Authorization for Release of Medical Information

LI Orthopedic Solutions is authorized to release protected health information about the above patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person/Entity to Receive Information Check each person/entity below that you approve to receive information	**Description of Information to be Released** Check type of information below that can be provide d to person/entity
Patient Contact Information: __ Voicemail Phone#(s): _____ __ Email Address: _____	__ Financial __ Medical Information __ Medications
__ Spouse (Provide Name & Phone#) Name: _____ Phone Number: _____	__ Financial __ Medical Information
__ Parent(s) (Provide Name & Phone#) Name: _____ Phone Number: _____	__ Financial __ Medical Information
__ Others(s) (Provide Name & Phone#) Name: _____ Phone Number: _____	__ Financial __ Medical Information

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forwards

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipie and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

LONG ISLAND
Orthopedic Solutions

David J. Weissberg, M.D. Financial Policy

Thank you for choosing Dr Weissberg for your orthopedic care. We are committed to providing quality medical care for you.. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior beginning treatment.

Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. As a courtesy, we will file claims to those plans with which we have a contracted agreement. If, however, your insurance company does not pay the claim within a reasonable amount of time, we will look to you for payment. All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered," you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the 1 st day of the month after the charge has printed on your statement. It is the policy of this office to turn accounts with balances overdue for 60 days or more to a collection agency. We would prefer not to take this course of action as it may adversely affect your ability to obtain credit in the future.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amounts as well as approved labs, radiology facilities, and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any costs incurred by this office because of incorrect information you provided to us will be passed on to you. If you have insurance coverage with a plan with which we do not participate or you currently have no health insurance, charges for your care and treatment are due at the time of service, unless prior financial arrangements have been set up.

Deductibles / Copays / Payments

Our insurance contracts require us to collect deductible amounts and copays at the time of service. Payment for past-due balances for previous services rendered is also expected when you are seen in this office. In the event that a payment is not made at the time of service, a $20 service charge will be added to your account balance. If your check is returned to us for insufficient funds, we will assess a $25 service charge to your account to defray fees charged to us by our bank. **All accounts sent to a collection agency will be charged a 40% service fee for collecting overdue accounts. Accounts become overdue after 90 days and will be sent to our collection agency for processing.**

Minors

A parent or legal guardian must accompany a patient under the age of 18 years on every visit to our office.

I hereby authorize David J. Weissberg, MD to release information required by my insurance company for payment of my medical bills or to review activities related to my healthcare provider's participation in my health plan. I assign David J. Weissberg, MD any and all benefits to which the patient or insured party is entitled for medical services rendered.

I have read this Financial Policy and agree to abide by it.

Patient Name (Please Print)	Signature of Patient or Parent/Guardian	Date

Patient Information

(Please Fill Out Completely)

Contact Information

Full Name: Last | First | Middle | (Maiden)

Address (Street or Box) | City | State | Zip

Do you reside in a nursing home? ☐ Yes ☐ No If yes, please list the name, address and phone number belo

Name: | Address: | Phone number:

Home Phone | Cell Phone | Work Phone | Date of Birth | Social Security #

Email | Sex | Marital Status ☐ Married ☐ Single ☐ Divorced

***2012 US Federal Government Requirement:**

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Language:

Are You Employed? Please list Employer, Occupation, Position and Address

☐ Yes ☐ No

If Student, Indicate School

Please Provide Name & Daytime Number of one of the following: ☐ Spouse ☐ Relative Other Than Parents ☐ Friend Name_____ Daytime Phone # _____

If Patient is a Minor please provide Parent or Guardian's Name | Social Security # | Date of Birth | Parent's Phone ( )

Parent's Employer / Employer's Address | Work Phone ( )

Insurance

Do you plan to file Worker's Compensation? ☐ Yes ☐ No | If yes, who should we call to verify compensation? | Company Name | Person to Verify | Phone ( )

Name of Primary Insurance Company: | Name of Policy Holder | Birth Date of Policy Holder | Social Security # of Policy Holder | Relationship to Policy Holder

1.

Group Number / Name | Policy Number | Is this a Medicare Advantage Plan? ☐ Yes ☐ No | Effective Date of Policy

Address | City | State | Zip

Name of Secondary Insurance Company: | Name of Policy Holder | Birth Date of Policy Holder | Social Security # of Policy Holder | Relationship to Policy Holder

2.

Group Number / Name | Policy Number | Effective Date of Policy

Address | City | State | Zip

Referral

How were you referred to our office?

☐ Another physician ☐ Former patient ☐ Newspaper ☐ A friend: (Please provide name)
☐ Employer ☐ Yellow Pages ☐ Web site (name)
☐ Insurance Co. ☐ Family member ☐ Other (please specify):

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Patient Medical History

Name: _____ Date of Birth: _____

Your Gender: 1 Female 2 Male

PREVIOUS HOSPITALIZATIONS & SURGERIES - Please list **ALL** surgeries, especially all spine, arm, and leg surgeries.

Reason for Visit or Surgery, include Part of Body	Date	Hospital, Facility and/or Physician
1.		
2.		
3.		
4.		

CURRENT MEDICATIONS

Medication/Supplement/Vitamin	Dose or Strength	How Often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

MEDICATION ALLERGIES and/or INTOLERANCES, LATEX ALLERGY ☐ None

Name of Medication to which you have a reaction	Type of Reaction
1.	
2.	
3.	
4.	

PHARMACY INFORMATION - Please list the pharmacy you primarily use

Pharmacy Name/Number (if known): _____

City/Town: _____ Phone # _____

Street/Intersection: _____

Social History

Tobacco Smoke - Everyone Please Respond

□ Never Smoker	□ Current everyday smoker	Packs per day _____
□ Former Smoker	□ Current some day smoker	Number of years _____
□ Unknown if ever smoked	□ Smoker, current status known	

Y	N	
□	□	Tobacco Chew, Snuff
□	□	Alcohol. If yes, approximate number of drinks per week _____
□	□	Street Drug Use

Do you live with anyone who can take care of you at home? □ Yes □ No

Y N **Patient Medical History**

- □ □ DVT, Blood Clot - 453.40
- □ □ Clotting disorder - 286.9
- □ □ Fibromyalgia - 729.1
- □ □ Old age joint disease - 719.90
  (osteo arthritis) - 715.90
- □ □ Lupus or other connective tissue disease - 710.0 (lupus), 710.9 (connective tissue disease)
- □ □ Gout - 274.9
- □ □ Osteoporosis - 733.00
- □ □ Multiple bone fractures
- □ □ Blood work diagnosed joint disease (e.g. rheumatoid arthritis) - 714.0
- □ □ Chronic Pain Disorder - 338.29
- □ □ Diabetes "Sugar" - 250.00
- □ □ Low Thyroid - 244.9
- □ □ High Thyroid - 242.90
- □ □ Recurrent infections
- □ □ History of MRSA; drug resistant infection V12.04
- □ □ HIV - 042
- □ □ Peripheral Artery Disease (PAD) - 443.9
- □ □ Heart Attack, Heart Disease - 412
- □ □ High Blood Pressure - 401.9
- □ □ Irregular Heartbeat - 427.9
- □ □ Murmur - 785.2
- □ □ Asthma - 493.90
- □ □ Bronchitis - 490
- □ □ Emphysema/COPD - 492.8, 491.20
- □ □ Chronic Lung Disease - 518.89
- □ □ Kidney Disease - 593.9
- □ □ Dialysis
- □ □ GERD, Reflux, Heartburn - 530.81, 787.1
- □ □ Liver Disease - 573.9
- □ □ Hepatitis Type _____ - A-070.1x, B-070.3x, C-070.70
- □ □ Psoriasis
- □ □ Crohn's Disease/Ulcerative Colitis - 555.9, 556.9
- □ □ Diverticulitis - 562.11
- □ □ Chronic disease type _____

Y N **Patient Medical History**

- □ □ Peripheral Neuropathy - 356.9
- □ □ Depression - 311
- □ □ Street Drug Addiction type _____ - 304.90
- □ □ Narcotics Addiction - 304.00
- □ □ Cancer - 239.9 type _____
- □ □ Stroke - 434.91
- □ □ Seizure Disorder - 345.90
- □ □ Traumatic Brain Injury - V54.52
- □ □ High Cholesterol - 272.0

Please list other disorders:

_____

_____

Y N **Family Medical History**

- □ □ Clotting Disorder
- □ □ Heart Disease
- □ □ Old Age Joint Disease (osteo arthritis)
- □ □ Connective Tissue Disease (e.g. Lupus)
- □ □ Diabetes (sugar)
- □ □ Neuropathy
- □ □ Muscle Disease: Name: _____
- □ □ Osteoporosis
- □ □ Cancer
- □ □ Blood Work Diagnosed Joint Disease (e.g. Rheumatoid Arthritis)

Y N **Patient Review of Systems**
(check all that have occurred in the past twelve months)

- □ □ Easy bleeding or bruising - 286.9
- □ □ Problems with anesthesia describe _____
- □ □ All over muscle pain - 729.1
- □ □ All over joint pain - 719.49
- □ □ Skin rash - 782.1
- □ □ Poor wound healing - 782.9
- □ □ Cramps legs/arms - 729.82
- □ □ Unexpected weight loss - 783.21
- □ □ Fever/chills - 780.60
- □ □ Infections in the last year type _____
- □ □ Fatigue - 780.79
- □ □ Headaches - 784.0
- □ □ Blurred vision - 368.8
- □ □ Difficulty swallowing - 787.20
- □ □ Chest pain - 786.50
- □ □ Palpitations - 785.1
- □ □ Fainting - 780.2
- □ □ Shortness of breath - 786.05
- □ □ Wheezing - 786.07
- □ □ Chronic cough - 786.2
- □ □ Constipation - 564.00
- □ □ Diarrhea - 787.91
- □ □ Black or bloody stools - 787.7
- □ □ Loss of control of bowels - 787.6
- □ □ Urinary frequency - 788.41
- □ □ Inability to empty bladder - 788.21
- □ □ Loss of control of bladder - 788.30
- □ □ Dizziness - 780.4
- □ □ Unsteady gait - 781.2
- □ □ Tremors - 781.0
- □ □ Cold or heat intolerance - 780.99
- □ □ Anxiety - 300.00

Patient Signature: _____ **Date:** _____

New Problem Questionnaire

Last Name: _____ **First Name**: _____ **Middle Initial:** _____

Primary Physician: _____
name clinic address phone

Referring Physician: _____
name clinic address phone

Age: _____ **(circle one) Left / Right Handed** **(circle one) Female / Male**

Where is your main problem? _____

What is your main problem you want the doctor to treat today? (please check all that apply)

□ Pain □ Numbness □ Swelling □ Weakness □ Stiffness □ Unstable Joint □ Wound

Other (please describe) _____

When did your problem begin? Please give the approximate date. _____

Briefly describe how your problem started: _____

_____

□ Job Injury □ Car Accident □ Sports Injury □ Suddenly □ Gradually

The problem is: □ constant or □ intermittent

Does your problem awaken you from sleep? □ yes □ no

The problem is: □ getting better □ getting worse □ staying the same

What worsens the problem?

□ Exercise □ Repetitive Motions □ Bending
□ Sitting □ Overhead Activities □ Stairclimbing
□ Standing □ Coughing, Sneezing, Straining □ Nothing
□ Walking □ Rest □ Other _____

What helps the problem?

□ Rest □ Ice □ Heat □ Medication □ Nothing □ Other: _____

Are any of the following activities limited because of your problem?

□ Dressing □ Bathing □ Toileting □ Feeding □ Getting up from a bed or chair

For this problem, what tests or treatments have you had and did they help?

ER _____ Physical Therapy _____ Nerve Test _____
Physician _____ X-Rays _____ UltraSound _____
Surgery _____ CT Scan _____ Chronic Pain Mgmt _____
Injection _____ MRI _____ Other _____
Medications _____

Are You Employed □ yes □ no **What is your occupation?** _____

Work Status

□ Regular Duty
□ Light Duty - on what date did you start light duty as a result of your new problem? _____
□ Not working - on what date did you last work as a result of your new problem? _____
□ Retired
□ Other _____

New Problem Questionnaire

If you are working, does your job require the following? (please check all that apply)

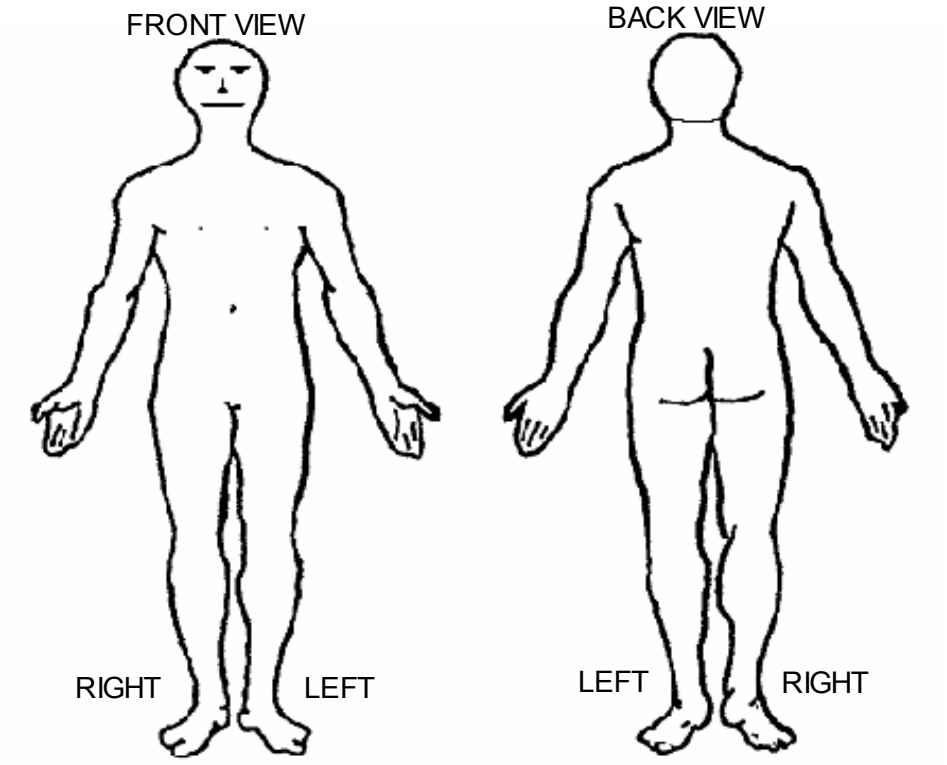
- □ Lifting 0 - 10 lbs
- □ Lifting 11 - 20 lbs
- □ Lifting 21 - 50lbs
- □ Lifting over 50 lbs
- □ Frequent Lifting
- □ Frequent Sitting
- □ Frequent Kneeling
- □ Frequent Bending
- □ Climbing
- □ Extended Walking
- □ Continuous Standing
- □ Sitting
- □ Repetitive hand motions
- □ Repetitive arm motions

Are you planning to apply to any of the following programs because of your problem?

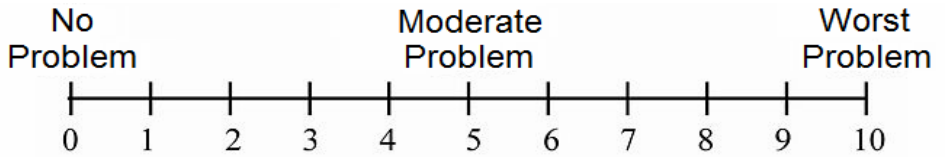
A. Disability □ yes □ no B. Worker's Compensation □ yes □ no

Mark where your problem is located using the symbols below. Place an "X" at the worst spot.

Aching	Numbness	Pins & Needles	Burning	Stabbing
ΔΔΔ	= = =	OOO	□□□	///



Please mark how bad your problem is now:



Are there any other acute problems or crises in your life now? □ Yes □ No

If yes, please explain: _____

Patient Signature: _____ **Date:** _____

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to individuals you must sign this form. Signing this form will only give consent to release this information to the following individuals indicated below. This consent form will not allow **Long Island Orthopedic Solutions** to release any other information to these individuals.

You have the right to revoke this consent in writing.

I authorize/allow **Long Island Orthopedic Solutions** to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient_____

2._____ Relation to Patient_____

3._____ Relation to Patient_____

Patient Name_____

Patient Signature_____ Date_____

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary for the staff of **Long Island Orthopedic Solutions** to leave messages for patients. At no time will a representative of Long Island Orthopedic Solutions discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name_____

Patient Signature_____ Date_____