How did you first hear about New York Bone & Joint Specialists? (Please check one selection below)

☐I'm a past patient
☐Business card at my doctor's office
☐My doctor personally told me
☐List from my doctor's office
☐My doctor's receptionist
☐My doctor's nurse, PA, or medical assistant
☐Yellow pages or white pages
☐Friend (Who?)_____

☐ My insurance company
☐NY Bone & Joint website
☐All Sports Physical Therapy website
☐Internet (Which site?):_____
☐Received a mailing or postcard
☐NY Bone & Joint Employee (Who?): _____
☐Received an email from: _____

☐ Other:_____

Patient Information Form

First Name:	**Last Name:**	**Middle Initial:**	**Suffix (Jr., Sr., Etc.):**	**Date:**
Address:				
City:	**State:**	**Zip Code:**	**Social Security #:**	**Date of Birth:**
E-mail Address:	**Cell Phone:**		**Home Phone:**	**Work Phone:**
Occupation:	**Employer:**		**Company Address:**	
Emergency Contact (First & Last Name):			**Emergency Contact Phone:**	**Emergency Contact Relationship:**
Referring Physician:	**Referring Physician Phone:**		**Referring Physician Address:**	

INSURANCE INFORMATION

Guarantor Name:	**Date of Birth:**	**Social Security #:**	**Self_____Other (Relation:_____)**
Insurance Name:		**Insurance Phone:**	
Insurance Address:			
Insurance Policy #:		**Insurance Group #:**	
Signature of Insured:			**Date:**

Patient Medical History

Name:_____ Date:_____

Referred to New York Bone & Joint Specialists by:_____

HISTORY:

Age:_____ Height:_____ Weight:_____ Dominant Hand: ☐Right ☐Left

Chief Complaint (Please check off one of the boxes and circle which side of the body, left or right):

☐ **Neck Pain (L/R)** ☐ **Shoulder Pain (L/R)** ☐ **Hand/Wrist Pain (L/R)** ☐ **Lower Back Pain (L/R)**

☐ **Knee Pain (L/R)** ☐ **Hip Pain (L/R)** ☐ **Elbow Pain (L/R)** ☐ **Other** _____

Injury Date: _____ Duration of pain:_____ How did injury occur?:_____

Where is your pain located? _____

When during the day do you have pain? _____

What makes your pain worse? _____

What makes your pain better? _____

Any numbness and tingling? _____

Describe your pain (check any that apply):

☐ Sharp ☐ Burning ☐ Shooting ☐ Achy ☐ Knife-like ☐ Twisting ☐ Deep ☐ Heavy ☐ Gnawing
☐ Throbbing ☐ Dull ☐ Pulsating ☐ Numbness ☐ Tingling ☐ Pressure

Using the numbers below, how severe is your pain? _____

0 (No pain)
1-2 (Tolerable without medication)
3-4 (Tell someone about my pain, take aspirin or Motrin)
5-6 (Mild narcotic, ex. Tylenol #3)
7-8 (Go to the emergency room, take strong narcotic)
9-10 (Admission to the hospital for pain control)

PAST MEDICAL HISTORY:

Please check any that apply: ☐ Hypertension ☐ Diabetes Mellitus ☐ Cancer ☐ Peptic Ulcer ☐ Gastritis

☐Reflux ☐ Angina ☐ Arrhythmia ☐ Seizures ☐ HIV ☐ Hepatitis

☐ Other: _____

Past Surgeries: _____

_____

Please list any medications you are taking: _____

_____

Do you have any allergies?: _____

NEW YORK BONE & JOINT SPECIALISTS

Name: _____ Date:_____

Family Medical History (parents, siblings, children or grandparents): _____

_____

SOCIAL HISTORY:

Type of job: _____

Drug: Yes/No How often: _____

Alcohol Yes/No How often: _____

Tobacco: Yes/No How often: _____

Who do you live with? _____

Hobbies: _____

REVIEW OF SYSTEMS (Please check any that apply): ☐ **All Negative**

Constitutional: ☐ Weight change, ☐ Weakness, ☐ Fatigue ☐ Fever
Eyes: ☐ Glasses ☐ Pain ☐ Tearing ☐ Double vision
Ears, nose, mouth and throat: ☐ Tinnitus ☐ Dizziness ☐ Pain ☐ Sinus ☐ Colds ☐ Sore throat
Cardiovascular: ☐ High blood pressure ☐ Rheumatic fever ☐ Murmurs ☐ Shortness of breath ☐ Chest pain ☐ Palpitations
Respiratory: ☐ Cough ☐ Sputum ☐ Coughing up blood ☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Chest pain **Gastrointestinal:** ☐ Difficulty swallowing ☐ Heartburn ☐ Vomiting ☐ Diarrhea ☐ Indigestion ☐ Pain ☐ Blood ☐ Stool changes
Genitourinary: ☐ Pain with urination ☐ Urinating at night ☐ Blood in urine ☐ Urgency ☐ Hesitancy ☐ Incontinence
Skin: ☐ Rash ☐ Lumps ☐ Itching ☐ Dryness ☐ Color change ☐ Hair changes ☐ Nail changes
Neurological: ☐ Fainting ☐ Blackouts ☐ Seizures ☐ Paralysis ☐ Memory loss
Psychological: ☐ Nervousness ☐ Tension ☐ Mood changes ☐ Depression ☐ Anxiety
Endocrine: ☐ Heat or cold intolerance ☐ Sweating ☐ Thirst ☐ Hunger ☐ Change in urination
Hematology/Lymphatic: ☐ Bruising ☐ Bleeding ☐ Transfusion reactions
Allergies/Immunological: ☐ Drug product or other allergies
Reproductive: ☐ Sexual dysfunction ☐ Pregnancy

Name of Primary Care Physician: _____

Phone:_____Fax: _____

Comments: _____

Patient's Signature:_____**Date:** _____

ASSIGNMENT OF BENEFITS & ADVANCE PATIENT NOTIFICATION FORM FOR ALL SERVICES

Signing this form helps ensure payment and acknowledges notification of your rights and coverage.

Your healthcare services are provided by Doctors, Physician Assistants, Acupuncturists and Physical Therapists of New York Bone & Joint Specialists. The healthcare providers are licensed in the State of New York and/or New Jersey.

I hereby assign to New York Bone and Joint Specialists, PLLC my right to receive reimbursement for medically necessary health care services, including surgical services, provided to me and/or to any beneficiary under my health benefits policy. I hereby authorize and direct my insurance carrier to make all such payments directly to New York Bone and Joint Specialists, PLLC for all claims. Such payments should be forwarded by my insurance carrier directly to New York Bone and Joint Specialists, PLLC, at the address below, in the form of a check payable to New York Bone and Joint Specialists, PLLC or, in alternative, a check payable to New York Bone And Joint Specialists, PLLC and me, as joint payee. I understand that I have the right, upon request, to be provided the amount, or estimated amount, I will be billed. Please note that such estimates cannot account for unforeseen medical circumstances that may arise while the services are performed. Please further note that such estimates are as of the date of provision of the information to you, and may be subject to change. I understand and agree that, if the check from the insurance company is made payable to New York Bone and JointSpecialists, PLLC and me as joint payees, that I promptly will endorse and deliver the check to New York Bone and Joint Specialists, PLLC or will write a personal check for the full payment that is due within (1) one week of receiving payment. I am aware that my health care provider will accept my insurance plan's out of network benefits as assigned since the provider does not participate in the plan. I will provide the entire Explanation of Benefits from my insurance carrier relating to the services provided.

New York Bone and Joint Specialists, PLLC
Administrative office address:
130 East 67th Street, Ground Floor
New York NY 10065

My signature, below, acknowledges my accepted information above and confirms my voluntary choice to obtain services from this provider at New York Bone and Joint Specialists, PLLC. I understand that I am responsible for payment for all services rendered and I agree to pay all charges denied or not covered by my insurance carrier. This assignment and authorization in no way releases me from this responsibility and imposes no obligation on New York Bone and Joint Specialists, PLLC to collect money on my behalf.

I have read and understand and agree with the above. A photocopy of this agreement shall be considered as effective and valid as the original.

Sign Name Here	Print Name Here	Date

Patient Name if Signing as Legal Representative	**Type of Representative Authority**

SELF-PAY AGREEMENT

The Self-Pay Agreement is intended to provide Self-Pay patients/legal guardians with an understanding of the financial aspect of healthcare services provided at New York Bone and Joint Specialist, PLLC. Self- Pay patients/legal guardians should read this agreement carefully before making a decision and proceeding with care.

- Self-Pay patients/legal guardians will receive a bill New York Bone and Joint Specialist, PLLC for healthcare services provided by New York Bone and Joint Specialist PLLC for non-covered services.
- A Self-Pay Agreement must be signed for each New York Bone and Joint Specialist PLLC account for which it applies
- Self-Pay patients/legal guardians will be required to make a minimum deposit at the time of service
- The patient/legal guardian will be responsible for full payment of charges, less the No Insurance Discount (NID) and less the deposit made at the time of service

The No Insurance Discount (NID) does not apply to:

- Patients that have insurance and select not to utilize their insurance
- Balances after all covered expenses or eligible services to be paid by a health benefits plan
- Amounts due according to the insurance plan Explanation of Benefits (i.e. deductible, co-insurance, and/or co- payment)
- Patients involved in grants or special programs, as these cases fall into a different set of circumstances

The patient has been registered as Self-Pay due to the following reason marked below:

❑ The patient/legal guardian does not have insurance coverage

OR

❑ The provider performing the above services or therapies is not a participating provider with my health insurance. Therefore, these services/therapies are not covered by my policy
___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)

❑ The scope of services rendered by this provider may not be covered by my health insurance policy
___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)

❑ The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician
___Bill Insurance ___Do Not Bill Insurance (Elective Self Pay)

❑ No claim will be sent to my insurance since it's my person decision not to use my health insurance benefits for the above service/therapy even though I understand that these services/ therapies are considered covered by my policy (elected – self pay)

The patient/legal guardian elects to have their insurance billed first; the patient/legal guardian will be liable for all balances incurred after all eligible services and covered expenses to be paid by a health benefits plan. The No Insurance Discount (NID) will only apply if the patient's insurance plan does not cover any services.

My signature below acknowledges receipt of the Self Pay Agreement

Patient/Legal Guardian Signature Date

Self-Pay Agreement Explained by:

Staff Name (Print) Date

HIPAA Omnibus Notice of Privacy Practices

Revised 2024 *Effective as of September 24, 2013*

New York Bone and Joint Specialists/ All Sports Physical Therapy
Phone: (212) 759-4553
E-Mail:
info@nyboneandjoint.com
www.nyboneandjoint.com

Upper East Side Office:
130 East 67th St., GF
New York, NY 10065

Midtown West Office:
67 W. 55th St., Ste. 205
New York, NY 10019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors,may use and disclose your "Protected Health Information" (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

This Notice is provided to you as a requirement of HIPAA. There are several other privacy laws that also apply to HIV-related information, family planning information, mental health information, psychotherapy notes, and substance abuse information. These laws have not been superseded, and the disclosure of such information is specifically subject to more strict privacy standards and most uses and disclosures require express authorization from you.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose your PHI. Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment - We may use and disclose PHI for your treatment and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations - We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the orthopedic or physical therapy care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services - We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

WE MAY ALSO USE AND DISCLOSE PHI IN THE FOLLOWING CIRCUMSTANCES:

Required by Law - We may use or disclose your PHI if law or regulations require the use or disclosure.

Public Health - We may disclose your PHI to a public health authority who is permitted by law to collect or receive the information. For example, the disclosure may be necessary to prevent or control disease, injury or disability; report births and deaths; or report reactions to medications or problems with medical products.

Communicable Diseases - We may disclose your PHI, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight - We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, or other regulatory programs.

Food and Drug Administration - We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events; track products, enable product recalls; make repairs or replacements; or conduct post-marketing reviews.

Legal Proceedings - We may disclose PHI during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Law Enforcement - We may disclose PHI for law enforcement purposes, including information requests for identification and location; and circumstances pertaining to victims of a crime.

Coroners, Funeral Directors, and Organ Donations - We may disclose PHI to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose PHI to funeral directors as authorized by law. PHI may be used and disclosed for cadaver organ, eye or tissue donations.

Research - We may disclose PHI to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Threat to Health or Safety - Under applicable Federal and State laws, we may disclose your PHI to law enforcement or another health care professional if we believe in good faith that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security - When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission, including determination of fitness for duty; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your PHI, under specified conditions, to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

Workers' Compensation - We may disclose your PHI to comply with workers' compensation laws and similar government programs.

Inmates - We may use or disclose your PHI, under certain circumstances, if you are an inmate of a correctional facility.

Parental Access - State laws concerning minors permit or require certain disclosure of PHI to parents, guardians, and persons acting in a similar legal status. We will act consistently with the laws of this State (or, if you are treated by us in another state, the laws of that state) and will make disclosures following such laws.

Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes - We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

USES & DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

Individuals Involved in Your Care or Payment for Your Care - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief - We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Fundraising - In the event you are contacted for fundraising purposes, you have the right to opt out of such fundraising communications with each solicitation.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes; and
2. Disclosures that constitute a sale of your PHI

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But any disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding PHI we have about you:

Right to Inspect and Copy - You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this PHI, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 130 E 67th Street; New York, NY 10065***. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.
Wemay not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records - If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach - You have the right to be notified upon a breach of any of your unsecured PHI.

Right to Amend - If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 130 E 67th Street; New York, NY 10065***.

Right to an Accounting of Disclosures - You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 130 E 67th Street; New York, NY 10065***.

Right to Request Restrictions - You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 130 E 67th St; New York, NY 10065***. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments - If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications - You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to: ***NY Bone & Joint Specialists/ All Sports Physical Therapy HIPAA Privacy Officer; 130 E 67th St; New York, NY 10065***. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice - You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.nyboneandjoint.com. To obtain a paper copy of this notice, please ask the front desk at any of our locations.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, or for more information about the complaint process, contact: ***NY Bone & Joint Specialists/ All Sports Physical Therapy; Attn: HIPAA Privacy Officer; 130 E 67th Street; New York, NY 10065***. All complaints must be made in writing. You will not be penalized for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number (212) 759-4553

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE
(This form is not for verification of hospital treatment)

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

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

PROVIDER'S NAME AND ADDRESS*

New York Bone and Joint Specialists
130 East 67th Street
New York, NY 10065

KINDLY COMPLETE AND SUBMIT THIS FORM AS SOON AS POSSIBLE. **PLEASE NOTE, THIS COMPLETED FORM MUST BE SUBMITTED TO THE INSURER AS SOON AS REASONABLY POSSIBLE BUT NO LATER THAN 45 DAYS OR 180 DAYS AFTER THE TREATMENT DATE, DEPENDING UPON THE POLICY ENDORSEMENT IN EFFECT AT THE TIME OF THE ACCIDENT. IF YOU ARE UNSURE OF THE APPLICABLE TIME REQUIREMENT, KINDLY CONTACT THE CLAIMS REPRESENTATIVE TO DETERMINE WHICH DEADLINE IS APPLICABLE TO THIS CLAIM**

IF YOU HAVE PREVIOUSLY SUBMITTED AN EARLIER REPORT ON THIS ACCIDENT, YOU NEED ONLY NOTE ANY CHANGES FROM THE INFORMATION PREVIOUSLY FURNISHED AND ADDITIONAL CHARGES.

1. PATIENT'S NAME AND ADDRESS

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

5. DIAGNOSIS AND CONCURRENT CONDITIONS

6. WHEN DID SYMPTOMS FIRST APPEAR? DATE: CONDITION?	7. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS DATE:

8. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES ☐ NO ☐ IF YES, state when and describe:

9. IS CONDITION SOLELY A RESULT OF THIS AUTOMOBILE ACCIDENT?

YES ☐ NO ☐ IF "NO", explain:

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

YES ☐ NO ☐

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

YES ☐ NO ☐ NOT DETERMINABLE AT THIS TIME ☐
IF "YES", describe:

12. PATIENT WAS DISABLED (UNABLE TO WORK) FROM:

_____ THROUGH _____

13. IF STILL DISABLED THE PATIENT SHOULD BE ABLE TO RETURN TO WORK ON (Date):_____

VERIFICATION OF TREATMENT BY ATTENDING PHYSICIAN OR OTHER PROVIDER OF HEALTH SERVICE

14. WILL THE PATIENT REQUIRE REHABILITATION AND/OR OCCUPATIONAL THERAPY AS A RESULT OF THE INJURIES SUSTAINED IN THIS ACCIDENT?

YES ☐ NO ☐ IF YES, describe your recommendation below:

15. REPORT OF SERVICES RENDERED -- ATTACH ADDITIONAL SHEETS IF NECESSARY

DATE OF SERVICE	PLACE OF SERVICE INCLUDING ZIP CODE	DESCRIPTION OF TREATMENT OR HEALTH SERVICE RENDERED	FEE SCHEDULE TREATMENT CODE	CHARGES

TOTAL CHARGES TO DATE $ _____

16. IF TREATING PROVIDER IS DIFFERENT THAN BILLING PROVIDER COMPLETE THE FOLLOWING:

TREATING PROVIDER'S NAME	TITLE	LICENSE OR CERTIFICATION NO.	BUSINESS RELATIONSHIP CHECK APPLICABLE BOX		
			EMPLOYEE	INDEPENDENT CONTRACTOR	OTHER (SPECIFY)

17. IF THE PROVIDER OF SERVICE IS A PROFESSIONAL SERVICE CORPORATION OR DOING BUSINESS UNDER AN ASSUMED NAME (DBA), LIST THE OWNER AND PROFESSIONAL LICENSING CREDENTIALS OF ALL OWNERS (Provide an additional attachment if necessary).

18. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES ☐ NO ☐

19. ESTIMATED DURATION OF FUTURE TREATMENT

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of the health provider and must be signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20 of this form.

20. _____(IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, YOU MAY NOT <u>ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21)</u>

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: _____ _____

PATIENT DATE

SIGNED NAME: _____ _____

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.

22. _____ (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? ☐ YES ☐ NO

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

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

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

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

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

ASSIGNMENT OF BENEFITS FORM

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

I, _____ ("Assignor") hereby assign to

(Print Patient's Name)

New York Bone and Joint Specialists, ("Assignee) 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 _____ , notwithstanding 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)**
	(Date of signature)
(Address of Provider)	