PATIENT NO FAULT INFORMATION

NP NI FU INJ FX AC DOCTOR_____ ACCT#_____

The Central Orthopedic Group, LLP PLV / RVC / MASS

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 **CAR OR MOTORCYCLE (PLEASE CIRCLE)**

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: MUST FILL OUT 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

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is <u>not</u> for verification of hospital treatment)

NAME AND ADDRESS OF INSURER OR SELF-INSURER*	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE <u>BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT</u>. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM.**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

2. DATE OF BIRTH	3. SEX	4. OCCUPATION (IF KNOWN)

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR?
DATE: _____

7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE: _____

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES ☐ NO ☐

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

_____
(DATE)

CONTINUE ON PAGE 2

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES
			TOTAL CHARGES TO DATE$	

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____ **(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)**

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHTS, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME _____ SIGNED _____

PATIENT PATIENT DATE

CONTINUE ON PAGE 3

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 X_____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: **X**_____

Patient/Guardian Signature: **X**_____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 _____

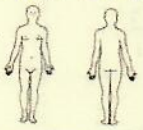
CHIEF COMPLAINT:
WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? (DESCRIBE YOUR PROBLEM IN DETAIL) _____

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

Physician _____ *Date* ____ / ____ / ____

Signature

VITAL SIGNS:

(To be completed by Medical Assistant)

Temp: _____

Pulse: _____

Weight: _____

BMI: _____

Initial: _____