ORTHOPEDICS & SPORTS MEDICINE, P.C.

Patient Information

Patient Name: ______________________ DOB: ______________ Marital Status: M / S / O
MM/DD/YY

Address: ______________________ City: ______________ State: ______ Zip: ________

Home #: ______________________ Cell #: ______________________ SS # ______ - ______ - ______

Email: ____

Primary Language: ______________ Race: ______________ Ethnicity: ______________ Gender: Male Female

Employer: ______________________ Occupation: ______________ Phone #: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Emergency Contact: ______________________ Relationship: ______________ Phone #: ______________

If Patient Is a Minor, Name of Guarantor: ______________________________

Address (if different from above): ______________________ City: ______________ State: ______ Zip: ______

Medical Information

How Did You Hear About Our Office?: ______________________________

Primary Care Doctor: ______________________ City: ______________ State: ______ Phone #: ______________

Pharmacy Name: ______________________ City: ______________ State: ______ Phone # : ______________

No Fault Insurance Information

Insurance Company Name: ______________________________ Phone #: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Date of Accident: ______________ Claim #: ______________ Policy #: ______________

Policy Holder: ______________________ Relationship: ______________________

Adjuster Name: ______________________ Adjuster Phone #: ______________________

Private Insurance Name: ______________________ Private Insurance Id #: ______________________

Attorney Information

Attorney Name: ______________________________ Phone #: ______________________

Address: ______________________ City: ______________ State: ______ Zip: ________

Orthopedics & Sports Medicine, P.C.

Patient Name: ______________________ DOB: ____________ Date: ____________
MM/DD/YY

Chief Complaint: Injured or Painful body part(s): If bilateral, check both and circle the side which is worse.

Shoulder	Upper Arm	Elbow	Forearm	Wrist	Hand	Finger(s)	Hip	Thigh	Knee	Calf	Ankle	Foot	Toe(s)
□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L	□R □L

□Neck □Mid-Back □Low Back

Do you have: □ Pain □ Wound □ Numbness □ Mass □Stiffness

Date injury occurred: ____________________

Date of onset symptoms: ____________________

Where did injury occur? □ Work □ Home □ Auto □ Sports □ Other:

If injury occurred at work, did you notify your supervisor? □ Yes □ No

Were you seen in the ER? □ Yes □ No If yes did you bring your discharge papers? □ Yes □ No

Any prior injuries or problems to same body part? □ Yes □ No Describe: ____________________

Describe in your own words how/when/where this injury occurred: ____________________

____

____

____

____

____

____

____

____

____

Please Initial: __________

ORTHOPEDICS & SPORTS MEDICINE, P.C.

Información del Paciente

Nombre del Paciente:____________________ Fecha de Nacimiento: ______________ Estado Civil: C / S /O
MM/DD/AA

Dirección:______________________________ Ciudad:__________ Estado:________ Zip:________

Numero de Casa #:______________ Celular #:________________ ss# _____ - _____ - _____

Email: ____

Idioma Primario:__________ Raza:_________ Etnicidad:__________ Género: Masculino____Femenino____

Empleador:______________________ Ocupación:____________________ Teléfono#:__________

Dirección:_________________________ Ciudad:______________ Estado:________ Zip:________

Contacto de Emergencia:__________________ Relación:_______________ Teléfono#:____________

Si el Paciente es Menor de Edad, Nombre del Garante:____

Dirección (si es diferente):_________________________ Ciudad:____________ Estado:_____Zip:______

Información Médica

¿Cómo se enteró acerca de nuestra oficina?:____

Médico Primario: __________________ Ciudad:______________ Estado:______ Teléfono #:________

Nombre de Farmacia:_________________ Ciudad:______________ Estado:_____ Teléfono #:________

Información Sobre el Seguro sin Culpa

Nombre del Seguro: ________________________________ Teléfono #:_____________________

Dirección : _________________________Ciudad: ____________ Estado: ________ Zip:________

Fecha del Accidente: _________ Numero de Reclamación #:________________ Numero de Póliza#:________

Persona Encargada del Póliza: ______________________________ Relación:________________

Nombre del Ajusto : ____________________________ Numero de Ajusto #: __________________

Seguro Privado: __________________________ Identificación de Seguro Privado#: ______________

Información del Abogado

Nombre del Abogado: ____________________________ Numero de Abogado #: _______________

Dirección: _________________________ Ciudad: _______________ Estado: ________ Zip: ________

Orthopedics & Sports Medicine, P.C.

Nombre de Paciente: ______________________ Fecha de Nacimiento: ____________ Fecha: ____________
MM/DD/AA

Queja Susanivo: Parte Affectado(s)

Hombro	Alto Brazo	Codo	Antebrazo	Muñeca	Mano	Dedo(s)	Cadera	Muslo	Rodilla	Pantorrilla	Tobillo	Pies	Dedo
□D □I	□D □I	□D □I	D □I	□D □I	□D □I	□D □I	□D □I	□D □I	□D □I	□D □I	□D □I	□D □I	□D □I

□ Cuello □ Medio-Espalda □ Bajo Espalda

Estoy aquí para: □Dolor □Lesión □Entumecido □Una Masa □Rigidez

Fecha de accidente: ______________________

Fecha de Inicio de Síntomas: ______________________

¿Dónde ocurrió la lesión? □ Trabajo □ Casa □ Carro □ Deporte □ Other: ______________________

Si la lesión se produjo en el trabajo, notificó a su supervisor? □ Sí □ No

Te observaron en el Hospital? □ Sí □ No. En caso afirmativo traes tus papeles? □ Sí □ No

Has tenido lesiónes previas o problemas a la misma parte del cuerpo? □ Sí □ No Describir: ______________________

____

Describir en sus propias palabras cómo/cuando/donde ocurrió esta lesión: ______________________

____

____

____

____

____

____

Por favor Iniciales: ________

www.osmpc.com

219 Blooming Grove Turnpike New Windsor, New York 12553 Tel.: 84-561-8060 Fax: 845-561-8523

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ______________________________ hereby authorize Orthopedics & Sports Medicine, P.C. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me, to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Orthopedics & Sports Medicine, P.C., can refuse to treat me.

Such records may be released to my attorney, another physician, or any other healthcare professional, or facility, for the purpose of treatment, discussing my condition, consulting on my case, or reviewing my medical records.

I have been informed the Orthopedics & Sports Medicine, P.C. has prepared a notice, which more fully describes the uses, disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have that right to review such notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Orthopedics & Sports Medicine, P.C. in writing, but if I revoke my consent, such as revocation will not affect the actions that Orthopedics & Sports Medicine, P.C. took before receiving my revocation.

I understand the Orthopedics & Sports Medicine, P.C. has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Orthopedics & Sports Medicine, P.C. restrict how my individually identifiable information is used and/or disclosed to carry out treatment, payment and health care operations. I understand the Orthopedics & Sports Medicine, P.C. does not have to agree to such restrictions, but that once such restrictions are agreed to, Orthopedics & Sports Medicine, P.C. must adhere to such restrictions.

I give permission for Orthopedics & Sports Medicine, P.C. and staff to discuss health or health insurance issues with; ☐ myself only, ☐ my spouse, ☐ my parents, ☐ my children, ☐ other: ______________________________.

____

List Names & DOB

X ____

Signature of Patient or Patient's Representative Date of Birth

____

Printed Name of Patient or Patient's Representative

____

Relationship to Patient Today's Date

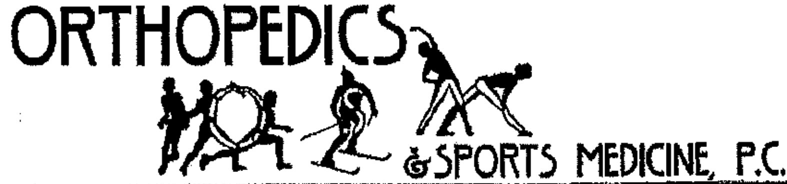
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices for Orthopedics & Sports Medicine, P.C.

X ____

Signature Date

www.osmpc.com



219 Blooming Grove Turnpike New Windsor, New York 12553 Tel.: 84-561-8060 Fax: 845-561-8523

CONSENTIMIENTO PARA LA DIVULGACIÓN DE INFORMACIÓN PARA TRATAMIENTO, PAGO Y OPERACIONES DE ATENCIÓN DE LA SALUD

Yo, ______________________ autorizo a Orthopedics & Sports Medicine, P.C. para usar y discutir informacion de salud que especificamente me identifica a mi para proveerme tratamiento de salud y pagos. Yo entiendo que aunque este consentimiento es voluntario, si yo rehuso firmar este consentimiento, Orthopedics & Sports Medicine, P.C. pueden también darme tratamiento.

Mi expediente se le puede enviar a mi abogado, doctor o otro profesional de salud o facilidad para proveer tratamiento, discutir mi condición de salud o revisar mi expediente médico.

Orthopedics & Sports Medicine, P.C. a preparado un formulario el cual describe los usos y revelaciones que pueden hacer acerca de mi salud revelante atratamientos medicos, pagos y modos de trata mientos de salud.

Es mi entendimiento que yo tengo el derecho de revocar este consentimiento en cualquier momento notificandoles por escrito a Orthopedics & Sports Medicine, P.C. pero si yo revoco este consentimiento las acciones tomadas anteriormente por Orthopedics & Sports Medicine, P.C. no seran afectadas.

Es mi ententimiento que Orthopedics & Sports Medicine, P.C. tiene derecho de cambiar sus practicas de privacidad. Yo puedo solicitar pruebas de este cambio en cualquier momento.

Es mi ententimiento que puedo pedir a Orthopedics & Sports Medicine, P.C. restringir cómo mi informacion identificable sea usada o divulgada para llevar a cabo tratamientos medicos y pagos. Es mi ententimiento que Orthopedics & Sports Medicine, P.C. no tiene que estar de acuerdo con estas restriccines, pero una vez que se hayan llegado a un acuerdo Orthopedics & Sports Medicine, P.C. tendra que adherirse a ellas.

Yo autorizo Orthopedics & Sports Medicine, P.C. y su personal a discutir mis problemas médicos y de segudo plan médico con, ☐ conmigo solamente, ☐ mi pareja, ☐ mis padres, ☐ mis hijos, ☐ otros ______________________.

____

Nombres y Fecha de Nacimiento

X ______________________________

Firma del Paciente o Representante   Fecha de Nacimiento

____

Escriba el Nombre del Paciente o Representante

____

Relacion al Paciente   La Fecha

RECONOCIMIENTO DE RECIPET DEL AVISO DE PRÁCTICAS DE PRIVACIDAD

Yo por la presente reconozcel recibo de la notificación de prácticas de privacidad para ortopedia & Sports Medicine, P.C.

X ______________________________

Firma   La Fecha

NEW YORK VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURING ON AND AFTER 3/1/02)

I, _________________________, ("Assignor") hereby assign to **Orthopedics & Sports Medicine, P.C.**,
(Print patient's name)
("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 15 (the NO-FAULT statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _______________, not withstanding any other agreement to the contrary.
(Print accident date)

The agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR ANY INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print Name of Patient)

(Signature of Patient)

(Address)

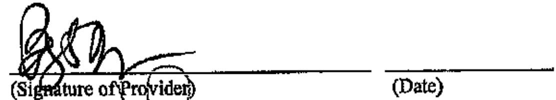
(Date)

(City, State) (Zip Code)

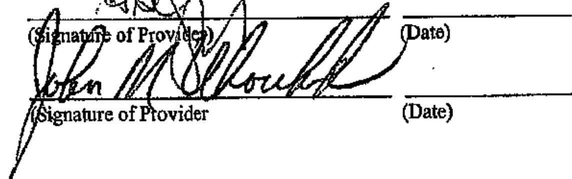
□ Barry S. Hyman, M.D.

□ Gina C. Del Savio, M.D.

□ John M. Uhorchak, M.D.


(Signature of Provider) (Date)

(Signature of Provider) (Date)


(Signature of Provider) (Date)

Orthopedics & Sports Medicine, P.C.
219 Blooming Grove Turnpike
New Windsor, NY 12553

NYS FORM NF-AOB (Rev 3/2004)

10/2008 rph

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
		XXXXXXXXX
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:
In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Orthopedics & Sports Medicine, P.C 219 Blooming Grove Tpk, New Windsor, NY 12553

8. Name and address of person(s) or category of person to whom this information will be sent:
Myself

9(a). Specific information to be released:

☐ Medical Record from (insert date) ________ to (insert date) ________

☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: ________

Include: (*Indicate by Initialing*)

_______ Alcohol/Drug Treatment

_______ Mental Health Information

_______ HIV-Related Information

Authorization to Discuss Health Information

(b) ☐ By initialing here ________ I authorize ________
Initials — Name of individual health care provider
to discuss my health information with my attorney, or a governmental agency, listed here:
____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☒ At request of individual ☐ Other:	11. Date or event on which this authorization will expire: End of treatment
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X________________ Date: ________
Signature of patient or representative authorized by law.

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

ORTHOPEDICS & SPORTS MEDICINE, P.C.

Financial Policy

Patients with Non-Participating Plans

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD. Payment arrangements can be made for surgical fees.

Usual and Customary Rates

The fees billed to your insurance carrier are our "usual and customary" rates, which are competitive with physicians of the same specialty in our area. Insurance carries, however, have their own methods of determining "usual and customary," which are often lower. You are responsible for paying the difference between your insurance company's determination of "allowable charges" and the doctor's fee schedule.

Patients Enrolled in Participating Plans

You are directly responsible to know what the referral requirements are for your plan. Patients must have their referrals in order to be seen within network. If you choose to be seen without your referral, you are considered "out of network" and, therefore, full payment will be required for that day's visit. In addition, you are responsible to pay your deductibles, and any services not covered by your plan. Please check directly with your plan if you are unsure about this. As a courtesy, we will submit appropriate claims to your carrier. We will retain a copy of your health insurance identification card, which you must have with you. WITHOUT THIS CARD, PAYMENT IN FULL IS EXPECTED AT THE TIME OF VISIT. Your insurance card must contain your policy, group or plan numbers and also the correct mailing address for claims to be submitted, along with their telephone number for verification purposes. You are responsible to pay all of your own deductibles. In the event your insurance changes to a plan in which the doctors do not participate with, payment in full will be due at the time of your visit. We will provide a form to submit to the carrier for your reimbursement noting any payment received.

Workers Compensation

If this is a work related injury, you must be prepared to provide all pertinent data regarding your accident and billing information. This must include the claim or case number, date of injury, description and location of injury and the insurance carrier's mailing address and telephone number for billing purposes. It must also include the employer's name (at the time of injury), address and telephone number. Since we follow the NYS guidelines for NYS Workers Compensation, patients cannot be seen without this information presented at the time of the office visit. If the case is denied, it is understood that your private insurance will be billed, and if they do not pay, the patient is directly responsible to pay the bill.

No Fault

Patients should be prepared to pay their bills in full at the prevailing NYS fee schedule for No Fault and Workers Compensation. An exception can be made is we receive verification in writing from the No Fault Carrier to include the specific patient's name, medical benefit ceiling, deductible and whether or not it has not been met. The patient, or course, is responsible to pay the deductible, but with this information in writing, we will bill the carrier directly for reimbursement. If for any reason, the carrier does not pay, the patient is directly responsible and agrees to pay the bills.

Minor Patients (Children under the age of 18)

The adult accompanying a minor to this office is responsible for full payment. In order to authorize treatment, minor patients should not report to the office without a responsible adult present.

Medicare Patients

The doctors are participating Medicare providers and will submit all claims directly to Medicare. Payment for the 20% differential is to be paid immediately upon receipt of our bill. You are responsible to pay your deductibles. If secondary insurance carrier information is provided, including policy, group, plan numbers along with correct mailing address for claims to be submitted and telephone numbers of the insurance company, our billing company will automatically submit these for you. Please be advised that if Medicare should reject your charges for services, of DME's brace, casts, etc. are not covered, you will be responsible for the Medicare allowable fee for these charges.