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_____

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

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)

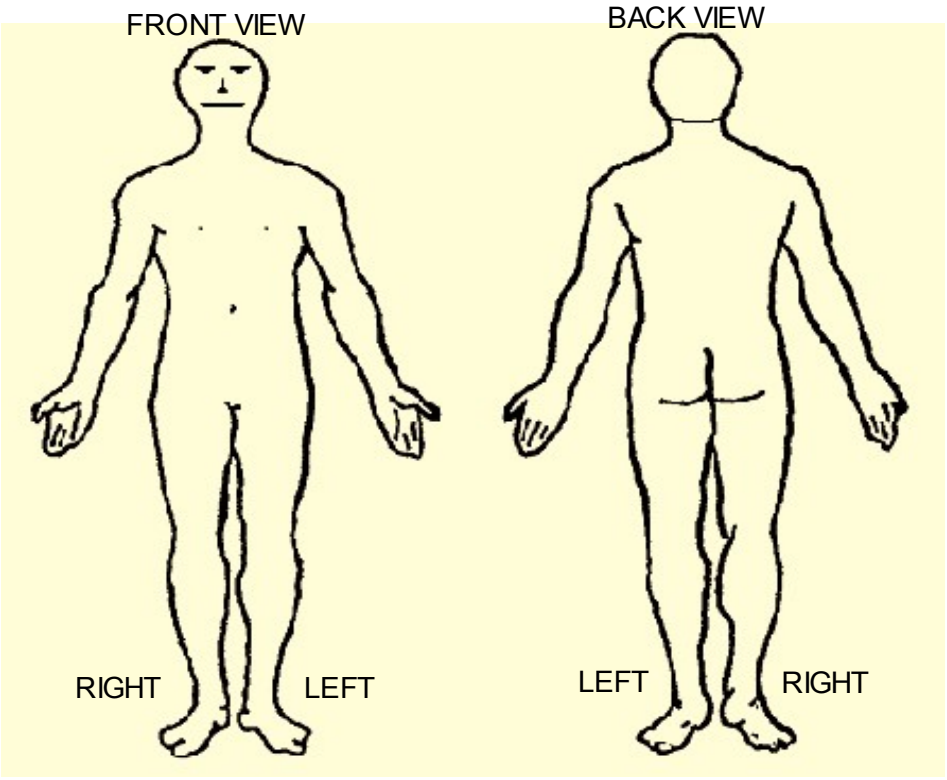
- □ Lifting 0 - 10 lbs
- □ Lifting 11 - 20 lbs
- □ Lifting 21 - 50lbs
- □ Lifting over 50 lbs
- □ Frequent Lifting
- □ Frequent Sitting
- □ Frequent Kneeling
- □ Frequent Bending
- □ Climbing
- □ Extended Walking
- □ Continuous Standing
- □ Sitting
- □ Repetitive hand motions
- □ Repetitive arm motions

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

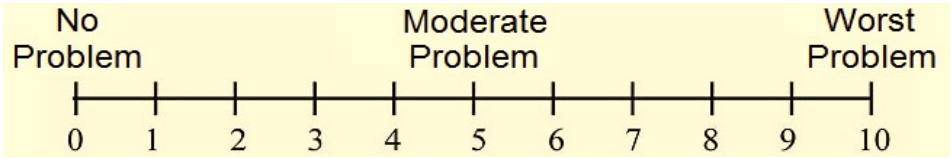
A. Disability □ yes □ no B. Worker's Compensation □ yes □ no

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:** _____

PHYSICIAN'S RELEASE TO RETURN TO WORK FORM

Employee's Name:	Date:
Physician's Name:	Telephone #:

To be completed by Physician

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

(A) The above named employee has been released by the above named physician to return to Full Duty as of _____(Date) with NO RESTRICTIONS.

(B) The above named employee has been released by the above named physician to Return to Work on _____(Date) WITH THE FOLLOWING RESTRICTIONS through _____(Date):

Check applicable boxes and provide limitations/restrictions.	
☐ Lifting (Max weight in lbs) _____lbs.	☐ Walking _____ hours per day
☐ Repetitive Lifting _____lbs.	☐ Standing _____ hours per day
☐ Carrying _____lbs.	☐ Sitting _____ hours per day
☐ Pushing/pulling _____lbs.	☐ Crawling _____ hours per day
☐ Pinching/Gripping _____lbs.	☐ Kneeling _____ hours per day
☐ Reaching over head	☐ Squatting _____ hours per day
☐ Reaching away from body	☐ Climbing _____ hours per day
☐ Repetitive Motion Restrictions:	
☐ Other Restrictions:	
These limitations/restrictions are:	☐ Temporary limitations/restrictions ☐ Permanent limitations/restrictions

IF THE ABOVE RESTRICTION CONSTITUTE MODIFIED DUTY AND SUCH DUTY IS NOT AVAILABLE, IT IS ASSUMED THAT THE EMPLOYEE WILL BE SENT HOME RATHER THAN RETURN TO WORK. My signature indicates that I have read and understand the employee's job description and the listed tasks within the job description and that my findings are based on my medical assessment of this employee's physical capabilities as compared to the essential functions of the job.

Physician's Name (Please Print):			
Physician's Signature:		Date:	

I AGREE THAT:
I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

Employee's Signature:		Date:	

New Workers' Compensation Intake Form ONLY

Is this a Work related Accident? [ ] No [ ] Yes

Demographics

Name:	E-mail:
Address:	
Date of Birth:	SSN:
Home Phone:	Cell Phone:
Marital Status [ ] Single [ ] Married [ ] Domestic Partner [ ] Divorced/Widowed	Spouse/Partner:
Emergency Contact:	Relationship: Phone:

Employment

Employer:
Employer's Address:
Employer's Phone:

WC Insurance

Name of Workers men Carrier:	
Claim Number:	Date of Injury:
Mailing Address for Carrier: , , ,	

Claim Examiner's Information

Adjustor's Name:	
Adjustor's Phone:	Adjustor's Fax:
Adjustor's Address:	

Nurse Case Manager

NCM Name:	
NCM Phone:	NCM Fax:
NCM Address:	

Attorney's Information

Attorney's Name:	
Attorney's Address: , , ,	
Attorney's Phone:	Attorney's Fax:

Referring M.D.	Primary Care M.D.
Name:	Name:
M.D. Phone:	M.D. Phone:

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			

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 _____

_____

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.