WORKMAN'S COMPENSATION PATIENT 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** _____

COMPENSATION INSURANCE INFORMATION

Name of Insurance Company _____ Address _____

Date of injury _____ Contact Person _____Contact Telephone(____)_____

Did you report your injury to your Employer? Yes ____ No ____ Are you currently working? Yes _____ No _____

Policy # _____ Case# _____ Date last worked: _____

Name of Employer: _____ Address: _____

Telephone# (_____)_____ Contact Person: _____

PRIVATE 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 Workman's Compensation information or if it is determined by Workman's Compensation Board that the condition is not a result of a work related injury, 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 STATE | Workers' Compensation Board

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

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

PO Box 5205, Binghamton, NY 13902-5205 • www.wcb.ny.gov

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

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

Claimant's Name	Claimant's Social Security or Tax Identification Number	Case Number ☐ WCB ☐ DB ☐ Discrimination ☐ PFL and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC/PFL CASE NUMBER AND/OR DATE OF ACCIDENT(S)

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 cases(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 _____,
(NAME OF A SPECIFIC PERSON, CORPORATION, ASSOCIATION OR PUBLIC OR PRIVATE ENTITY)

at _____.
(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 - use blue ink if possible) 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.

Pursuant to Workers' Compensation Law Section 110-a:

3. Individual authorization. Notwithstanding the restrictions on disclosure set forth under subdivision one of this section, a person who is the subject of a workers' compensation record may authorize the release, re-release or publication of his or her record to a specific person not otherwise authorized to receive such record, by submitting written authorization for such release to the board on a form prescribed by the chair or by a notarized original authorization specifically directing the board to release workers' compensation records to such person. However, in accordance with section one-hundred twenty-five of this article, no such authorization directing disclosure of records to a prospective employer shall be valid; nor shall an authorization permitting disclosure of records in connection with assessing fitness or capability for employment be valid, and no disclosure of records shall be made pursuant thereto. It shall be unlawful for any person to consider for the purpose of assessing eligibility for a benefit, or as the basis for an employment-related action, an individual's failure to provide authorization under this subdivision.

4. It shall be unlawful for any person who has obtained copies of board records or individually identifiable information from board records to disclose such information to any person who is not otherwise lawfully entitled to obtain these records.

5. Any person who knowingly and willfully obtains workers' compensation records which contain individually identifiable information under false pretenses or otherwise violates this section shall be guilty of a class A misdemeanor and shall be subject upon conviction, to a fine of not more than one thousand dollars.

6. In addition to or in lieu of any criminal proceeding available under this section, whenever there shall be a violation of this section, application may be made by the attorney general in the name of the people of the state of New York to a court or justice having jurisdiction by a special proceeding to issue an injunction, and upon notice to the defendant of not less than five days, to enjoin and restrain the continuance of such violations; and if it shall appear to the satisfaction of the court or justice that the defendant has, in fact, violated this section, an injunction may be issued by such court or justice, enjoining and restraining any further violation, without requiring proof that any person has, in fact, been injured or damaged thereby. In any such proceeding, the court may make allowances to the attorney general as provided in paragraph six of subdivision (a) of section eighty-three hundred three of the civil practice law and rules, and direct restitution. Whenever the court shall determine that a violation of this section has occurred, the court may impose a civil penalty of not more than five hundred dollars for the first violation, and not more than one thousand dollars for the second or subsequent violation within a three year period. In connection with any such proposed application, the attorney general is authorized to take proof and make a determination of the relevant facts and to issue subpoenas in accordance with the civil practice law and rules.

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.

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. **initial here_____**

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 _____**

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_____

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

OVER →

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 here

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.

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT AND AUTHORIZE TO RELEASE: 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. _____

_____

I _____, agree that the initialed information 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_____

OVER →

PATIENT HISTORY FORM

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.

TODAY'S DATE ____/____/____ DATE OF LAST PHYSICAL EXAM ____/____/____

LAST NAME _____ FIRST NAME _____ MIDDLE _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH ____/____/____ AGE _____

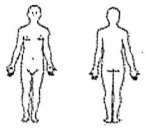
CHIEF COMPLAINT:
WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL) _____

HISTORY OF PRESENT ILLNESS

Please answer the following questions

WHERE IS YOUR PAIN OR PROBLEM?

Front Back



Left Right

If you are in pain, on a Scale of 1-10, with 10 being the most severe, circle the number that best describes your pain.

1 2 3 4 5 6 7 8 9 10

WHEN DID THIS PROBLEM START?

DOES ANYTHING HELP OR MAKE THE PROBLEM WORSE?

HOW LONG DOES THE PROBLEM LAST?

❑ 30 minutes ❑ 1 hour ❑ It is always there

OTHER _____

IS ANYTHING ELSE OCCURRING AT THE SAME TIME?

Check Yes or No

❑ Yes ❑ No If yes, please explain.

❑ Nausea ❑ Rash ❑ Headaches

Other _____

IS YOUR PAIN ❑ Dull ❑ Sharp

❑ Always there Other _____

DOES THE PROBLEM INTERFERE WITH YOUR NORMAL FUNCTIONS?

❑ Yes ❑ No If yes, please explain:

Physician Use Only:
(Comments/Notes)

MEDICAL HISTORY

Do you take any of the below Daily ? :

Daily Aspirin ❑ Yes ❑ No

Blood Thinners ❑ Yes ❑ No

Oral Contraceptives ❑ Yes ❑ No

CURRENT MEDICATIONS ❑ None

Check One:

Are you ❑ Right or ❑ Left handed?

Possibility of being pregnant? ❑ Yes ❑ No

MEDICAL PROBLEMS ❑ None
(ex: diabetes, high blood pressure, heart disease, cancer)

PREVIOUS SURGERIES ❑ None
Date

PLEASE LIST:

DRUG ALLERGIES ❑ None

LATEX ALLERGY? ❑ Yes ❑ No

TAPE / ADHESIVE ❑ Yes ❑ No

FOOD/ENVIRONMENTAL ALLERGIES ❑ None

OVER ⇨

FAMILY AND SOCIAL HISTORY

LIST ANY SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY. ❑ None

(example: diabetes, tuberculosis, heart disease, cancer)

	RELATIONSHIP

Check One:	Yes	No
Do you smoke? (If yes, how much) _____	❑	❑
Do you drink? (If yes, how much) _____	❑	❑
Do you live alone?	❑	❑

Occupation _____

REVIEW OF SYSTEMS

Do you currently have any of these symptoms? *Check* **YES or NO. Please explain any YES answers in the space provided**

CARDIOVASCULAR:	Yes	No
Chest Pain	❑	❑
Varicose Veins	❑	❑
High Blood Pressure	❑	❑
Other _____		

CONSTITUTIONAL:	Yes	No
Fever	❑	❑
Chills	❑	❑
Headache	❑	❑
Other _____		

EYES :	Yes	No
Blurred Vision	❑	❑
Double Vision	❑	❑
Eye Pain	❑	❑
Other _____		

GASTROINTESTINAL:	Yes	No
Abdominal Pain	❑	❑
History of Ulcers	❑	❑
Indigestion/Heartburn	❑	❑
Nausea/Vomiting	❑	❑
Other _____		

GENITOURINARY:	Yes	No
Urine Retention	❑	❑
Painful Urination	❑	❑
Urinary Frequency	❑	❑
Other _____		

HEMATOLOGIC/ LYMPHATIC:	Yes	No
Swollen Glands	❑	❑
Blood Clotting Problem	❑	❑
Other _____		

INTEGUMENTARY:	Yes	No
Skin Rash	❑	❑
Boils	❑	❑
Persistent Itch	❑	❑
Other _____		

MUSCULOSKELETAL:	Yes	No
Joint Pain	❑	❑
Neck Pain	❑	❑
Back Pain	❑	❑
Other _____		

NEUROLOGICAL:	Yes	No
Tremors	❑	❑
Dizzy Spells	❑	❑
Numbness/Tingling	❑	❑
Other _____		

PSYCHOLOGICAL:		
History of Depression	YES	NO
Sleep Disturbances	YES	NO
Anxiety Disorder	YES	NO
Other _____		

RESPIRATORY:	Yes	No
Wheezing	❑	❑
Frequent Cough	❑	❑
Shortness of Breath	❑	❑
Other _____		

PHYSICIAN USE ONLY: *(Comments/Notes)*

X _____

Signature of Patient/Authorized Individual

_____ / _____ / _____

Date

VITAL SIGNS:

(To be completed by Medical Assistant)

Temp: _____

Pulse: _____

Weight: _____

BMI: _____

Initial: _____

Physician _____ *Date* ____ / ____ / ____

Signature

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