _____

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 _____ (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.**

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

Workers' Compensation Registration Form

Referring Physician: _____
Referring MD Phone #: _____

Patient Number: _____

Carrier Case #: _____ WCB#: _____

Last Name: _____ First Name: _____

Social Security #: _____ Date of Birth: _____ Gender: Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Date of injury/illness: _____

On the date of injury/illness what was the patient's job title or description: _____
_____

Briefly describe how and where injury occurred: _____
_____

Are you presently working? ___Yes ___ No If No when did you stop? _____
If Yes, Check: Regular Duty____ Light Duty____

If you stopped, when did you return? _____

Employer at time of this injury: _____

Employer Address: _____

Employer Phone #: _____ Contact: _____

Employer's Insurance Carrier: _____

Carriers Address: _____

Adjustor Name and Phone #: _____

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay (MD Name _____) his usual and customary fees for services rendered to the above named claimant in the above identified case. I authorize the provider to release any information necessary to substantiate a claim.

Signature: _____ Date: _____

Employee Claim C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled on on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A: YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ___/___/___

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: _____ 5. Phone Number: (___) _____ Gender: ☐ Male ☐ Female

Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (___) _____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ___/___/___ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

_____

_____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

_____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

_____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ___/___/___ 2. Time of Injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

_____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

_____

5. What were you doing when you were injured or became ill (e.g. unloading a truck, typing a report) _____

_____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

_____

_____

7. Explain fully the nature of your injury/illness; list the body parts affected (e.g., twisted left ankle and cut to forehead):

_____

_____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: ___/___/___
First MI Last

D. YOUR INJURY OR ILLNESS continued

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ Orally ☐ in writing Date notice given: ___/___/___

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ___/___/___ ☐ No, skip to Section F.

2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ___/___/___ ☐ regular duty ☐ limited duty

3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed

4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ___/___/___ ☐ None received (skip to question F-5)

2. Were you treated on site? ☐ Yes ☐ No

3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (___) _____

4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____

5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM**

6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ___/___/___

On behalf of Employee: _____ Print Name: _____ Date: ___/___/___

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ___/___/___

Print Name: _____ Title: _____

ID No., if any: R_____ If Licensed Representative, License No.: _____ Expiration Date: ___/___/___

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157
State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604
Statler Towers 107 Delaware Ave. BUFFALO 14202 (866) 211-0645
130 Main Street W. ROCHESTER 14614 (866) 211-0644
935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident
IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).		

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

Orthopedic Spine Care of Long Island P.C., at
Name of a Specific Person, Corporation, Association or Public or Private Entity

206 East Jericho Turnpike, Huntington Station, NY 11746.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

_____ _____
Claimant's Signature (ink only) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

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

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

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

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

Claimant's Signature _____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

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

Workers' Compensation Law Section 32

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

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

TO THE HEALTH CARE PROVIDER

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

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

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:	

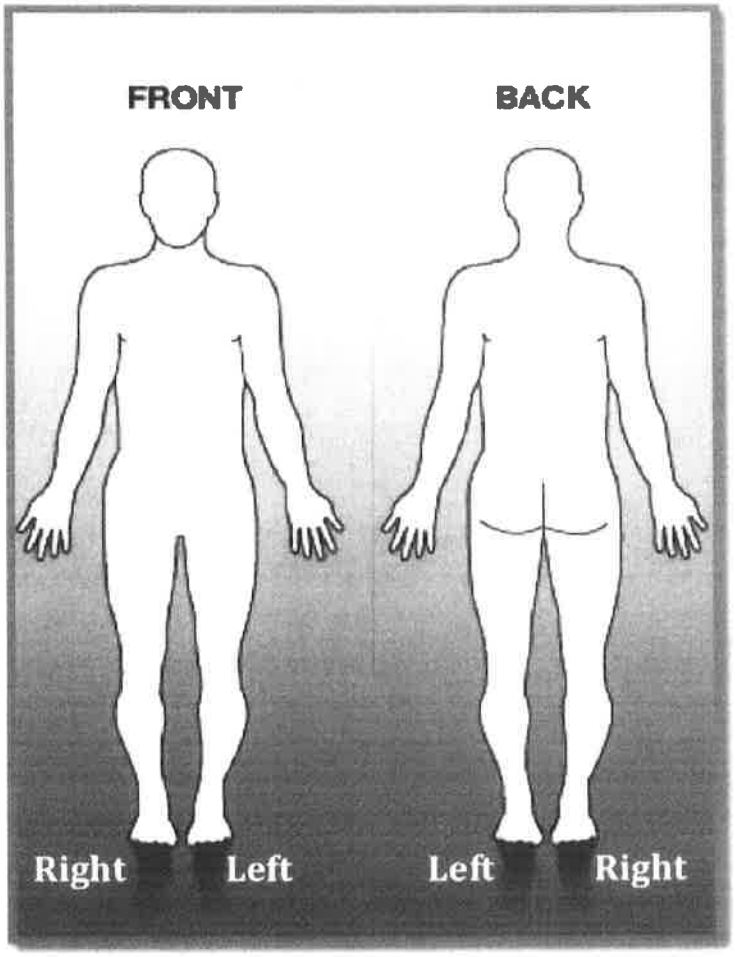
Where Is Your Pain Located Now?

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

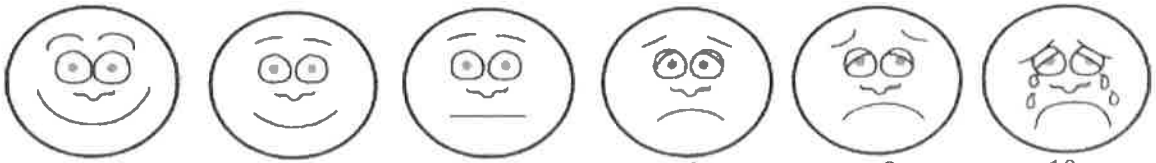
Ache	Numbness	Pins & Needles	Burning	Stabbing
^^^	0000	=======	XXXX	////

Indicate Pain in the Following Areas:

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



Please Circle Appropriate Level:



0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

Orthopedic
SpineCare of Long Island
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206 E. Jericho Turnpike, Huntington Station, NY 11746

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, Roxicodonė), 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