NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER		New York	

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature_____ Date _____

Provider's Name and Address David J Weissberg, MD

800 WOODBURY RD, SUITE 100G, WOODBURY, NY 11797-0000

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

WORKER'S COMPENSATION/AUTO ACCIDENT INTAKE FORM

Patient's Information

Appointment Date/Time: (FETCHA)_____

Last Name: (APELLIDO) _____ First Name:(NOMBRE) _____

Diagnosis:(DIAGNOSTICO)_____ DOB:(FETCHA DE NACIEMIENTO)_____

Referring Physician:(MEDICO DE REFERENCIA)_____

Address: (DIRECCION)_____

Phone:(NUMERO DE TELEFONO) _____

Email:(CORREO ELECTRONICO_____

Insurance Information: Symptoms related to Worker's Compensation or Auto (Please Circle)

Información del seguro: síntomas relacionados con la compensación del trabajador o el automóvil (marque con un círculo)

Primary Insurance: (SEGURO) _____

Policy Holder's Name:(NOMBRE DE LOS TITULARES DE POLIZAS) _____

DOB:_____

Member ID :(MIEMBRO ES EL NUMERO) _____

Group Number: (NUMERO DE GRUPO)_____

Worker's Compensation / Auto Accident:

Name of Insurance (Patient's PIP carrier for Auto OR Employer's Insurance Carrier for Worker's Compensation)

Claim Number: (NUMERO DE RECLAMACION)_____

Date of Accident: (FETCHA DE ACCIDENT)_____

Adjuster's Name: (NOMBRE DE LOS AJUSTADORES)_____

Adjuster Phone Number: (NUMERO DE TELEFONO DE LOS ADJUSTADORES)_____

Employer: (EMPLEADOR)_____

Company Number: (NUMERO DE TELEFONO) _____

Claims Address: (DIRECCION DE RECLAMACIONES)_____

Are you being represented by an attorney? Y / N

Tiene un abogado? Si o No

Name: (NOMBRE)_____

Phone: (NUMERO DE TELFONO)_____

Is Authorization required (for W/C)? Y / N From:_____ To:_____ Auth #:_____
Apprvd DX:_____

Is PIP and/or MedPay available (for Auto Accidents) Y / N Amount?_____

I understand the benefits as quoted by my insurance company. Benefits are not a guarantee of payment. All claims are subject to review and medical necessity.

_____

Patient's Signature (FIRMA) Date(FETCHA)

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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 SIDA/VIH			HEPATITIS HEPATITIS		
ALCOHOLISM ALCOHOLISMO			HERNIA HERNIA/QUEBRADURA		
ANEMIA LA ANEMIA			HERNIATED DISC HERNIA DE DISCO		
ARTHRITIS ARTRITIS			KIDNEY DISEASE ENFERMEDAD RENAL		
ASTHMA ASMA			LIVER DISEASE ENFERMEDAD HEPÁTICA		
BLEEDING DISORDER ENFERMEDAD HEMORRAGICA			MIGRAINES LAS MIGRAÑAS		
BRONCHITIS BRONQUITIS			MONONUCLEOSIS LA MONONUCLEOSIS		
CANCER EL CANCER			MULTIPLE SCLEROSIS ESCLEROSIS MÚLTIPLE		
CATARACTS CATARATAS			OSTEOPOROSIS OSTEOPOROSIS		
CHEMICAL DEPENDENCY DEPENDENCIA DE DROGAS			PARKINSON'S DISEASE LA ENFERMEDAD DE PARKINSON		
DIABETES			PINCHED NERVE NERVIO PELLIZCADO		
EMPHYSEMA ENFISEMA			PNEUMONIA NEUMONÍA		
EPILEPSY EPILEPSIA			PROSTHESIS PRÓTESIS		
FRACTURES FRACTURAS			RHEUMATOID ARTHRITIS LA ARTRITIS REUMATOIDE		
GLAUCOMA			STROKE DERRAME CERABRAL		
GOUT GOTA			THYROID PROBLEMS PROBLEMAS DE LA TIROIDES		
HEART DISEASE ENFERMEDAD CARDIACA			TUBERCULOSIS 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) YES / 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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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)

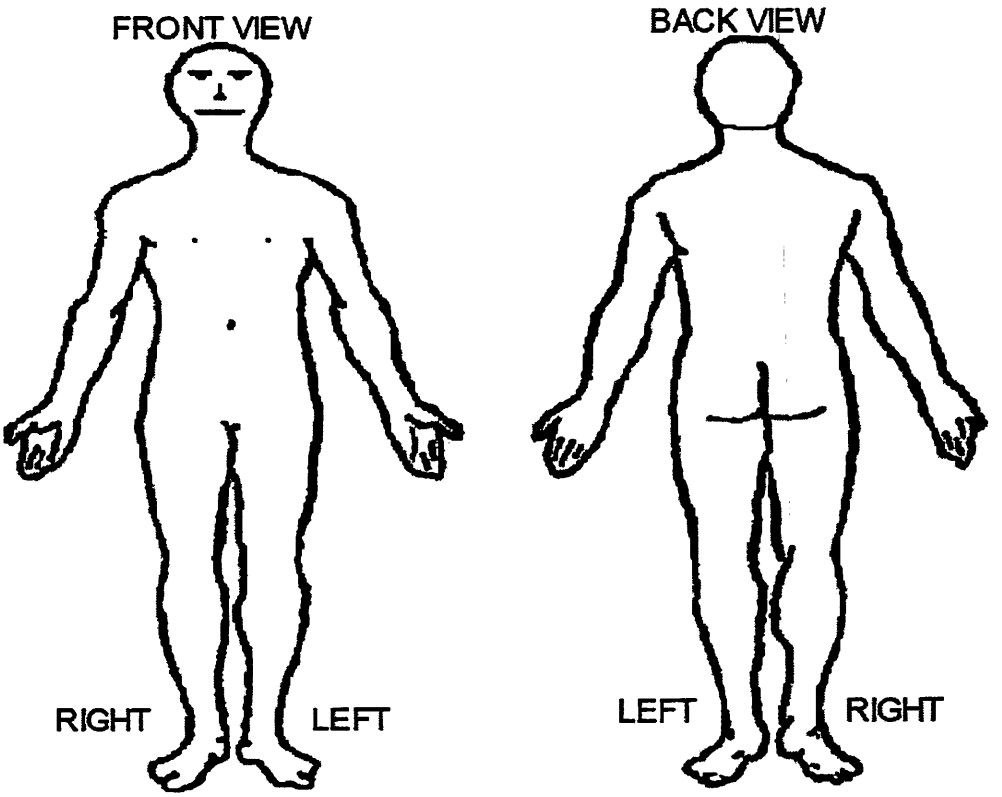
- ☐ Lifting 0 - 10 lbs
- ☐ Lifting 11 - 20 lbs
- ☐ Lifting 21 - 50lbs
- ☐ Lifting over 50 lbs
- ☐ Frequent Lifting
- ☐ Frequent Sitting
- ☐ Frequent Kneeling
- ☐ Frequent Bending
- ☐ Climbing
- ☐ Extended Walking
- ☐ Continuous Standing
- ☐ Sitting
- ☐ Repetitive hand motion
- ☐ Repetitive arm motions

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

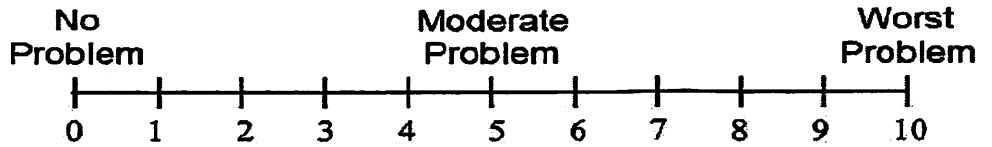
A. Disability ☐ yes ☐ no B. Worker's Compensation ☐ yes ☐ no

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

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: _____