LONG ISLAND
Orthopedic Solutions

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 the Provider and the providers representatives (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. My email address is _____@_____.

By signing this form, I also understand that if this provider does not have a contract with my insurance plan, the fees for services will be as they are listed on www.fairhealthconsumer.org.
A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____
Patient Date

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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** _____ **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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ACCIDENT / INJURY INFORMATION

WERE YOU IN A CAR ACCIDENT? YES / NO **WERE YOU?** DRIVER / PASSENGER
(ESTUVO EN UN ACCIDENTE) *(CONDUCTOR O PASAJERO?)*

DO YOU HAVE AN ATTORNEY REPRESENTING YOU REGARDING THIS ACCIDENT / INJURY? YES / NO
(TIENE UN ABOGADO POR ESTE ACCIDENTE)
ATTORNEY NAME _____ **PHONE NUMBER** _____
(ABOGADO) *(TELEFONO)*

DATE OF ACCIDENT/INJURY_____**IS THIS A WORKER'S COMPENSATION CLAIM?** YES / NO
(FECHA DEL ACCIDENTE) *(SEA UN ACCIDENTE DEL TRABAJO)*

WERE YOU TRANSPORTED FROM THE ACCIDENT / INJURY SCENE BY AMBULANCE? YES / NO
(HABIA TRANSPORTADO POR AMBULANCIA)

HOSPITAL WHERE YOU WERE TREATED _____
(NOMBRE DEL HOSPITAL DONDE OCCURE TRATAMIENTO)

OTHER DOCTORS THAT HAVE TREATED YOU FOR THIS INJURY _____
(PORFAVOR INDIQUE EL NOMBRE DEL DOCTOR QUE TRADADO DESDE QUE PASO EL ACCIDENTE)

AUTOMOBILE/WC INSURANCE INFORMATION

YOUR INSURANCE _____ **PHONE NUMBER** _____
(NOMBE DE SU SEGURO DEL AUTO) *(TELEFONO)*

POLICY NUMBER_____ **CLAIM NUMBER** _____
(NUMBERO DEL POLITICA) *(NUMERO DEL RECLAMO)*

DO YOU HAVE MEDICAL PAYMENT COVERAGE OR PIP ON YOUR POLICY? YES / NO AMOUNT $ _____
(CUBRE MEDICAL SU ASEGURANZO DE AUTOMOVIL?) *(CANTIDAD)*
OTHER DRIVER'S INSURANCE _____**PHONE NUMBER** _____
(POLITICA DEL AUTO QUE SE GOLPE) *(TELEFONO)*

POLICY NUMBER_____**CLAIM NUMBER** _____
(NUMBERO DEL POLITICA) *(NUMERO DEL RECLAMO)*

HEALTH INSURANCE INFORMATION

INSURANCE COMPANY _____ **PHONE NUMBER** _____
(ASEGURANZO) *(TELEFONO)*

ADDRESS _____
(DIRECCION) ***ADDRESS*** ***CITY*** ***STATE*** ***ZIP***

NAME OF INSURED _____**RELATIONSHIP** _____
(NOMBRE DE EL ASEGURANZO) *(RELACION)*

ID # _____ GROUP # _____ **EMPLOYER** _____
(NUMERO DEL IDENTIFICACION) **(NUMERO DEL GRUPO)** **(EMPLEO)**

SOCIAL SECURITY NUMBER _____-_____-_____ **DATE OF BIRTH** _____
(NOMBRE DEL SEGURO SOCIAL) *(FECHA DE NACIMIENTO)*

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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) 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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DAILY ACTIVITY CHECKLIST

This checklist is designed to help us understand how much discomfort, pain, and/or difficulty you experience while performing your daily activities. Please check (✓) only **ONE** column for each activity that most applies to your level of discomfort.
If you regularly perform an activity that is not listed, please write that activity in the blank boxes at the bottom and indicate your level of discomfort / difficulty. If you have any questions about how to complete this form, the staff will be more than happy to assist you.

Esta lista de verificación es diseñado para ayudar nos comprender cuanto molesta, dolor y/o dificultad experiencias cuando estás haciendo ciertas actividades. Por favor completa la lista de verificación por marcando solamente **una** columna para cada actividad que mas aplica a tu nivel de molesta, dolor, y/o dificultad para aquella actividad. No marque más que una columna para cualquier actividad. Si una actividad no se aplica porque no hace esa actividad (por ejemplo, si no está empleado, o no tiene niños que cuidar" marca "no aplicable" columna.

Activity *Actividad*	**Not Applicable** *No Aplicable*	**No Discomfort or Difficulty** *No molesta*	**Minimal Discomfort or Difficulty** *Me molesta*	**Moderate Discomfort or Difficulty** *Me molesta moderada*	**Major Discomfort or Difficulty** *Molesta Mayor*	**Can't do this because of Discomfort or Difficulty** *No puedo hacer*
Sitting *Sentado*						
Standing *De pie*						
Bending Agachando						
Lifting *Levantando*						
Walking Caminando						
Lying Down *Acostado*						
Sleeping Dormido						
Driving *Manejando*						
Working *Trabajando*						
Housework *Limpieza*						
Dressing *Vestir se*						
Personal Hygiene *Cuidado Personal*						
Caring for Children *Cuidado de los ninos*						
Using computer *Usando Computadora*						
Exercising *Ejercicios/Deportes*						
Watching TV *Mirando televisor*						

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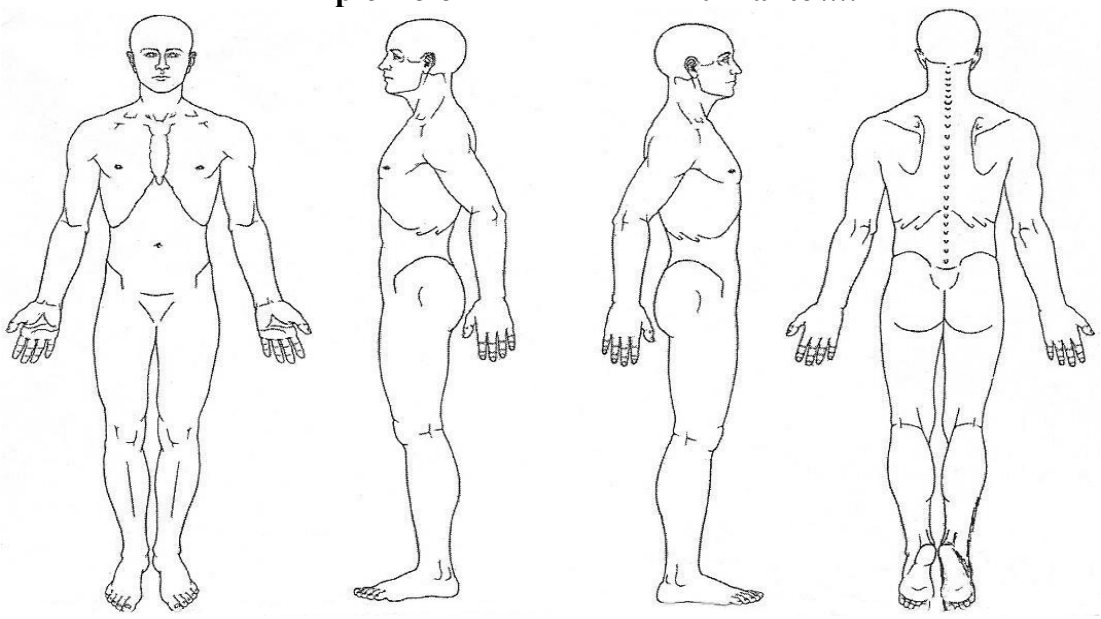
Name _____Date_____File _____

Please mark the areas on the picture below that correspond to the areas of your body where you feel the described sensations. Use appropriate symbols. Mark areas of radiation. Include all affected areas.
DO NOT SIMPLY CIRCLE THE AREA OF INVOLVEMENT PLEASE.
Numbness ---- Pins & Needles oooo Burning xxxx Aching ** Stabbing ////**

Usando los simbolos del abajo; indique las areas en su cuerpo donde se siente las sintomas. Incluye todos los partes que estan afectados.
Entumido ----- Hormigueo oooo Dolor que quema xxxx
Imple Dolor ** Punzante ////**



Please place a vertical mark on the line below to indicate the severity of your complaint.
Marque (/) en la linea del nivel de dolor que siente ahorita en la parte mas lastimada entre no dolor y insoportable dolor

Headache *Dolor de cabeza*	No Pain	_____	Worse Pain Experienced
Neck Pain *Dolor del cuello*	No Pain	_____	Worse Pain Experienced
Middle Back Pain *Dolor de espalda media*	No Pain	_____	Worse Pain Experienced
Low Back Pain *Dolor de espalda baja*	No Pain	_____	Worse Pain Experienced
Other _____ *Otro*	No Pain	_____	Worse Pain Experienced

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RESPONSIBILIDAD FINANCIERO

RENUNCIA DE LAS VENTAJAS DE SEGURO PARA CASOS DE LOS DAÑOS CORPORALES

_____ Si hay una póliza de seguro de automóvil que tiene cobertura del "pago médico" o PIP que se pueda utilizar para mi tratamiento, convengo que todos los dineros médicos del pago de la compañía de seguros dicha de automóvil deben ser utilizados satisfacer cualquier equilibrio excepcional con DAVID J WEISSBERG,MD,PC y el cheque debe ser escrita directamente a DAVID J WEISSBERG,MD,PC. Este acuerdo reemplazará el resto de los acuerdos, contractuales o de otra manera, incluyendo pero no limitado a los acuerdos con los abogados u otras agencias o agentes.

_____ Reconozco que estoy eligiendo no utilizar, o no tengo, seguro médico privado incluyendo Medicare y Medicaid. También entiendo que no habrá facturación retroactiva a mi seguro médico privado incluyendo Medicare y Medicaid.

_____ Entiendo que firmaré un embargo preventivo (gravamen de terceros) personal o del abogado, que es un aplazamiento del pago, no un perdón de pago.

_____ Reconozco, si mi cuenta no es pagada dentro de treinta (30) días de la fecha del establecimiento de la demanda de los daños corporales, mi cuenta se puede enviar a una agencia de colección. Seré responsable de todo el abogado honorarios y costes de la corte

BENEFICIOS DE SEGURO MEDICOS

Como cortesía a nuestros pacientes, tratamos a mandar la cuenta a su compañía del seguro médico para pagar los servicios de terapia. Entiende que su póliza de seguro es un contrato entre usted y su compañía de seguros. También, esté enterado que algunos, y quizás todos los, servicios médicos que proporcionamos no pueden ser cubiertos o consideraba inferior razonable y necesario su plan específico del seguro médico.

_____ Todos los co-pagos, deductibles, o porciones pacientes de la responsabilidad son debidos cuando se proporcionan los servicios. Cualquier cantidad no cubierta por su compañía de seguros es su responsabilidad. Esto incluye pero no es limitado a; cargas para las visitas de la oficina, los honorarios administrativos, las fuentes, y las radiografías.

_____ Autorizo todos los pagos del seguro para ser hecho directamente al DAVID J WEISSBERG,MD,PC por los servicios del terapia recibidos. Estoy enterado que en el acontecimiento que mi seguro médico no paga servicios rindió; puedo ser sostenido financieramente responsible.

DECLARACIÓN DEL UTILIZACION DEL SEGURO

_____ Reconozco que estoy eligiendo no utilizar, o no tengo, seguro médico privado incluyendo Medicare y Medicaid. También entiendo que no habrá facturación retroactiva a mi seguro médico privado incluyendo Medicare y Medicaid.

Reconozco que soy el paciente, padre o representante legal del paciente o del paciente. Entiendo el siguiente:

Las cuentas médicas incurridas en en esta oficina hay la responsabilidad única del paciente o los padres del paciente o del representante legal sin importar estado del seguro y/o resultado del pleito pendiente.

Nombre_____ Fecha_____

_____ _____

Firma del paciente/padre/representante legal Fecha

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Irrevocable Assignment, Lien and Authorization, and Financial Agreement

I authorize any insurance carrier to pay directly to my physicians such sums as may be due and owing to them. If I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any medical insurance, personal injury protection, and medical payment coverage, I agree to immediately make payment to you upon receipt of those monies. **If I have not reached my annual health insurance deductable on my private health insurance plan, I agree to pay the uncovered amount when invoiced.**

I do hereby authorize DAVID J WEISSBERG,MD,PC to furnish my attorney(s) and/or claims adjustors any and all medical information, bills, and records which they may request to all illnesses and injuries suffered by me, my wife, my husband, or children including, but not limited to, the injuries sustained on the date of accident identified below.

I further irrevocably assign to you, and authorize and direct my attorney(s), if applicable, to pay from the proceeds of any settlement, judgment or insurance policy, all reasonable fees for health care services, equipment, supplies, preparation of reports, and testimony provided by you as a result of the injury or condition sustained on the date of accident. I understand that this in no way relieves me of my personal primary responsibility to pay for such services, and that the signing of this form does not prohibit customary billing by you. I further understand that my responsibility to you for payment is not contingent on any settlement, judgment or verdict.

I further authorize my attorney(s) upon your request to notify you of any substantial change in the status of the cause of action related to the illness or injuries described above which would affect my ability to pay for the health care services rendered. I further authorize and direct my attorney(s) to notify you should their representation of my interests in connection with the illnesses and injuries by terminated for any reason.

I further understand that if, for any reason, my attorneys terminate their representation of me related to an accident for which I am receiving care at DAVID J WEISSBERG,MD,PC, that all invoices for services performed are due and payable immediately, and that I will be billed for any further treatment in normal course. DAVID J WEISSBERG,MD,PC retains the right to refuse to perform services due to unpaid invoices.

I further understand that because of long delays in trial dockets, many personal injury cases are not tried or settled until a date, which is beyond the three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

I further agree that should DAVID J WEISSBERG,MD,PC refer this matter to an attorney for collections that I shall pay a 40% administrative fee and be responsible for DAVID J WEISSBERG,MD,PC reasonable attorney's fees.
A photocopy of this Authorization shall be as binding as the original.

Date of Accident:_____ Patient Name

(Printed):_____

Guarantor's Name:_____ Relationship to Patient: _____

Patients Signature: _____Date Signed: _____

Patient Address: _____

Attorney Acknowledgement and Cooperation Agreement

The undersigned attorney for the patient referred to above agrees to comply fully with the foregoing "Irrevocable Assignment, Lien and Authorization, and Financial Agreement" and agrees to advise the named DAVID J WEISSBERG,MD,PC in writing the status of the claim of the patient within five (5) days of the request and agrees to notify the assignee within ten (10) days if the attorney ceases to represent this patient and/or if the claim is dropped or denied. If this case continues beyond fifteen (15) months from the initial date of service Mid-Atlantic Spinal Rehab & Chiropractic may release the bill for services directly to the patient/guarantor for payment within thirty (30) days.

Attorney Name: _____

Attorneys' Address: _____

Fax#: _____ Phone#: _____

Attorneys' Signature: _____ Date Signed: _____

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MEDICATION SHEET

Today's Date:

Pharmacy:

Drug Food Allergies/Reactions:

_____

_____

Please list your medications/herbs/vitamins below or indicate you have a list for the staff to photocopy, and give to the receptionist. ❑ Provided for the staff to photocopy.

Medication/Herbal/ Vitamin Name "Please Print"	***Dosage/ Strength***	***Route – How do you take?*** ***Example: By Mouth***	***Frequency – How often do you take?*** ***Example: Twice a day***	***Last time you took medication?***

Person completing the list: _____ **Date:** _____

MEDICATION SHEET

Patient Name:_____ **DOB:** _____

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize David J. Weissberg, MD, PC to release my records and any information requested to the following individuals.

1. **_____ Relation to Patient:_____**
2. **_____ Relation to Patient:_____**
3. **_____ Relation to Patient:_____**
4. **_____ Relation to Patient:_____**

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature