PATIENT NO FAULT INFORMATION

NP NI FU INJ FX AC DOCTOR_____ ACCT#_____

The Central Orthopedic Group, LLP PLV / RVC

DATE _____

Patient **Last name**_____ **First**_____ DOB_____ Age _____

Parent or Guardian (if under 18)_____ Contact Phone # _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Home Phone # _____ Work # _____ Cell # _____

S.S. #_____ Male____ Female____ Employer_____ **Email:**_____

Referring Physician _____ Address _____

Telephone #_____ Fax #_____

Primary care physician (if different from referring physician) _____

Address _____ Telephone # _____ Fax #_____

BODY PART_____ **RIGHT / LEFT** (*CIRCLE*)

Date of Injury_____ **Duration of Problem** _____

Seen in Emergency room? YES OR NO (*CIRCLE*) **Date**_____ **Name of Facility**_____

X-Rays Taken ? YES OR NO Date _____ **Facility** _____

MRI/ CT SCAN Taken? YES OR NO Date _____ **Facility** _____

Pharmacy Name _____ **Telephone #** _____ **Address** _____

NO FAULT INFORMATION

Name of Insurance Company _____ Address _____

Date of Accident _____ Claim Representative _____ Telephone # _____

Did you report your accident to your carrier? Yes ____ No ____ Did you complete a NF2 form? Yes _____ No _____

Policy # _____ Policy Holder _____ File/Claim# _____

PRIVATE INSURANCE INFORMATION:

Name of Insurance Company _____ Policy #_____

Name of Policy Holder _____ Relationship to Patient _____

DOB of Policy Holder _____ S.S. # of Policy Holder _____

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company _____ Policy #_____

Name of Policy Holder _____ Relationship to Patient _____

DOB of Policy Holder _____ S.S. # of Policy Holder _____

MEDICAL INFORMATION RELEASE

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to : The Central Orthopedic Group, LLP. I understand that I am financially responsible for treatment rendered.

_____

Signature of Patient or Authorized Representative: Date

GUARANTEE AGREEMENT

1. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES
In the event that I fail to provide the Central Orthopedic Group, LLP with valid No Fault information or if it is determined by the No fault Carrier that the condition is not a result of the accident as state above, I agree to pay for all medical services rendered to me by the Central Orthopedic Group, LLP.

_____

Signature of Patient or Authorized Representative: Date

UPDATED 3/2017

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

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

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
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 _____, not withstanding any other agreement
(Print accident date)
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)

_____ _____
(Print name of Provider) (Signature of Provider)

_____ _____
(Date of signature)

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

MEDICARE PATIENTS:

We will submit to Medicare for the Medicare allowed amount. The patient is responsible for the deductible and the 20% co-insurance, which can be billed to the secondary insurance. It is your responsibility to give the Central Orthopedic Group your secondary insurance so that we can bill your balance for you. Not all secondary's cover this deductible.

I request that payment of authorized Medicare benefits be made on my behalf to the Central Orthopedic Group for services furnished to me by the provider. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services. I understand the terms of the Central Orthopedic Group as stated above._____

Initial here

OUT OF NETWORK INSURANCE:

If you have an insurance plan that has Out Of Network Policy, you may agree to see a Doctor who does not participate with your carrier. Please sign below stating that you agree to pay your Doctor the amount that is paid to you by your insurance and any out of network portion that is your responsibility _____

Initial here

SCHOOL, SPORTS, CAMPS OR TOWN ACTIVITIES:

Patients who have been involved in a sports related accident through schools, camps, or town activities. We do not accept third party billing! You are responsible for all charges according to your own insurance policy agreement. Once all fees are paid to us by your insurance carrier and by you, we will then issue you a paid receipt for you to forward to the third party payor involved. They will reimburse you directly. _____

Initial here

PERSONAL INJURY PATIENTS:

You are responsible for all services directly to The Central Orthopedic Group, LLP. Once all services have been paid in full, we will then issue you a paid receipt for you to forward to your outside party involved _____

Initial here

WORKERS' COMPENSATION INJURY:

You are responsible for providing the Central Orthopedic Group, LLP with your Workers' Compensation billing information. If this is not received at the initial visit, we will collect a $250 deposit prior to the service. This $250 deposit is payable in cash or credit card only. This deposit will be refunded to you once all your billing information is received and verified. _____

Initial here

NO FAULT INJURIES:

You are responsible for providing the Central Orthopedic Group, LLP. Your No Fault billing information at the time of your initial visit. If this is not received at the initial visit, we will collect a $250 deposit prior to the service. This $250 deposit is payable in cash or credit card only. This deposit will be refunded to you once all your billing information is received and verified. _____

Initial visit

IN NETWORK INSURANCE:

PRIVATE INNETWORK INSURANCE WILL BE COLLECTED AT THE TIME OF YOUR INITIAL VISIT ALONG WITH A PHOTO COPY OF YOUR VALID IDENTIFICATION CARD. You will be responsible to know your insurance. If a referral is needed it is your responsibility to GET ONE or your visit will be canceled. If you have a coinsurance, deductible and or copay you are responsible to pay this at the time of your visit. KNOW YOUR INSURANCE EACH SERVICE YOU ARE RECEIVING MAY REQUIRE A SEPARATE COINSURANCE, COPAY OR DEDUCTIBLE. PLEASE DO NOT ASSUME PAYING YOUR COPAY IS YOUR ONLY RESPONSIBILITY.

I _____, agree that the initialed paragraph above it true and correct to the best of my

Print responsible party name

knowledge. I hereby permit my insurance company or the company that is processing my claims to pay The Central Orthopedic Group, LLP directly.

Patient name: _____

Patient/Guardian Signature_____Print_____date_____

THE CENTRAL ORTHOPEDIC GROUP, LLP DOCTOR _____ LOCATION: PLV / RVC / MASS

DATE:_____ PATIENT NAME:_____ACCOUNT #_____

CONSENT INFORMATION

CONSENT TO TREAT:

The information I have given to the Central Orthopedic Group is complete and true to the best of my knowledge. I authorize the doctors/PAs and staff of The Central Orthopedic Group, LLP, to administer such procedures and treatment as they see necessary. The Central Orthopedic Group physicians/PAs and staff have implied no guarantee of cure. **Patient initials_____ Date:_____**

CONSENT TO TREAT A MINOR CHILD:

The information I have given to the Central Orthopedic Group, pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors/PAs and staff of the Central Orthopedic Group, LLP, to administer such procedures and treatment as they see necessary to my child/ward in my legal custody, (if no any legal attachments) I have a signed letter giving permission to sign all documents as acting guardian. **Parent/Guardian initials _____Date:_____**

FOR WOMAN ONLY:

The doctor/PA or a staff member of the Central Orthopedic Group, LLP, has advised me that x-rays can be hazardous to an unborn child. At this time and to the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patient initials_____Date:_____

PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster and/or attorney involved in this case.

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

Central Orthopedic Group, LLP
651 Old Country Road
Plainview, NY 11803

Patient/Guardian Signature_____Date_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT:

I acknowledge that upon my request I will be provided with a copy of Central Orthopedic Group, LLP, HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information. _____

Signature:_____Name (Print):_____Date_____

HIPAA AUTHORIZATION TO RELEASE

I authorize/give permission to the following people to receive my protected health information. **List Family friends, doctors,** ETC…

_____

_____

Signature_____ Print name: _____Expiration Date_____

Signature:_____Parent/Guardian (print name)_____Date:_____

PLV RVC MASS

Patient History FU / NI / NP DATE _____ MD _____ Account #_____

Note: THIS IS A CONFIDENTIAL RECORD AND WILL BE KEPT IN YOUR DOCTOR'S OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR AUTHORIZATION TO DO SO.

LAST NAME _____ FIRST NAME _____ MIDDLE_____

DATE OF BIRTH _____ AGE_____ RIGHT HANDED / LEFT HANDED/ AMBIDEXTROUS (CIRCLE ONE)

CHIEF COMPLAINT: WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL)

_____

IS THIS WORK RELATED: YES/NO IS THIS CAR RELATED: YES/NO DATE OF INJURY: _____

DESCRIBE _____

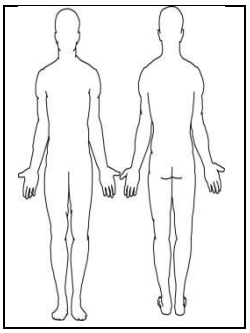
WERE XRAYS TAKEN YES / NO FACILITY _____ DATE _____ DO YOU HAVE FILMS YES / NO

WAS MRI/CT TAKEN YES / NO FACILITY _____ DATE _____ DO YOU HAVE FILMS YES / NO

WERE YOU TREATED IN THE HOSPITAL YES / NO URGENT CARE YES / NO ANOTHER DOCTOR YES / NO

NAME:_____ NAME:_____ NAME:_____

WHERE IS PAIN OR PROBLEM _____ RIGHT / LEFT_____MARK AREA AFFECTED--->



ON WHAT SCALE IS YOUR PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10 (0=NO PAIN 10 = EXTREME PAIN)

IS YOUR PAIN DULL/ SHARP/ ALWAYS THERE EXPLAIN_____

IS ANYTHING ELSE OCCURING AT THE SAME TIME? YES/ NO NAUSEA/ RASH /HEADACHE /OTHER_____

DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS _____

IS THERE ANYTHING THAT HELPS TO RELIEVE THE PAIN _____

DOCTORS USE ONLY

DAILY ASPIRIN YES / NO

BLOOD THINNERS YES / NO

ORAL CONTRACEPTIVES YES / NO

POSSIBILITY OF BEING PREGNANT YES / NO

ALLERGIES: MEDS OR ENVIORNMENT

_____☐ None

_____

_____

MEDICATIONS _____ ☐ None

_____

_____

_____

_____

_____

MEDICAL PROBLEMS_____☐ None

_____

_____

_____

_____

_____

FAMILY AND SOCIAL HISTORY

LIST ANY SERIOUS ILLNESS IN YOUR IMMEDIATE FAMILY: CIRCLE ONE:

_____ RELATIONSHIP _____ DO YOU SMOKE YES OR NO

_____RELATIONSHIP_____ HOW MUCH _____

_____RELATIONSHIP_____ DO YOU DRINK YES OR NO

_____RELATIONSHIP_____ HOW MUCH _____

OCCUPATION: _____DO YOU LIVE ALONE YES OR NO

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THESE SYMPTOMS? CIRCLE CORRECT RESPONSE AND EXPLAIN IN SPACE PROVIDED.

CARDIOVASCULAR: CHEST PAIN VARICOSE VEINS HYPERTENSION DEFIBRILLATOR PACEMAKER OTHER:_____ ☐ None

CONSTITUTIONAL: FEVER CHILLS HEADACHE OTHER:_____ ☐ None

EYES: BLURRED VISION DOUBLE VISION EYE PAIN OTHER:_____ ☐ None

GASTROINTESTIONAL: ABDOMINAL PAIN HISTORY OF ULCERS INDIGESTION/HEARTBURN NAUSEA/VOMITING
OTHER_____ ☐ None

GENITOURINARY: URINE RETENTION PAINFUL URINATION URINARY FREQUENCY OTHER:_____ ☐ None

HEMATOLOGIC/LYMPHATIC: BLOOD CLOTTING PROBLEM SWOLLEN GLANDS OTHER: _____ ☐ None

INTEGUMENTARY: SKIN RASH BOILS PERSISTENT ITCH OTHER: _____ ☐ None

MUSCULOSKELETAL: JOINT PAIN NECK PAIN BACK PAIN OTHER: _____ ☐ None

NEUROLOGICAL: TREMORS DIZZY SPELLS NUMBNESS / TINGLING OTHER: _____ ☐ None

PSYCHOLOGICAL: HISTORY OF DEPRESSION SLEEP DISTURBANCES ANXIETY DISORDER OTHER: _____ ☐ None

RESPIRATORY: WHEEZING FREQUENT COUGH SHORTNESS OF BREATH OTHER: _____ ☐ None

PREVIOUS SURGERIES: _____ ☐ None

_____

_____

X_____
SIGNATURE OF PATIENT /AUTHORIZED INDIVIDUAL

Date _____

VITALS TO BE COMPLETED BY MA
BMI _____
TEMP _____
HEIGHT _____
WEIGHT _____

MA INITIAL _____

PHYSICIAN _____DATE _____