# ORTHOPEDICS & SPORTS MEDICINE, P.C.

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 # : ______________

**Employer Information**

Employer at Time of Injury: ______________________ Date of Accident: ______________

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

**Workers Compensation Information**

Carrier Name: ______________________________ Phone #: ______________________

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

WCB #: ______________ Carrier Case #: ______________ Adjuster Name: ______________ Phone: ______________

Explain How Injury Occurred/Body part that's injured: ______________________________

______________________________________________________________________

Have you missed work due to this injury: ________ Have you returned to work: ________ Date returned: ________

## Orthopedics & Sports Medicine, P.C.

Patient Name: ________________________ DOB: __________ (MM/DD/YY) Date: __________

**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 del Empresario**

Empleador en el momento de la lesión: ______________________________ Fecha del Accidente: _________

Dirección del Empresario: _____________________________ Ciudad: ___________ Estado: _______ Zip:_____

**Información del Compensación**

Nombre del Seguro de Compensación: ______________________________ Teléfono #: ________________

Dirección: ________________________________ Ciudad: _______________ Estado: ________ Zip: _______

WCB #:__________ Numero del Caso: ____________ Nombre del Sustantivo:____________ Teléfono #:________

Explicar cómo lesión corporal producido parte que está herido: ______________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Ha faltaba al trabajo debido a esta lesión: ________ Has regresado a trabajar: __________ Fecha qué regreso: ________

# 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: ________

# ORTHOPEDICS

# & SPORTS MEDICINE, P.C.

WWW.OSMPC.COM

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

## WORKERS' COMPENSATION PATIENTS

Our physician's participate in the New York State Workers' Compensation Program. In general, your carrier will be billed directly for all of your services. You will be directly responsible to pay for any services or equipment denied for payment under this program. In addition, it is your responsibility to provide our office with accurate billing information, the name of your carrier and their address, case number and date of the accident. If the case has not been established, we must have a copy of the C-2 filed with your employer in addition to the above information.

Because of the many parties involved and the complex legalities often associated with acceptance and denial of the cases, all of our Workers' Compensation are required to provide an **"insurer of last cause"** on file with our office. Usually, this is your **PRIVATE INSURANCE**. You will be asked to provide a copy of your insurance card with your current employer for this purpose. In the event your services are formally denied, we can submit these claims directly to your insurance carrier. If your doctor is a participant in your private insurance plan, your financial responsibility would be determined by your primary insurance carrier and their contract with your employer as defined on an Explanation Of Benefits (EOB) once we submit to them for payment. Most often, this would involve a co-payment and any uncovered services.

If your Workers' Compensation is DENIED and your insurance plan is one in which your doctor is NOT participating, you will be directly responsible to pay your bill. Payment arrangements can be made, of course, but you will have the obligation to pay this bill yourself. Should this account be referred to a Collection Agency, your failure to pay will be reported to the Credit Reporting Agencies which may adversely affect your credit rating.

If you have NO INSURANCE and your Workers' Compensation is DENIED, you are directly responsible to pay your bill. In this insurance also, payment arrangements can be made, but the bill is your obligation. When patients have no insurance support at all, our offices will extend a 20% courtesy of our usual and customary fees, provided the account is PAID IN FULL WITHIN 30 DAYS.

If you have an Attorney, the Attorney may, with your permission, have copies of your records free of charge. Final examinations, percentage of loss, etc. are provided only at the request of the insurance carrier, unless your Attorney elects to pay for this examination.

## ********PATIENT STATEMENT AND SIGNATURE********

I HAVE READ AND UNDERSTAND MY PHYSICIAN'S POLICY REGARDING WORKERS' COMPENSATION AND WILL COMPLY.

Signature of Patient ______________________ Date ____________

Name of Patient (Please Print) ______________________ Date ____________

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# ORTHOPEDICS & SPORTS MEDICINE, P.C.

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.: 845-561-8060 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 rehusar 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. ha preparado un formulario el cual describe los usos y revelaciones que pueden hacer acerca de mi salud relevante a tratamientos médico, 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 serán afectadas.

Es mi ententimiento que Orthopedics & Sports Medicine, P.C. tiene derecho de cambiar sus prácticas 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 médicos y pagos. Es mi ententimiento que Orthopedics & Sports Medicine, P.C. no tiene que estar de acuerdo con estas restricciones, pero pero una vez que se haya llegado a un acuerdo Orthopedics & Sports Medicine, P.C. tendrá 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 Orthopedic & Sports Medicine, P.C.

X ___________________________________________________________
Firma La Fecha

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.