**South Island Orthopedics, P.C.**

657 Central Avenue
Cedarhurst, NY 11516
T: 516-295-0111
F: 516-295-9438

205 Froehlich Farm Blvd
Woodbury, NY 11797
T: 516-364-0070
F: 516-364-0242

## PATIENT REGISTRATION FORM (Please Print)

| Today's Date: | **Thank you for selecting South Island Orthopedics, P.C.** |
|---|---|

### PATIENT INFORMATION

| Patient's Last Name: | First: | Middle: | Gender: | Age: |
|---|---|---|---|---|
| | | | | |

| Patient's Birth Date: mm/dd/yyyy | Marital Status: ○ S ○ M ○ D ○ W ○ SEP | Social Security: | Preferred Language: |
|---|---|---|---|
| | | | |

| Street Address: | Apt # | City/Town: | State: | Zip Code: | Home Phone Number: |
|---|---|---|---|---|---|
| | | | | | |

| Mobile Phone Number: | Work Phone Number: | Email Address: | Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ Email |
|---|---|---|---|
| | | | |

| Name of Employer: | Address: | City/Town: | State: | Zip: |
|---|---|---|---|---|
| | | | | |

### SPOUSE INFORMATION

| Last Name: | First: | Contact Number: |
|---|---|---|
| | | |

### EMERGENCY CONTACT

| Name: | Relationship to Patient: |
|---|---|
| Primary Telephone Number: | Secondary Telephone Number: |

| **REFERRAL SOURCE** | **Primary Care Physician** |
|---|---|
| How did you learn about us? Internet ☐ Friend/Family ☐ Physician ☐ Attorney ☐ Other ☐ | Primary Care Physician Name: |
| Please list the name and number of the referral source: | Street Address: |
| | City, State, Zip: |
| | Telephone Number: |

### PHARMACY INFORMATION

| Name (Local): | Address: | Telephone #: | Fax#: |
|---|---|---|---|
| Name (Mail Away): | Address: | Telephone #: | Fax#: |

### HEALTH INSURANCE INFORMATION

**Primary Insurance:** Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

| Insurance Name: | Group Number: |
|---|---|
| | ID Number: |
| Insured's Name (if not self, spouse or parent listed above): | Birth Date: |

**Secondary Insurance:** Patient's Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other: ☐

| Secondary Insurance Name: | Group Number: |
|---|---|
| | ID Number: |

| Insured's Name (if not self, spouse or parent listed above): | Birth Date: |
|---|---|

**SYMPTOM SPECIFICATIONS (Give only a brief description in one to two sentences)**

Please list your symptoms and complaints relating to your visit today:

**PATIENT REGISTRATION FORM CONTINUED (Please Print)**

**MEDICAL TREATMENT HISTORY**

Are these symptoms related to an accident? ☐ YES ☐ NO

| | |
|---|---|
| Did you go to the hosptial? ☐ YES ☐ NO | If yes, list hopsital name: |
| Were you: ☐ Out-Patient ☐ In-Patient | Any X-Rays/MRI's or testing performed? |
| Have you seen any doctors for this inury and/or condition: ☐ YES ☐ NO | If yes, what type? |

Medication(s) Prescribed:

**NO FAULT MOTOR VEHICLE ACCIDENT**

| | |
|---|---|
| Insurance Company Name: | Insurance Phone Number: |
| Policy Holder Name: | Claim Representative: |
| Claim #: | Policy# |

Was the accident reported to the insurance company? ☐ YES ☐ NO

Was the accident reported to the police? ☐ YES ☐ NO **( If yes, provider the front desk with a copy of the police report. )**

Where you the: ☐ Driver ☐ Passenger ☐ Pedestrian

| | |
|---|---|
| # of people in the Vehicle: | Where was the vehicle hit? ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side |

Were you working at the time of accident? ☐ YES ☐ NO

**WORKERS COMPENSATION-WORK ACCIDENT**

| | |
|---|---|
| Insurance Carrier: | Employer Name & Address (at the time of accident) |
| Claim/Carrier Case #: | |
| WCB #: | |
| Claim/Case Manager: | Telephone Number: |

Was injury reported to your employer? ☐ YES ☐ NO

Name & Phone number of Supervisor Reported to:

**Injury Specifications**

| | | |
|---|---|---|
| Date of Injury: | Accident occurred in: City: | State: |

Injury resulted from: ☐ Motor Vehicle Accident ☐ Work Accident ☐ Other

- If other please specify:

Do you have an attorney representing you for this injury? ☐ YES ☐ NO

| | | |
|---|---|---|
| Attorney Firm Name: | | Telephone Number: |
| Did you miss any time at work as a result of the injury? ☐ YES ☐ NO | 1st Date Missed: | Date of Return: |

**PATIENT/GUARDIAN SIGNATURE: _____DATE: _____/_____/_____**

**IF GUARDIAN, PRINT RELATIONISHIP TO PATIENT: _____**

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## Patient Permissions and Preferences Form

**Patient Name:**_____ **Date of Birth:** _____
**Last** **First** **MI**

I authorize **South Island Orthopedics, P.C.,** to discuss my health information with the following personal representative(s).

| Name: | Relationship: | Telephone: |
|---|---|---|
| Name: | Relationship: | Telephone: |

☐ I decline at this time to list a personal representative to discuss my health information.

**PATIENT AUTHORIZATION -AUTHORIZATION TO CALL**

It is the policy of **South Island Orthopedics, P.C.,** to confirm appointments via telephone or in some cases with an automated appointment confirmation service.

**I wish to be contacted in the following manner ( Check all that apply):**

**Home Telephone:**_____

☐ OK to leave message with detailed information*
☐ OK Leave message with call back number only

**Cell Phone:** _____

☐ OK to leave message with detailed information*
☐ Leave message with call back number only

**Written Communication**

☐ OK to mail home address
☐ OK to mail to my work/office address ( provide address)
☐ OK to fax to this number _____

**Work Telephone:** _____

☐ OK to leave message with detailed information *
☐ Leave message with call back number only

Other:
☐ OK to text ( text messaging fees may apply)

**Patient/Patient Representative signature:** _____ Date: _____
**Print Name (if other than patient):** _____
**Relationship to Patient:** _____

*detailed information may include but is not limited to: lab results, diagnosis, treatment instructions

PLEASE NOTE, THE ABOVE INFORMATION WILL BE IN EFFECT UNTIL YOU REVOKE IT IN WRITING TO THE PRACTICE

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## Medical History Questionnaire

**Name:** **Age:** **Date of Birth:**

**Hand Dominant** ☐ **Right** ☐ **Left** **Date of Injury:** _____ **Height:** _____ **Weight:** _____

**Chief Complaint:** please describe, in detail, your current injury or complaint (which limb, initial symptoms, aggravating activities)

**Past Medical History:** (i.e., diabetes, high blood pressure, kidney, liver, heart problems)

**Present Medication:** please list all the medications and supplements you are taking or have taken in the last month

**Allergies:** please list allergies to food or medication

**Past Surgeries/Illness/Accidents and Hospitalizations:**

**Family History:**

Father: AGE _____ ☐ Living ☐ Deceased ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke
Other:

Mother: AGE ____ ☐ Living ☐ Deceased ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke
Other:

**Review of Systems:** Have you ever been diagnosed by a physician with any of the following?

**Head and Neck**
☐ Severe Headaches ☐ Double Vision ☐ Swelling in Neck ☐ Dizzy Spells ☐ Difficulty Hearing
☐ Fainting ☐ Failing Vision ☐ Prolonged Hoarseness ☐ Stroke

**Heart and Lungs**
☐ Chest Pain ☐ High Blood Pressure ☐ Pneumonia ☐ Heart Attack ☐ Difficulty Breathing
☐ Skipping Heart Beats ☐ Chronic Cough/TB ☐ Ankles Swell ☐ Heart Defects/Murmurs

**Stomach and Intestines**
☐ Persistent Nausea ☐ Diabetes ☐ Stomach Ulcers ☐ Heartburn Regularly ☐ Hepatitis/Jaundice
☐ Black or Blood in stool ☐ Appetite Loss ☐ Hemorrhoids ☐ Chronic Diarrhea/Constipation

**Urinary Tract-etc.**
☐ Excess Urination ☐ Urinary Problems ☐ Painful/Excess Menstruation ☐ Difficulty Urination
☐ Passes any Stone ☐ Bleed Between Periods ☐ Blood in Urine ☐ Retention of Urine ☐ Pregnancies # _____

**Muscle Joints Nerves**
☐ Tingling Sensations ☐ Memory Loss ☐ Seizures ☐ Numbness ☐ Personality Changes
☐ Depression ☐ Disturbance in Walking ☐ Paralysis ☐ Varicose Veins ☐ Muscle Jerking
☐ Speech Disturbance

**Other:**
☐ Skin Disorders ☐ Bleeding Disorders ☐ EBV ☐ CMV ☐ HIV
☐ Thyroid Disorder ☐ ALL OTHER NEGATIVE

**Occupation/Position:**

Do you smoke or have you been a smoker? _____ _____ packs per day x _____ years
Do you drink alcohol? _____ How Much? _____ Non-Prescribing drug use _____

Date Reviewed _____ Physician's Signature _____

OCA Official Form No.: 960

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**[This form has been approved by the New York State Department of Health]**

| Patient Name | Date of Birth | Social Security Number |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
South island Orthopedics, P.C. 205 Froehlich Farm Blvd, Woodbury, NY 11797

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

| 10. Reason for release of information:<br>☐ At request of individual<br>☐ Other: | 11. Date or event on which this authorization will expire: |
|---|---|
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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# AUTHORIZATION TO RELEASE INFORMATION

I authorize and instruct my insurance carrier, _____,to provide all information requested by **South Island Orthopedics, P.C.** including but not limited to state of origin of policy, deductible/co payment information and/or policy maximum information and to verify benefit eligibility, pre-certify procedures, and predetermine benefits as necessary under this policy.

**Patient Name (printed):**_____

**Patient Signature:** _____

**Date:** _____

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

| NAME AND ADDRESS OF INSURER * | NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE* |
|---|---|
| | |

| DATE | POLICYHOLDER | POLICY NUMBER | DATE OF ACCIDENT | CLAIM NUMBER |
|---|---|---|---|---|
| | | | | |

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

| 1. YOUR NAME | 2. PHONE NOS. HOME | BUSINESS |
|---|---|---|
| | | |

| 3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE) | 4. DATE OF BIRTH | 5. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

| 6. DATE AND TIME OF ACCIDENT A.M. ○ P.M. ○ | 7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE |
|---|---|
| | |

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ A TRUCK, ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

| | YES | NO |
|---|---|---|
| 11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE? | ☐ | ☐ |
| WERE YOU A PASSENGER IN THE MOTOR VEHICLE? | ☐ | ☐ |
| WERE YOU A PEDESTRIAN? | ☐ | ☐ |
| WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD? | ☐ | ☐ |
| DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE? | ☐ | ☐ |

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO**

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

| 14. AMOUNT OF HEALTH BILLS TO DATE: | 15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? | 16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? |
|---|---|---|
| $ _____ | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 17. DID YOU LOSE TIME FROM WORK? | DATE ABSENCE FROM WORK BEGAN: | HAVE YOU RETURNED TO WORK? |
|---|---|---|
| YES ☐ NO ☐ | | YES ☐ NO ☐ |

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

| 18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS? | NUMBER OF DAYS YOU WORK PER WEEK: | NUMBER OF HOURS YOU WORK PER DAY: |
|---|---|---|
| | | |

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
|---|---|---|---|
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |
| EMPLOYER AND ADDRESS | OCCUPATION | FROM | TO |

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

| | YES | NO |
|---|---|---|
| NEW YORK STATE DISABILITY? | ☐ | ☐ |
| WORKERS' COMPENSATION? | ☐ | ☐ |

CONTINUATION ON NEXT PAGE

**APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE**

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

**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.**

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

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

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW**
**VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE**
**(This form is <u>not</u> 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* |
|---|
| South Island Orthopedics, P.C.<br>205 Froehlich Farm Blvd<br>Woodbury, NY 11797 |

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 <u>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</u>. 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

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

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 [x] NO [ ] IF "NO", explain:

10. IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?

YES [ ] NO [x]

11. WILL INJURY RESULT IN SIGNIFICANT DISFIGUREMENT OR PERMANENT DISABILITY?

YES [ ] NO [ ] NOT DETERMINABLE AT THIS TIME [x]
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK)

FROM: _____ THROUGH: _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON:

_____
(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 [x] 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).

Dr. Eric Freeman License# 299298

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES [x] 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 _____ SIGNED _____
PROVIDER OF HEALTH CARE SERVICE (Assignee) PROVIDER OF HEALTH CARE SERVICE DATE

HAS AN ORIGINAL AUTHORIZATION OR ASSIGNMENT PREVIOUSLY BEEN EXECUTED? [X] YES [ ] NO

IS THE ORIGINAL SIGNATURE OF THE PARTIES ON FILE? [X] 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 |
|---|---|---|---|
| | | 83-4136040 | |

*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** South Island Orthopedics, PC **, ("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) | |
| **(Print name of Provider)** | **(Signature of Provider)** |
| 205 Froehlich Farm | (Date of signature) |
| Woodbury, NY 11797 | |
| (Address of Provider) | |

TID: #83-4136040

NYS FORM NF-AOB (Rev 1/2004)

Patient Name: _____

NG MR #:_____Date of loss: _____

# South Island Orthopedics, P.C.

Cedarhurst/Woodbury
P.O Box 9317
Garden City, New York 11530
Office: (516) 294-4590 (Option 2)
Facsimile: (978) 313-8477
EMAIL: LiensFax@HealthPlusMgmt.com

## MEDICAL LIEN

Attorney Name:

_____

_____

_____

I hereby authorize and direct my attorney, to pay directly to **South Island Orthopedics, P.C.** 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, **South Island Orthopedics, P.C.**

_____ _____

ATTORNEY'S SIGNATURE DATE

***NOTE TO ATTORNEY***

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

*South Island Orthopedics, P.C.*
*657 Central Avenue Cedarhurst NY 11516*

# ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the HIPAA Notice of Privacy Practices.

_____

Signature

_____

Printed Name

_____

Date

If representative's signature appears above please list patient name and relationship to patient:

_____

Patient Name

_____

Relationship to Patient