# MOTOR VEHICLE/NO-FAULT INTAKE FORM

Name (PLEASE PRINT) _____ Date of Birth _____

## CARRIER INFORMATION

Insurance Carrier Name: _____ Carrier Phone No. _____

Address: _____

Policy No. _____ Claim No. _____ Date of Accident: _____

## INJURY INFORMATION

Was the accident reported to your carrier? ☐ yes ☐ no

Have you filed an application for no-fault benefits with the carrier? ☐ yes ☐ no

Were you the driver of the vehicle or a passenger? _____

How did the accident happen? _____

_____

Have you lost time from work? ☐ yes ☐ no If yes, how much? _____

Have you seen another physician for this condition? ☐ yes ☐ no Doctor's Name: _____

Were x-rays taken? ☐ yes ☐ no Other tests? ☐ yes ☐ no If yes, please list test and facility where taken: _____

## ATTORNEY INFORMATION

Attorney's Name: _____ Phone No. _____

Address: _____

May we contact your attorney regarding your case? ☐ yes ☐ no

## AUTHORIZATION

I, the undersigned, certify that the information given above is correct. I clearly understand and agree that all services rendered to me that are not covered, are charged directly to me, and that I am personally responsible for payment in the event that my claim for No-Fault benefits are denied.

Patient's Signature: _____ Date: _____

Please note: In this instance, we will attempt to bill any back-up insurance you may have prior to billing you directly.

Revised 10/06/10

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**
**(This form is not 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* | Robert . Doutney, PA<br>800 WOODBURY RD, WOODBURY, NY 11797-0000 |
|---|---|

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 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. 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

- - , , , New York

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

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) | 13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON: |
|---|---|
| FROM: _____ THROUGH: _____ | _____ (DATE) |

CONTINUE ON PAGE 2

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**
**PAGE 2**

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

**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**
**PAGE 3**

**PATIENT:** Your health provider may agree to have you assign your right to No-Fault benefits from your insurer directly to your health provider (**Assignment of Benefits**). If you and your health provider agree to an assignment of benefits, you must both sign the agreement contained in # 21 or the prescribed NF-AOB form or its equivalent. The language contained in the assignment of benefits is mandatory and may not be altered or avoided by any other language added to this agreement or other written agreement.

21. _____ **(IF YOU HAVE CHOSEN TO ASSIGN YOUR BENEFITS TO THE HEALTH PROVIDER BY CHECKING THIS OPTION, YOU MAY NOT ALSO ENTER INTO AN AUTHORIZATION TO PAY BENEFITS CONTAINED IN ITEM #20 ABOVE)**

**ASSIGNMENT OF NO-FAULT BENEFITS:**

**I HEREBY ASSIGN TO THE HEALTH CARE PROVIDER INDICATED BELOW ALL RIGHTS, PRIVILEGES AND REMEDIES TO PAYMENT FOR HEALTH CARE SERVICES PROVIDED BY THE ASSIGNEE TO WHICH I AM ENTITLED UNDER ARTICLE 51 (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, NOTWITHSTANDING ANY OTHER AGREEMENT TO THE CONTRARY. THIS 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**

PRINT NAME _____ SIGNED _____
PATIENT (Assignor) PATIENT DATE

PRINT NAME David J Weissberg, MD SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? ☐ YES ☐ NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? ☐ YES ☐ NO

**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 THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN 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.**

| DATE | PROVIDER'S SIGNATURE | IRS/TIN IDENTIFICATION NO. | WCB RATING CODE IF NONE, SPECIALTY |
|---|---|---|---|
| | | | |

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to David J Weissberg, MD, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (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
(Print accident date)
to the contrary.

This 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 THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN 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)**

_____ _____
(Date of signature)

_____
(Address of Patient)

David J Weissberg, MD _____
**(Print name of Provider)** **(Signature of Provider)**

800 WOODBURY RD, SUITE 100G _____
(Date of signature)

WOODBURY, NY 11797-0000
(Address of Provider)

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David J. Weissberg, MD, FAAOS, PC
*Diplomate, American Board of Orthopedic Surgery*

## ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Assignment of Insurance Benefits – Appointment as Legal Authorized Representative I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to Dr Weissberg and his affiliated providers and law firms (hereinafter, "My Authorized Representatives") and I appoint them as my authorized representative with the power to:

- ✓ File medical claims with the health plan
- ✓ File appeals and grievances with the health plan
- ✓ Institute any necessary litigation and/or complaints against my health plan naming me as plaintiff in such lawsuits and actions if necessary (or me as guardian of the patient if the patient is a minor)
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party including the health plan

I certify that the health insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

**Authorization to Release Information**

I hereby authorize My Authorized Representatives to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

**ERISA Authorization**

I hereby designate, authorize, and convey to My Authorized Representatives to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause of action including litigation against my health plan (even to name me as a plaintiff in such action) that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines. I authorize communication with the Provider and his authorized representatives by email and my email address is _____@_____. I understand I can revoke this authorization in writing at any time

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

Patient _____ Date _____

Susan M. Condreras, PAC
379 Oakwood Road, Suite C, Huntington Station, NY 11746
P: 631.351.0295, F: 631.351.0265

Tom Heinisch, PA
400 Montauk Highway, Suite 108, West Islip, NY 11795
P: 631.482.9192, F: 631.482.9195

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**PATIENT INFORMATION (PLEASE PRINT)**
**(Informaction del Paciente)**

**NAME** _____
(NOMBRE) FIRST (APPELLIDO)LAST MIDDLE

**HEIGHT**_____ **WEIGHT**_____
*(Altura)* *(Peso)*

**SOCIAL SECURITY NUMBER** _____-_____-_____ **DATE OF BIRTH** _____ SEX M / F
*(NUMERO DE SEGURO SOCIAL)* *(FECHA DE NACIMIENTO)*

**ADDRESS** _____ **APT. #** _____
*(DIRECCION)*

**CITY** _____ **STATE** New York **ZIP** _____
*(CIUDAD)* *(ESTADO)* *(CODIGO POSTAL)*

**HOME PHONE** (_____) _____ **CELL PHONE** (_____)
_____
*(TELEFONO)* *(TELEFONO CELULAR)*

Si desea recibir recordatorios de la cita por mensaje de texto por favor facilítenos su información del portador:_____

**EMAIL ADDRESS** _____
*(CUENTO DEL CORREO ELECTRONICO)*

**¿QUIERES RECIBIR RECORDATORIOS POR CORREO ELECTRÓNICO? SI** ☐ **NO** ☐

**MARITAL STATUS** (CIRCLE) SINGLE / MARRIED / DIVORCED / WIDOWED
*(SOLTERO(A))* *(CASADO(A))* *(DIVORCIADO(A))* *(VIUDO(A))*

**EMPLOYMENT** (CIRCLE) NONE / FULL-TIME / PART-TIME / STUDENT / RETIRED / DISABLED
*(Sin Empleo)* *(Tiempo Completo)* *(Tiempo Parte)* *(Estudiante)* *(Retirado)* *(Discapacitado)*

**EMPLOYER** _____ **OCCUPATION** _____
*(EMPLEO)* *(TRABAJO)*

**EMPLOYER ADDRESS** _____ **TELEPHONE** _____
*(DIRECCION DEL EMPLEO)* *(TELEFONO DEL EMPLEO)*

**SPOUSE / PARENT /EMERGENCEY CONTACT INFORMATION**
*(Esposo/Padre/Contacto en Caso de Emergencia)*
(THIS INFORMATION IS REQUIRED FOR MINOR PATINTS OR PATIENTS WITH GUARDIANS)

**NAME** _____ _____
*(NOMBRE DEL ESPOSO O PADRE) FIRST* *LAST* *(RELACION) RELATIONSHIP*

**DATE OF BIRTH** _____ SEX M / F **PHONE** (_____) _____
*(FECHA DE NACIMIENTO)* *(TELEFONO)*

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# HEALTH HISTORY

NAME _____ DATE _____
NOMBRE FECHA

## MEDICATIONS

List all prescription OR over the counter medications you are currently using (Indique medicamentos de receta del Medico o sin receta que estas usando ahora):

_____
_____
_____

Place a mark by "yes" or "no" if you have had any of the following: (Elija todos los que apliquen a usted)

| CONDITION (Condicion) | YES (Si) | NO (No) | CONDITION (Condicion) | YES (Si) | NO (No) |
|---|---|---|---|---|---|
| AIDS/HIV<br>SIDA/VIH | | | HEPATITIS<br>HEPATITIS | | |
| ALCOHOLISM<br>ALCOHOLISMO | | | HERNIA<br>HERNIA/QUEBRADURA | | |
| ANEMIA<br>LA ANEMIA | | | HERNIATED DISC<br>HERNIA DE DISCO | | |
| ARTHRITIS<br>ARTRITIS | | | KIDNEY DISEASE<br>ENFERMEDAD RENAL | | |
| ASTHMA<br>ASMA | | | LIVER DISEASE<br>ENFERMEDAD HEPÁTICA | | |
| BLEEDING DISORDER<br>ENFERMEDAD HEMORRAGICA | | | MIGRAINES<br>LAS MIGRAÑAS | | |
| BRONCHITIS<br>BRONQUITIS | | | MONONUCLEOSIS<br>LA MONONUCLEOSIS | | |
| CANCER<br>EL CANCER | | | MULTIPLE SCLEROSIS<br>ESCLEROSIS MÚLTIPLE | | |
| CATARACTS<br>CATARATAS | | | OSTEOPOROSIS<br>OSTEOPOROSIS | | |
| CHEMICAL DEPENDENCY<br>DEPENDENCIA DE DROGAS | | | PARKINSON'S DISEASE<br>LA ENFERMEDAD DE PARKINSON | | |
| DIABETES | | | PINCHED NERVE<br>NERVIO PELLIZCADO | | |
| EMPHYSEMA<br>ENFISEMA | | | PNEUMONIA<br>NEUMONÍA | | |
| EPILEPSY<br>EPILEPSIA | | | PROSTHESIS<br>PRÓTESIS | | |
| FRACTURES<br>FRACTURAS | | | RHEUMATOID ARTHRITIS<br>LA ARTRITIS REUMATOIDE | | |
| GLAUCOMA | | | STROKE<br>DERRAME CERABRAL | | |
| GOUT<br>GOTA | | | THYROID PROBLEMS<br>PROBLEMAS DE LA TIROIDES | | |
| HEART DISEASE<br>ENFERMEDAD CARDIACA | | | TUBERCULOSIS<br>LA TUBERCULOSIS | | |

1. Have you ever been to a chiropractor? YES / NO
   Ha solicitado tratamiento por quiropractico?

2. In the last 24 months (not including this injury) have you been to any of the following?
   En los dos anos pasados ha solicitado tratamiento con:
   a. Medical Doctor(Medico) YES / NO LAST VISIT _____
   b. Physical Therapist (Terapia Fisica) Y ES / NO LAST VISIT _____
   c. Medical Specialist (Especialista) YES / NO LAST VISIT _____

3. Have you ever had surgery? If yes, please list surgery and year. YES / NO
   Indiqe cirugias; tipo y el ano:
   a. Year _____ Surgery _____
   b. Year _____ Surgery _____
   c. Year _____ Surgery _____

4. Have you ever had a broken bone? If yes, please list year and bone. YES / NO
   Indique fracturas del hueso y ano:
   a. Year _____ Bone _____
   b. Year _____ Bone _____
   c. Year _____ Bone _____

5. Have you ever had a work-related injury? If yes, please list year and injury. YES / NO
   Ha tenido accidentes del trabajo? Indique tipo y ano del herida
   a. Year _____ Injury _____
   b. Year _____ Injury _____
   c. Year _____ Injury _____

6. Have you ever been in a car accident? If yes, list all of your previous car accidents (even if you were not injured, whether you were at fault or not).
   Ha tenido otros accidentes del auto? Indique el ano y tipo de herida YES / NO
   a. Year _____ Injured YES / NO Injury _____
   b. Year _____ Injured YES / NO Injury _____
   c. Year _____ Injured YES / NO Injury _____

7. Do you exercise?
   Haces ejercicios? Nunca / A veces / Cada dia
   NEVER / SOMETIMES / EVERYDAY

8. Describe your activity level while at work.
   En su trabajao que haces mas? SENTANDO / DE PIE / TRABAJO LIJERO / TRABAJO DURO
   SITTING / STANDING / LIGHT LABOR / HEAVY LABOR

9. How many days of work have you missed since this accident / injury? _____
   Cuantos dias no puede trabajar debido a este accidente?

10. Do you smoke? YES / NO _____ packs/day
    Fuma cigarillos? Cuantos por dia?

11. Do you drink alcohol? YES / NO _____ drinks/week
    Toma Alcohol? Cuantas bebidas por dia?

12. (Women) Are you pregnant? YES / NO _____ due date
    (A mujeres) Esta embarazada? Cuantos meses?

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**David J. Weissberg, MD, FAAOS, PC**
*Diplomate, American Board of Orthopedic Surgery*

# Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Please indicate the following authorization by checking yes or no:

I authorize Dr. David Weissberg and/or his associates to leave a message regarding my diagnostic studies (lab results/ x-rays /MRIs/CT scans) or other health related iniormation:

On my: home phone yes _____ no _____; cell phone yes _____ no _____ At work yes _____ no _____

I authorize the disclosure of my health information to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Check one:

_____ This authorization will NOT expire _____ This authorization will expire on (date) _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the office of Dr. David Weissberg.

_____ _____

Signature of patient or legal representative Date

379 Oakwood Road, Suite C, Huntington Station, NY 11746
P: 631.351.0295, F: 631.351.0265

400 Montauk Highway, Suite 108, West Islip, NY 11795
P: 631.482.9192. F: 631.482.9195

# 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)

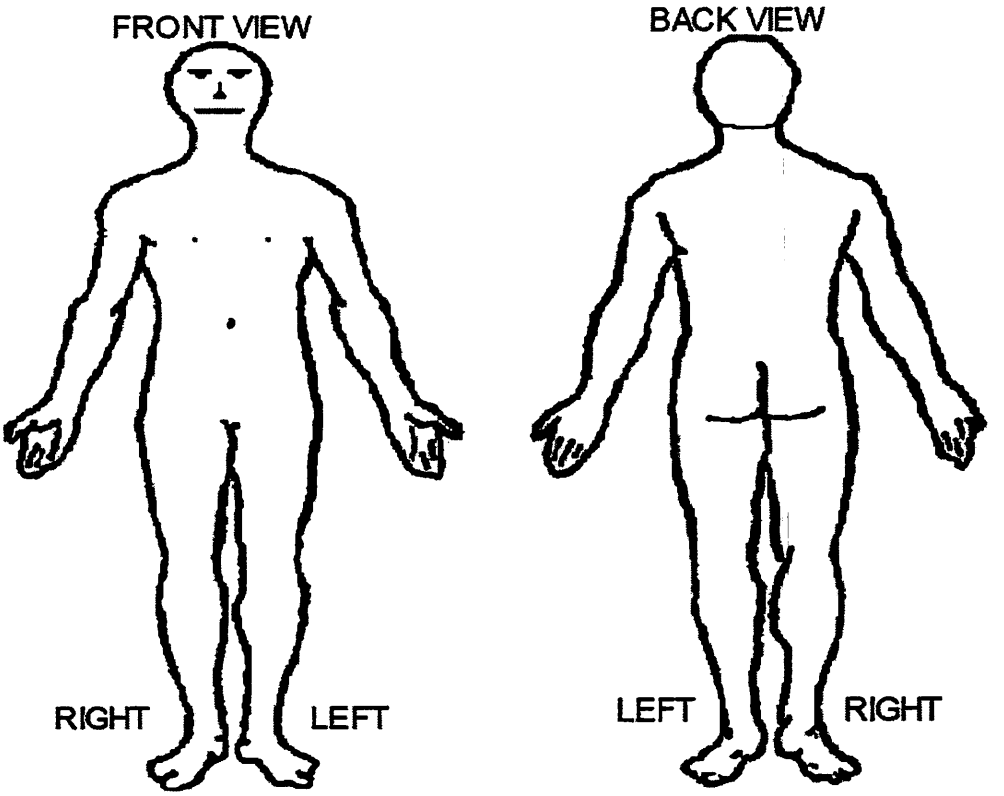
- ☐ Lifting 0 - 10 lbs
- ☐ Lifting 11 - 20 lbs
- ☐ Lifting 21 - 50lbs
- ☐ Lifting over 50 lbs
- ☐ Frequent Lifting
- ☐ Frequent Sitting
- ☐ Frequent Kneeling
- ☐ Frequent Bending
- ☐ Climbing
- ☐ Extended Walking
- ☐ Continuous Standing
- ☐ Sitting
- ☐ Repetitive hand motion
- ☐ Repetitive arm motions

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

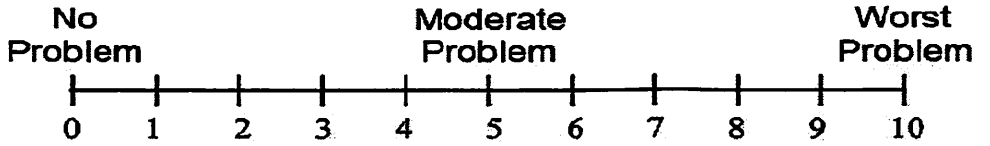
A. Disability ☐ yes ☐ no B. Worker's Compensation ☐ yes ☐ no

**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:** _____

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# 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 Name:_____

Date of loss: _____

# MEDICAL LIEN

Attorney Name:

_____

_____

_____

I hereby authorize and direct my attorney, to pay directly to **David J. Weissberg, MD, PC** such sums as may be due and owing for professional services rendered to me both by reason of this accident and by reason of any other bills that are due to the provider and to withhold such sums from any settlement of judgment as is necessary to adequately protect the provider.

I hereby further give a lien to the provider on any proceeds to which I may become entitled as a result of any settlement of judgment in any claim or litigation arising out of the injuries for which I have been treated of injuries in connection therewith, whether such proceeds are remitted directly to me or to you my attorney.

I fully understand that I am directly responsible to the provider for all professional bills submitted by the provider for services rendered to me by the provider and that this agreement is made solely for the providers' additional protection and in consideration of the provider awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Attorney agrees to notify the doctors immediately of the name and contacting information of any attorney substituted in his or her place.

_____ _____

PRINT PATIENT NAME DATE

_____ _____

SIGNATURE OF PATIENT SIGNATURE OF PARENT/GUARDIAN

ACKNOWLEDGEMENT OF ASSIGNMENT & LIEN BY ATTORNEY

The undersigned being the attorney of record on his own behalf and on behalf of any other attorney or attorneys who are associated with the undersigned or who are substituted in his stead for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect, **David J. Weissberg, MD, PC**

_____ _____

ATTORNEY'S SIGNATURE DATE

***NOTE TO ATTORNEY***

**PLEASE SIGN AND RETURN ONE COPY TO THE PROVIDERS OFFICE; KEEP A COPY FOR YOUR RECORDS**

Name: _____

Date of birth:____/____/_____

Phone# : _____

**Do you have a lawyer? YES NO**

Lawyers name: _____

Lawyers address: _____

_____

Lawyers phone #: _____

Lawyers fax# :_____

**Do you have a chiropractor? YES NO**

Chiropractor's name: _____

Chiropractor address: _____

_____

Chiropractor phone #: _____

Chiropractor fax#: _____

**Do you have a physical therapist? YES NO**

Physical therapy name: _____

Physical therapy address: _____

_____

Physical therapy phone#: _____

Physical therapy fax#: _____

Nombre: _____

Fecha de nacimiento: ____/____/_____

Numero de telefono: _____

**Tiene un abogado? SI NO**

Nombre de Abogado: _____

Direccion de los abogados: _____

_____

Numero de telefono del abogado:

_____

Fax del abogado: _____

**Tienes un quiropractico? SI NO**

Nombre del Quiropractico :_____

Direccion de quiropractico: _____

_____

Numero de telefono: _____

Numero de fax: _____

**Tienes un terapista? YES NO**

Nombre de su terapia fisica: _____

Nombre de su terapia fisica: _____

_____

Numero de telefono: _____

Numero de fax: _____