SPINE MEDICINE & SURGERY OF LONG ISLAND

WORKERS COMPENSATION PATIENT REGISTRATION FORM

Referred by: ☐ Friend/Family ☐ Physical Therapist: _____ ☐ Physician: _____

☐ Chiropractor: _____ ☐ Attorney: _____ ☐ Other: _____

☐ Google ☐ Facebook ☐ Instagram ☐ YouTube ☐ Twitter ☐ ZocDoc ☐ HealthGrades ☐ Vitals ☐ WebMD ☐ Yelp

Last Name_____ First Name_____ Sex_____

Date of Birth_____ Age____ SS#____-____-_____

Street Address_____ City_____ State____ Zip_____

Phone Number_____ Cell Number_____

Email_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Pharmacy_____ Address_____ Phone_____

Employer_____ Address_____ Phone_____

Primary Care Physician_____ Phone_____

Attorney Name_____ Phone_____

Emergency Contact_____ Relationship_____

INJURY INFORMATION

Carrier Case #_____ WCB#_____ Date of injury_____

Body Part(s)_____ Job title at time of injury:_____

Briefly describe how and where injury occurred: _____

_____

Employer at time of injury_____ Phone_____

Employer Address_____ City_____ State____ Zip_____

Are you currently working? ☐ Yes ☐ No If no, when did you stop working?_____

If Yes, are you on ☐ Regular Duty ☐ Light Duty

If you stopped, when did you return to work?_____

***Continued on Page 2

For Office Use: Checked by:_____ Date:_____

WORKERS COMP INSURANCE INFORMATION

WC Insurance Carrier_____

Carrier Address_____ City_____ State____ Zip_____

Adjustor Name_____ Phone_____

In the event I fail to fully prosecute the claim for Workers' Compensation for this injury or condition or it is determined by the Workers' Compensation Board that the injury or condition is not a result of a compensable Workers' Compensation case, I hereby agree to pay New York Spine Medicine and Surgery d/b/a Spine Medicine and Surgery of Long Island (the Practice) the usual and customary fees for services rendered to the above claimant. I authorize the Practice to release any information necessary to substantiate a claim.

Patient Signature_____ Date_____

For Office Use: Checked by:_____ Date:_____

SPINE MEDICINE & SURGERY OF LONG ISLAND

HIPAA Notice of Privacy Practices
Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, share information in a disaster relief situation, include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: Marketing purposes, sale of your information. We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Run our organization, bill for your services: We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans or other entities

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues, research: We can share health information about you for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety. We can use or share your information for health research.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests, Work with a medical examiner or funeral director: We can share health information about you with organ procurement organization or with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
  For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

I understand and acknowledge that by signing below, I received a copy of the **Notice of Privacy Practices** which describes how New York Spine Medicine and surgery, PLLC d/b/a Spine Medicine and Surgery, Dr. Daniel E. Choi ("the Practice") may use and share my protected health information (PHI).

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extend the state law provides greater access rights) and/or
- Refuse to sign this authorization.

_____ _____

Patient Signature or Authorized Representative **Date**

_____

Print Name

SPINE MEDICINE & SURGERY OF LONG ISLAND

Financial Agreement /Assignment of Benefits
Medical Records Authorization

Patient Name_____ Date of Birth_____

I understand and acknowledge that by signing below, I hereby authorize payment directly to New York Spine Medicine and surgery, PLLC d/b/a Spine Medicine and Surgery, Dr. Daniel E. Choi ("the Practice") 285 Sills Rd. Bldg 5-6, Ste G. Patchogue, NY 11772 for services rendered to me, as specified below.

COMMERCIAL INSURANCE

- **I am aware and understand that Dr. Daniel E. Choi is NOT in network with any commercial plans ("the Plan(s)") except for Medicare plans, Workers Compensation, and No Fault. I understand that the Practice will file a claim on my behalf and work with my insurance carrier to obtain payment. As required by law, and in accordance with the terms of my policy, I am in understanding that I may be responsible for deductibles and/or coinsurances.**
- **I understand that the Practice does not have any contract, expressed or implied, with any commercial plans.**
- **I understand that due to Dr. Daniel E. Choi's out of network status, the Explanation of Benefits and checks for services rendered by Dr. Choi may be sent directly to my home. I am in understanding that these checks are payment for services rendered by the Practice. I am in agreement to submitting the EOB and check to the Practice within 5 days of receiving in the mail.**

NON-COVERED SERVICES

- **I understand that the Plan defines what services and items are covered and what services and items are not covered by the Plan. I accept full responsibility for payment for any potentially non-covered services that I have accepted if my Plan determines that such services are not covered or not authorized after treatment has been administered.**
- **I agree to cooperate with the Practice to obtain all necessary authorizations required by my Plan.**

MEDICARE

- **I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.**
- **I authorize the Practice to release to the Centers for Medicare and Medicaid Services ("CMS" or "Medicare") and its agents any information needed to determine my Medicare benefits or the benefits payable for related services.**
- **I authorize my Medicare benefits to be paid to the Practice for services furnished to me by the Practice.**
- **I understand that for covered services, I am only responsible for coinsurance and deductibles as determined by the Medicare carrier and payment for any non-covered services. Coinsurance and deductibles can be billed to a secondary insurance if I have one.**

RELEASE OF INFORMATION

- **I authorize the Practice having treated me, to release to Medicare, Medicaid, governmental agencies, insurance carriers, or others who are financially liable for medical care, all information needed to substantiate payment for such medical care and if required, of pre-certification/prior approval processes, and permit representatives thereof to examine and make copies of all records relating to such care and treatment. This information may include information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV.**
- **I understand that the Practice may also disclose on an anonymous basis any information concerning my care that is necessary or appropriate for the advancement of medical research/education and/or for the collection of statistical data pursuant to State or Federal law.**

ASSIGNMENT OF BENEFITS:

- **I hereby assign to New York Spine Medicine and Surgery, PLLC d/b/a Spine Medicine and Surgery of Long Island, Dr. Daniel E. Choi all monies and/or benefits to which I am entitled from my commercial insurance, third party payor, Workers Compensation policy, No Fault policy, government agencies, or those who are financially liable for my medical care. I request that payment of authorized benefits be made on my behalf to the Practice.**

FINANCIAL AGREEMENT

- **I hereby guarantee payment to the Practice for all charges and fees incurred for services rendered to me.**
- **In return for services provided to me by the Practice, I will pay my account at the time service is rendered to me or will make financial arrangements satisfactory to the Practice for payment.**
- **In the event my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand that my account may be charged interest at the legal rate if my account is delinquent.**
- **If my insurance Plan requires payment of coinsurances and/or deductibles, I agree to pay such coinsurance and/or deductible amounts to the Practice.**
- **I agree to be primarily responsible for the payment of the Practice's bill.**

_____ _____

Patient signature or Authorized Representative **Date**

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 New York Spine Medicine & Surgery, PLLC d/b/a Spine Medicine and Surgery of Long Island

285 Sills Rd. Bldg 5-6, Ste G. Patchogue, NY 11772

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.

SPINE MEDICINE & SURGERY OF LONG ISLAND

AUTHORIZATION OF DESIGNATED REPRESENTATIVE

I hereby authorize **New York Spine Medicine and Surgery, PLLC d/b/a Spine Medicine and Surgery of Long Island ("the Practice"),** any health care provider within the Practice, and/or billing specialist representing the Practice to act on my behalf in connection to my claim as my **Designated Representative.**

I authorize the above Designated Representative to appeal any and all claims on my behalf, obtain appeal information, make any request, and receive any notice in connection to my appeal.

As part of the appeal, I hereby authorize my insurance company to disclose and furnish to my Designated Representative personal medical information related to my appeal.

Patient Signature_____

Printed Name_____

Date_____

SPINE MEDICINE & SURGERY OF LONG ISLAND

PATIENT INTAKE FORM

Patient Name_____ **Age**_____

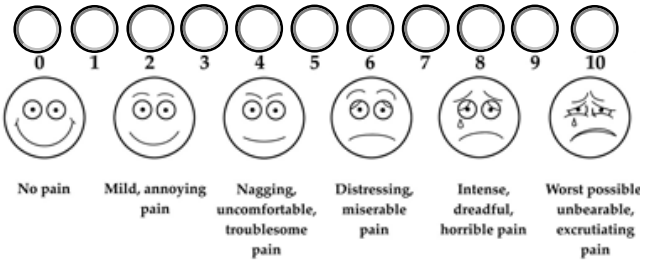
Current Height:____ ft. _____in. Current Weight_____ Occupation_____ ◯ R handed or ◯ L handed

Reason for your visit today (check all that apply):

☐ Low back pain (lumbar spine) ☐ Mid back pain (thoracic spine) ☐ Neck pain (cervical spine)
☐ Pain in the leg (sciatica): R or L ☐ Pain in the arm (radiculopathy): R or L ☐ Numbness in arms/hands
☐ Numbness in legs/feet ☐ Decreased walking tolerance ☐ Clumsiness in hands ☐ Loss of balance when walking
Other:_____

Date of Injury/Onset of Pain: ____/_____/_____ Was Injury related to: Work? ☐ Y ☐ N Auto Accident? ☐Y ☐N
How did the injury/car accident happen?_____
After Injury/Onset, did you present to an ED or Walk-In Clinic? ☐ Y ☐ N
If yes, which hospital/clinic?_____

Pain Assessment: Please fill in the pain rating below to describe severity of your pain **right now.**



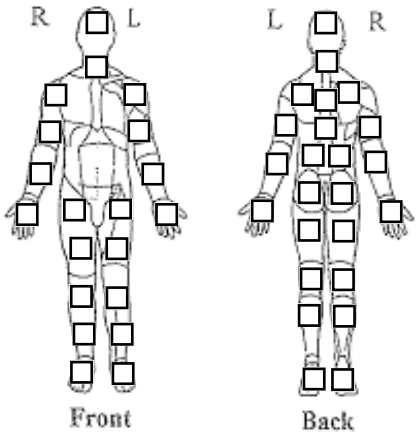
How would you characterize your pain? (i.e. Burning, throbbing, sharp, dull, cramping, stabbing, shooting)

_____

What makes the pain better? ☐ Rest ☐ Ice ☐ Heat
Other_____

What makes the pain worse?

☐ Sitting ☐ Standing ☐ Leaning forward ☐ Leaning back
☐ Walking ☐ Lying down ☐ Bending neck forward
☐ Extending neck back Other_____



Please shade in the area where you are experiencing pain currently.

Prior Imaging:

Which of the below spine imaging studies have you had for this problem? Add date of study.
☐ X-ray, Date:___/___/___ Facility done:_____ Body part ☐cervical ☐ thoracic ☐ lumbar
☐ CT Scan, Date: ___/___/___ Facility done:_____ Body part ☐ cervical ☐ thoracic ☐ lumbar
☐ MRI: Date: ___/___/___ Facility done:_____ Body part ☐ cervical ☐ thoracic ☐ lumbar

Previous Treatments:

Medications? ☐ NSAIDs (e.g. Meloxicam, Ibuprofen) ☐ Muscle relaxants (e.g. Flexeril) ☐ Gabapentin
☐ Tramadol, Lyrica ☐ Narcotics, Specify type/dosage:_____
Physical Therapy? ☐ Yes ☐ No If yes, date:_____ Name of PT:_____
Chiropractor? ☐ Yes ☐ No If yes, date:_____ Name of chiropractor:_____
Acupuncture? ☐ Yes ☐ No If yes, date:_____ **Massage Therapy?** ☐ Yes ☐ No If yes, date:_____
Int. pain management/Physiatrist? ☐ Yes ☐ No If yes, date:_____Name of physician:_____
☐ Epidural steroid injections, Date(s):_____ ☐ Facet injections, Date(s):_____ ☐ Trigger point injections
☐ Other treatments_____, Date:_____
Have you been to another physician for this problem? ☐ Yes ☐ No If yes, name and date:_____

SPINE MEDICINE & SURGERY OF LONG ISLAND

Patient Intake Form Continued – Page 2

Patient Name:_____

Review of Systems *(Check if you are experiencing or recently experienced any of these symptoms):*

General: ☐ Weakness ☐ Fatigue ☐ Fevers/chills ☐ Significant weight gain ☐ Significant weight loss
Skin: ☐ Rash ☐ Sores ☐ Itchiness ☐ Color changes ☐ Change in hair/nails
HEENT: ☐ Headache ☐ Dizziness ☐ Vision changes ☐ Ringing in ears ☐ Vertigo ☐ Sore throat
Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ Lower extremity swelling
Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing
Urinary: ☐ Increased urgency ☐ Burning or pain with urination ☐ Incontinence
Musculoskeletal: ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling
Neurological: ☐ Fainting ☐ Seizures ☐ Tremors/Involuntary movements
Hematological: ☐ Easy bleeding ☐ Easy bruising
Psychiatric: ☐ Anxiety ☐ Depression ☐ Sleep disturbances

Past Medical History: ☐ None

☐ Asthma
☐ COPD
☐ Diabetes
Last HgbA1c Value _____.
Date ___/___/___
☐ Heart disease
☐ Hypertension
☐ Hypercholesterolemia
☐ Blood clots
☐ Cancer – Type:_____.
☐ Neuropathy
☐ Parkinson's Disease
☐ Seizure/epilepsy
☐ Stroke
☐ Pulmonary embolus
☐ Arthritis
☐ Lupus
☐ Osteoporosis
☐ Rheumatoid arthritis
☐ Depression
☐ Anxiety
☐ Other:_____
_____

Past Surgical History: ☐ None ☐ Prior spinal surgery

Type of surgery	Hospital name	Date (approx.)	Post op Complication?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

If Yes to Post op complications, specify what:_____

Past Family History: ☐ No pertinent family history
Blood clots or pulmonary embolus: ☐ Yes ☐ No. Who?_____. Osteoporosis: ☐ Yes ☐ No. Who?_____
Specify other medical conditions and who: _____

Current Medications: ☐ No current medications
Please list all medications including supplements and vitamins

Name	Dosage	Frequency

Allergies: ☐ No known drug allergies ☐ Latex ☐ Shellfish ☐ Contrast Dye ☐ General anesthetic ☐ Penicillin ☐ Sulfa ☐ Seasonal
Other_____

Social History: Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow
Living Situation (Check all that apply): ☐ Alone ☐ With Family ☐ With Roommates ☐ With Spouse ☐ With Parent ☐ With Children ☐ In an apartment ☐ In a house ☐ With Stairs
Occupation:_____ ☐ Full time ☐ Part time ☐ Light duty ☐ Not working due to injury ☐ Unemployed ☐ Disabled
Currently Smoking: ☐ Yes ☐ No. If Yes, type of Tobacco_____. Packs per day_____. Age stopped smoking_____
Alcohol: ☐ None ☐ < 1/month ☐ Socially ☐ Less than 2 drinks/day ☐ More than 2 drinks/day ☐ Daily: drinks per day _____
Recreational drug use? ☐ No ☐ Yes, Specify_____
Do you exercise? ☐ No ☐ Yes, How many times a week?_____

_____	_____	_____
Print Name	Signature	Date