PATIENT REGISTRATION INFORMATION

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PLEASE COMPLETE ALL SECTIONS BELOW IN PRINT

PATIENT INFORMATION

Name:_____Date of Birth_____Age_____

Address:_____

City_____State_____Zip_____

Social Security:_____ Marital Status: Single Married Divorced Widowed

Optional: Ethnicity_____Language:_____Race:_____

Home #_____Cell # _____Work#_____

Emergency Contact / Relationship_____Phone # _____

Are you currently working? YES NO Employer/Name of School _____

Occupation:_____ Job Duties: _____

PRIVATE INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Member ID# _____ Member ID#_____

Group # _____ Group # _____

Relationship to Insured: _____ Relationship to Insured: _____

Employers Name _____ Employers Name _____

Phone # _____ Phone # _____

PATIENT REFERRAL INFORMATION

Who referred you to our office? _____Phone # _____

WORKERS COMPENSATION

Is this a work related injury? YES NO

Insurance Carrier:_____Date of accident_____

Insurance Address:_____

_____

Carrier Case# _____WCB# _____

Employer at the time of the accident: _____

Employers address & Phone# _____

Job title (when injured) _____ Did you report the injury YES NO

Briefly describe how the injury occurred: _____

_____

Have you had prior treatment for this injury? YES NO

If yes please explain _____

_____

Do you have an attorney? YES NO

If yes attorney name _____Phone #_____

NO-FAULT (AUTO ACCIDENT)

Is this a motor vehicle accident related injury? YES NO

Your car insurance carrier: _____Date of accident_____

Carrier address: _____

_____

Claim# _____ Adjuster name: _____

Adjuster phone# _____

Do you have an attorney? YES NO

If yes attorney name _____Phone #_____

PATIENT HEALTH QUESTIONNAIR

New York Neurosurgical, PLLC
Steven K. Jacobs MD., Ph.D

Chief Complaint: _____

_____

List any medical problems that **run in your family** (heart disease, high blood pressure, diabetes, etc…)

_____

SOCIAL HISTORY

Do you smoke? YES NO If yes how much/how often _____

Do you drink? YES NO If yes how much/how often_____

Do you have any tattoos? YES NO If yes where? _____

Do you have any piercings? YES NO If yes where?_____

L or R handed? Height _____ Weight _____BMI _____

PAST SURGICAL HISTORY

Please list any surgeries or major illnesses you have had in the past

Surgery / Hospital _____Year_____

Surgery / Hospital _____Year_____

Surgery / Hospital _____Year_____

Surgery / Hospital _____Year_____

Have you had any complications? _____

Anesthetic Complications? _____

ALLERGIES / MISCELLANEOUS

Pacemaker? YES NO

Latex Allergy? YES NO

Do you have any metal in your body? YES / NO

List any allergies to medications or metals _____

CURRENT MEDICATIONS

Medication:_____Dosage: _____Frequency_____

Medication:_____Dosage: _____Frequency_____

Medication:_____Dosage: _____Frequency_____

Medication:_____Dosage: _____Frequency_____

WHAT PHARMACY DO YOU USE?_____

ADDRESS OF PHARMACY _____

CURRENT MEDICAL CONDITIONS

Please check if you currently have or had any problems with:

_____Fever

_____Weight Loss

_____Glaucoma

_____Date of last eye exam

_____Hearing Loss

_____Ringing L or R

_____Balance Problem

_____Sinus problems

_____Headaches

_____High Blood Pressure

_____Chest pain / Angina

_____Date of last EKG

_____Asthma

_____Chronic Cough

_____Shortness of breath

_____ Neck Pain

_____ Nausea / Vomiting

_____ Indigestion or Pain when eating

_____Jaundice

_____ Change in bowel movements

_____Ulcer or Gastritis

_____Urinary Tract Infection

_____Difficulty starting or stopping stream

_____Renal / Kidney Problems

_____ Diabetes

_____ Increased Appetite

_____Anemia

_____ Hemophilia

_____Anxiety

_____Depression

_____Back Pain

_____Hepatitis C (current or past)

The above information is true to the best of my knowledge:

Signature: _____Date: _____

NEW YORK NEUROSURGICAL ,PLLC

4 Lafayette Court

Fishkill, NY 12524

Insurance Authorization

I request that payment of authorized Medicare Benefits and or my insurance company be made on my behalf to New York Neurosurgical , PLLC for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary TO PAY THE CLAIM. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. I know that I am responsible for any balance not covered by my insurance.

Signature: _____Date: _____

I authorize New York Neurosurgical, PLLC to deposit any payment(s) issued to me for claims(s) paid by "my insurance" for services rendered by New York Neurosurgical, PLLC that have been mailed directly to New York Neurosurgical, PLLC. I request all payments for claims to be mailed directly to New York Neurosurgical, PLLC.

Signature: _____Date: _____

Assignment of Benefits/Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to New York Neurosurgical and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The numbers you have provided us with will be used to contact you

May we speak to other members of your household? YES NO

If no, please specify who we can't speak to_____

Can we leave detailed messages at your

Home Phone Number YES NO

Cell Phone Number YES NO

Work Phone Number YES NO

(If NO is selected we will not leave a detailed message, instead we will leave contact information for you to reach us)

Signature _____ Date _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information (Please fill out this section if you wish a specific person to be able to obtain your medical information)

Please list any persons who can obtain your medical records, such as a primary care doctor

Name of Person / Facility Address Phone#

1. _____
2. _____
3. _____
4. _____

Signature _____ Date _____

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

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

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

This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH REATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my itials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of formation, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) dicated in Item 8.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is ohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I derstand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State ivision of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies e responsible for protecting my rights.

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 voke this authorization except to the extent that action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for enefits will not be conditioned upon my authorization of this disclosure.

Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this disclosure may no longer be protected by federal or state law.

THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL ARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).

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

Name and address of person(s) or category of person to whom this information will be sent:

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 result, 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**

uthorization 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)

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

ll items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a py 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.