

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: _____

THE CENTRAL ORTHOPEDIC GROUP

PLV / RVC / MASS

DATE: _____ DOCTOR: _____

NP

NI

FU

INJ

FX

AC

HOSP FU

OFFICE USE ONLY

LAST NAME: _____ FIRST: _____ DOB: _____ AGE: _____

SOCIAL SECURITY #: _____ M: _____ F: _____ Marital Status: _Married/Single/Divorced/Widow/Other_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____ CELL: _____ HOME: _____ W: _____

Ethnicity: _____ Primary Language: _____ Race: _____

EMERGENCY CONTACT NAME & #: _____

REFERRING DOCTOR: _____ TELEPHONE: _____ FAX: _____

ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ TELEPHONE: _____ FAX: _____

ADDRESS: _____

PHARMACY NAME: _____ **ADDRESS:** _____ **TELE:** _____

IF THE PATIENT IS A MINOR OR UNDER THE SUPERVISION OF A LEGAL GUARDIAN , THEN THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION:

GUARDIAN OR GUARANTOR _____ DOB: _____ SS#: _____

ADDRESS _____ CITY: _____ STATE: _____ ZIP CODE: _____ TELEPHONE# _____

PRIVATE INSURANCE NAME: _____ **POLICY#:** _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

DOB OF POLICY HOLDER: _____ SS# OF POLICY HOLDER: _____

EMPLOYER NAME AND ADDRESS: _____

SECONDARY INSURANCE:

INSURANCE COMPANY NAME: _____ POLICY #: _____

NAME OF POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

DOB OF POLICY HOLDER: _____ SS# OF POLICY HOLDER: _____

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: _____ NAME PRINT: _____ 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

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 INNENETWORK 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 _____

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--->

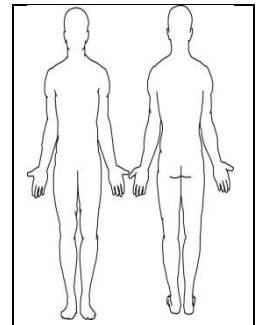
ON WHAT SCALE IS YOUR PAIN LEVEL: 0 1 2 3 4 5 6 7 8 9 10 (0=NO PAIN 10 = EXTREME PAIN)

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 _____



DAILY ASPIRIN YES / NO

BLOOD THINNERS YES / NO

ORAL CONTRACEPTIVES YES / NO

POSSIBILITY OF BEING PREGNANT YES / NO

MEDICATIONS _____ None

ALLERGIES: MEDS OR ENVIORNMENT

_____ None

MEDICAL PROBLEMS _____ None

DOCTORS USE ONLY

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

GASTROINTESTINAL: 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 _____