NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

Today's Date: _____

Last Name: _____ First Name: _____ M.I. _____

Address: _____ Apt ___

City: _____ State: _____ Zip: _____

Home (____)_____ Cell (____)_____ Work (____)_____

Email: _____

Date of Birth: _____ Sex: F / M Social Security # _____- ____- _____

Marital Status: S M D W

Who Referred You? _____ Phone (_____)_____

Address: _____ City: _____ State: ____ Zip: _____

Auto Insurance Carrier: _____ Insurance Phone # _____

Insurance Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Relation to Patient: _____

Insured Date of Birth: _____ **Case #** _____

Adjuster Name/#:

Family Doctor: _____Phone (_____)_____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____Occupation: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer Phone (____)_____ Are you still working? YES / NO

If NO, when was your last day? _____If YES, part time or full time? _____

Emergency Contact Name: _____Relation to patient: _____

Home (____)_____ Cell (____)_____ Work (____)_____

Accident date: _____/ _____/ _____ Attorney Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone (_____)_____ Fax (_____)_____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
(ASSIGNMENT OF BENEFITS FORM)

I, _____ ("Assignor") hereby assign to **McCulloch Orthopaedic Surgical Services, LLC** ("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 to the contrary.

This agreement may be revoked by the assignee when the 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 COMPERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSIST, ABETS SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO LAW ENFORCEMENT AGENGY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMITS A FRADULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT EXCEEDING FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____

Patient's Name | Patient's Signature/Date

_____

Patient's Address

Kenneth McCulloch, M.D.
_____

Provider | Providers Signature/Date

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

LIEN AGREEMENT

I hereby authorize and direct you, my attorney, or Insurance Company to pay directly to McCulloch Orthopaedic Surgical Specialists such sums as may be due and owing for Orthopaedic services rendered by Kenneth McCulloch, MD to me both by reason of this accident and by reason of any other bills that are due his/her office and withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor.

I hereby further give Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney or myself, as a result of the injuries for which I have been treated or injuries in connections therewith. I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for service rendered to me and that this agreement is made solely for said doctor's addition protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I also fully understand that if payment is not made as agreed upon I shall be responsible for any and all interest (**at 1.75% per month or 21% per annum**). All reasonable attorney fees, cost of collection and court costs incurred, in efforts to enforce this agreement. I hereby authorize my attorney to release *ultimate settlement figures, final disbursement and/or copy of settlement check* regarding my accident/injuries to ***McCulloch Orthopaedic Surgical Services.***

I agree to promptly notify said doctor on any charge or addition of *attorney*(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this Lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning it to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due payable.

I _____, benefit in this matter agree that I will attempt the independent medically exam that are scheduled by the insurance carrier as required by the terms of the insurance contract, in order to preserve the doctors ability to collect the medical billing. I understand that if I don't attend the scheduled independent medical exams I will be responsible for all medical bills that are outstanding as a result of said failure. Said Responsibility is in the form of billing to myself and for a lien.

X_____ _____
Patient's Signature **Date**

X_____ _____
Patient's Printed Name **Date**

X_____ _____
Attorney's Signature Date **Date**

X_____ _____
Attorney's Printed Name **Date**

Please sign, date and return one copy to doctor's office. Also keep a copy for your records.

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

Notice of Privacy Practice Policies

McCulloch Orthopaedic Surgical Services is committed to protecting the privacy of his patients. It is the intent of the above entity to comply with the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable New York State Law. This office:

1. Makes its Notice of Privacy Practice's available upon request to any person.
2. Provides the Notice in person not later than the date of the first service delivery after October 9, 2008.
3. Makes the Notice available at the office for individuals to take with them upon request.
4. Posts the Notice in a clear and prominent locations where it is reasonable to expect the individuals receiving service to read the notice.

By signing below, I hereby acknowledge that the full privacy policy has been made available to me and will continue to me upon my request.

_____

(Patient Signature / Date)

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

Authorization to Use or Disclose Health Information

Patient Name: _____

Patient Address: City, State, Zip:

Patient Phone Number: Patient Email:

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual and organization are authorized to make the disclosure: McCulloch Orthopaedic Surgical Specialists as well as any health care provider which I am referred to by the above.

3. The type of information to be used or disclosed as follows.
   Problem list & Medication list
   All histories and discharge summaries
   All lab results; All x-ray and imaging reports
   All consultation reports and films
   The entire record relating to my treatment

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to:

   Name: _____ Address: _____

6. This information for which I'm authorizing disclosure will be used for liability claim.

7. I understand that I have a right to revolve this authorization at any time. I understand that if I revolve this authorization, I must do so in writing and present my written revocation to the health management department. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire five years from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to Patient _____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

Medical Questionnaire

FAMILY HISTORY

Illness	Self	Family	Illness	Self	Family
Diabetes			Heart Problems		
High Cholesterol			Cancer		
Hypertension			Asthma		
Strokes			Seizures		

If other please specify: _____

SURGICAL HISTORY

Year	Procedure

Height (In): _____ Weight (Lbs): _____

Please list any allergies you may have:

_____

_____

Are you currently taking non-prescription drugs? YES / NO

If yes please specify: _____

_____

Are you currently taking prescription drugs? YES / NO

If yes please specify: _____

_____

SOCIAL HISTORY

Do you smoke? Packs per Day_____ YES / NO

Do you drink? How Often_____ YES / NO

HISTORY AND SYMPTOMS

Chief Complaint:

1. How long have you had this problem? _____
2. Was this a result of a fall or accident? YES / NO

If yes, please give date ___/____/____

3. Can you work or perform normal activities? YES / NO

If yes, are there any restrictions? _____

4. Check the symptom (s) associated with your chief complaint:

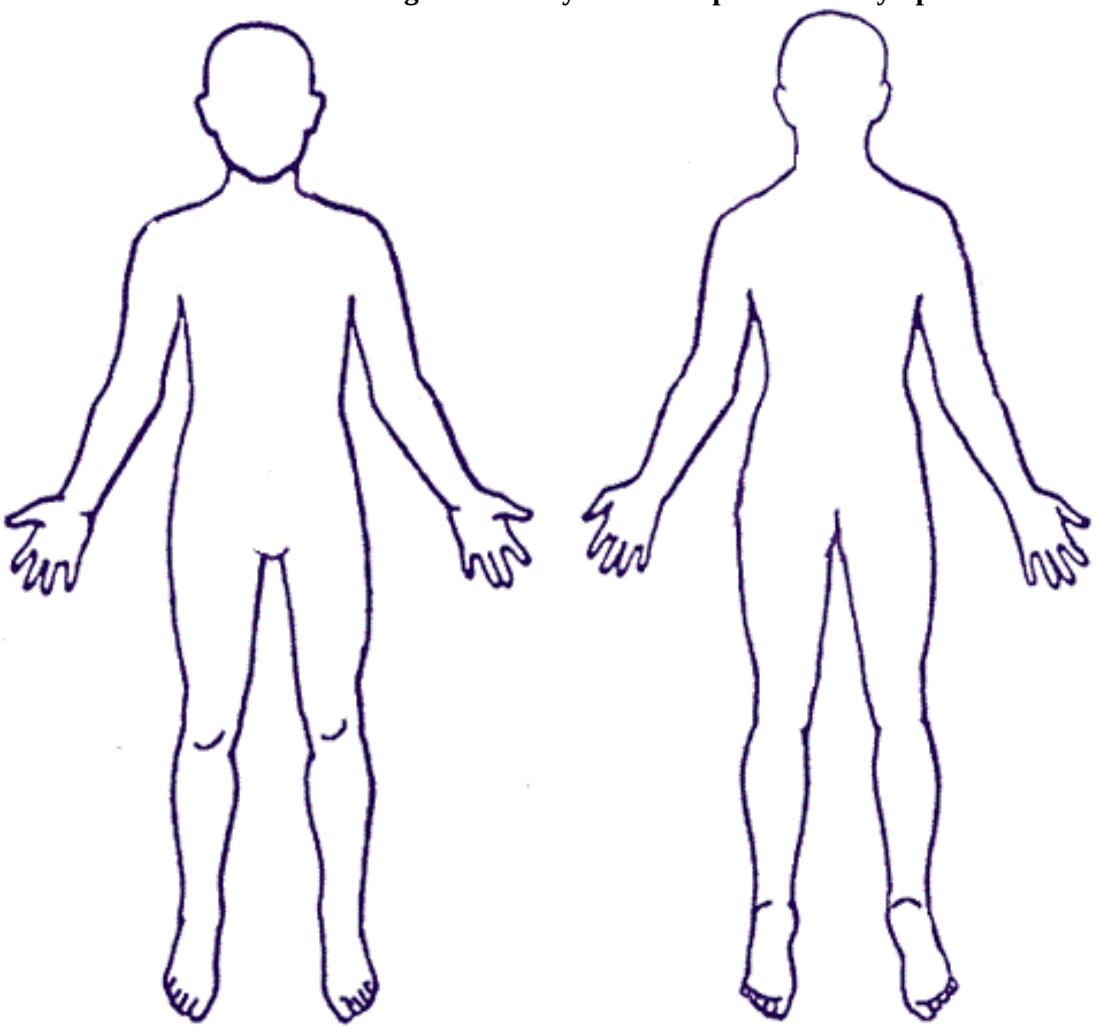
_____Pain _____Numbness _____Tingling _____Weakness _____Muscle Spasm

If other please specify: _____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

Please indicate on the diagram where you feel the pain and/or symptoms:



FRONT **BACK**

1. On a scale from 0 to 5 (5 being the worst) how severe is your pain at the onset? _____
2. On a scale from 0 to 5 how severe is your pain today? _____
3. Circle how bad your pain is based on the pictures below:

4. What is the quality of the pain?

Sharp Shooting Stabbing Dull Aching Intermittent Constant

If other, please specify: _____

NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

NF

5. What makes your problem worse? (Circle all that apply)

Standing	Sitting	Walking	Lifting	Exercise	Twisting
Lying Down	Squatting	Kneeling	Bending	Coughing	Sneezing

If other, please specify: _____

6. What treatments have you had for this problem? (Circle all that apply)

Epidural Injections	Physical Therapy	Massage	Stimulation (TEN)
Acupuncture	Trigger Point Injections	Brace	

If other, please specify: _____

7. Do you have: (Circle all that apply)

MRI Report/Films	X-Ray Films	EMG (Nerve Conduction Studies)
CT Scans	Disco gram	Bone Scan

If other, please specify: _____

8. What medications have you tried for this condition? _____

All information must be filled out before seeing the Doctor

I assign directly to MuCulloch Orthopaedic Surgical Services all medical insurance and health benefits. I understand that in the event that the charges are applied to my insurance deductible or charges not covered, or if invalid, that I am responsible for all balances due.

I authorize and holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

_____
Print Name

_____
Signature

_____
Date