THE CENTRAL ORTHOPEDIC GROUP WORKERS COMPENSATION LOCATIONS: PLV RVC MASS	NP___ NI___

DATE OF EXAM _____ DOCTOR _____ ACCOUNT #_____

PATIENT NAME: _____ DOB_____AGE_____

ADDRESS_____

SOCIAL SECURITY#_____ MALE ____ FEMALE _____

TELEPHONE#_____CELL# _____EMAIL :_____

PHARMACY _____TELEPHONE_____

ADDRESS:_____

WORK RELATED INJURY: YES / NO

BODY PART/PARTS REPORTED:_____

RIGHT SIDE _____ LEFT SIDE _____

HOW DID YOU INJURE YOURSELF:_____

DATE OF INJURY:_____WORK STATUS: _____ LAST DAY WORKED:_____

EMPLOYER: _____ TELEPHONE#_____

ADDRESS:_____

SUPERVISOR NAME: _____ TELEPHONE#_____

EMPLOYER'S INSURANCE COMPANY NAME: _____

ADDRESS_____

ADJUSTORS NAME_____TELEPHONE#_____

POLICY #_____CLAIM #_____WCB#_____

PRIMARY CARE DOCTOR:_____TELEPHONE:_____FAX:_____

ADDRESS:_____

WERE YOU REFERRED HERE FOR A CONSULTATION BY ANOTHER PHYSICIAN, PHYSICAL THERAPIST OR LAWYER (YES) (NO)

NAME:_____ADDRESS:_____PHONE/FAX_____

PATIENT/ GUARDIAN SIGNATURE:_____DATE: _____

PRINT NAME: _____ 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:_____

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 insurances 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 Benefits, 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 that you understand that you are responsible for any or all portions of your bill unless previously agreed upon. _____

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 provider by 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 IN NETWORK INSURANCE WILL BE COLLECTED AT THE TIME OF YOUR INITIAL VISIT ALONG WITH A PHOTOCOPY 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 statements I have initialed above are 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 print: _____Guardian name print:_____

Patient/Guardian Signature_____Date_____

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.

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 _____

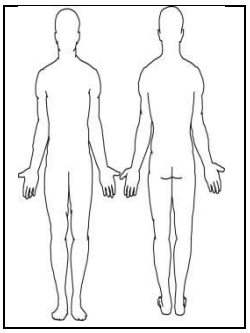
WERE XRAYS TAKEN YES / NO FACILITY _____ DATE _____ DO YOU HAVE FILMS YES / NO

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 _____