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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: _____ Insured Relation to Patient: _____ Case

Date of Birth: _____ Adjuster # _____ Adjuster

Name/#: _____ Number: _____

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 (____)_____

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PHARMACY

Name of The Pharmacy: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Number: _____

Manhattan: 110 Duane Street., 1st Floor., New York, NY 10007 **P**: (212) 355-5555
Queens: 125-10 Queens Blvd., 2nd Floor., Suite 9., Kew Gardens, NY 11415 **P**: (212) 355-5555
New Jersey: 381 Teaneck Avenue , NJ 07666 **P**: (212) 355-5555

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

I, _____("Assignor") hereby assign to **McCulloch Orthopaedic Surgical Services PLLC** ("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

MCCULLOCH ORTHOPAEDIC SURGICAL SERVICES, PLLC - DISCLOSURE OF PHYSICIAN OWNERSHIP

New York: This notice is provided to you pursuant to the New York Public Health Law § 238-d. Practitioner disclosure requirements, and any other state and/or federal laws and regulations which may apply. New York state passed a law due to concerns that there may be a conflict of interest where a health practitioner makes a referral to a health care provider for the furnishing of any health related items or services where such practitioner (or immediate family member of such practitioner) has a financial relationship with or a financial interest in the health care provider. With certain exceptions, such referrals may be prohibited. The financial relationship must be disclosed to the patient as a condition to the referral. The patient must also be advised of his/her her right to utilize a specifically identified alternative health care provider if any such alternative is reasonably available.

New Jersey: This notice is provided to you pursuant to section 3 of P.L.1989, c.19 (C.45:9-22.6) and New Jersey Statutes Title 45 - 45:9-22.6 - Written disclosure form, and any other state and/or federal laws and regulations which may apply. Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has a financial interest, the state of New Jersey passed a law which prohibits physicians, with certain exceptions, from referring patient to a facility in which the physician (or any of his/her immediate family members) have a financial interest. The referral can be made under the condition that the physician must disclose this financial interest to patients and advise them of alternative places where they may go to obtain these services. These disclosures are intended to help patient's make a fully informed decision about their health care.

I acknowledge that I have been placed on specific notice that Dr. Kenneth McCulloch and Dr. Mark Bursztyn, owners of McCulloch Orthopaedic Surgical Services, PLLC, have a financial and ownership interest in the New Horizon Surgical Center, LLC., Fifth Avenue Surgical Center, L.L.C., All City Family Healthcare Center L.L.C., and Surgicore Surgical Center, L.L.C. I have been informed that I have a right to be treated at a different facility of my own choosing if I so desire.

Additional Notice to New York No-Fault Patients Scheduled for Procedures to be performed at New Horizon Surgical Center, LLC. or Surgicore Surgical Center, L.L.C:

Under a basic New York automobile insurance policy, an injured party is entitled to fifty thousand ($50,000.00) dollars in personal injury protection ("PIP") benefits. If, however, the applicable automobile insurance policy provides for optional lines of coverage, such as Additional PIP or Optional Basis Economic Loss ("OBEL"), the PIP benefit limit may be raised from fifty thousand ($50,000.00) dollars to one hundred thousand ($100,000.00) dollars, or more. Pursuant to 11 N.Y.C.R.R. §68.6 ("Regulation 83"), when a health service is performed outside New York State, the permissible charge for such service, shall be the prevailing fee in the geographic location of the medical provider. If you are scheduled to have a medical procedure performed at New Horizon Surgical Center, LLC. or Surgicore Surgical Center, L.L.C please take notice that these facilities are located in New Jersey. As such, the prevailing fees associated with performing your upcoming procedure may be higher than if it were performed in New York State. While it is our intention to first seek payment from your no-fault insurer, under the assignment of benefits previously provided, should the cumulative cost of your medical care exceed your policy benefits, there is a possibility that payment may need to be sought from alternate sources, including but not limited to any secondary insurance

coverage that you may have or from the proceeds of your personal injury action. Should you have any questions or require further information, please do not hesitate to ask a member of our staff.

I have read the above disclosure and additional notice. After being fully informed of the above facts and rights, of my own volition, I expressly elect to have the procedure performed at one of the above-listed centers. Any questions I may have had regarding this notice have been fully answered.

_____

PRINTED PATIENT NAME

_____ _____

PATIENT SIGNATURE DATE

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LIEN AGREEMENT

I hereby authorize and direct you, my attorney, or Insurance Company to pay directly to Kenneth McCulloch, M.D. such sums as may be due and owing him/her for Orthopaedic services rendered 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, PLLC***

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 medical 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.

www.nysportsandjoints.com

Manhattan	110 Duane St., 1st Fl., New York, NY, 10007	P: (212) 588-1919 F: (212) 588-1896
Queens	125-10 Queens Blvd Kew Gardens NY 11415	P: (718) 275-1919 F: (718) 275-1955
New Jersey	381 Teaneck Avenue, Teaneck, NJ, 07666	P: (212) 588-1919 F: (212) 588-1896

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Notice of Privacy Practice Policies

Kenneth McCulloch, M.D. 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. The office of Kenneth McCulloch, M.D.:

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)

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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: Kenneth McCulloch, M.D. 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 re-disclosed 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 _____

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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? How many packs per day?_____ YES / NO
Do you drink? How often?_____ How much?_____ 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

Other - please specify: _____

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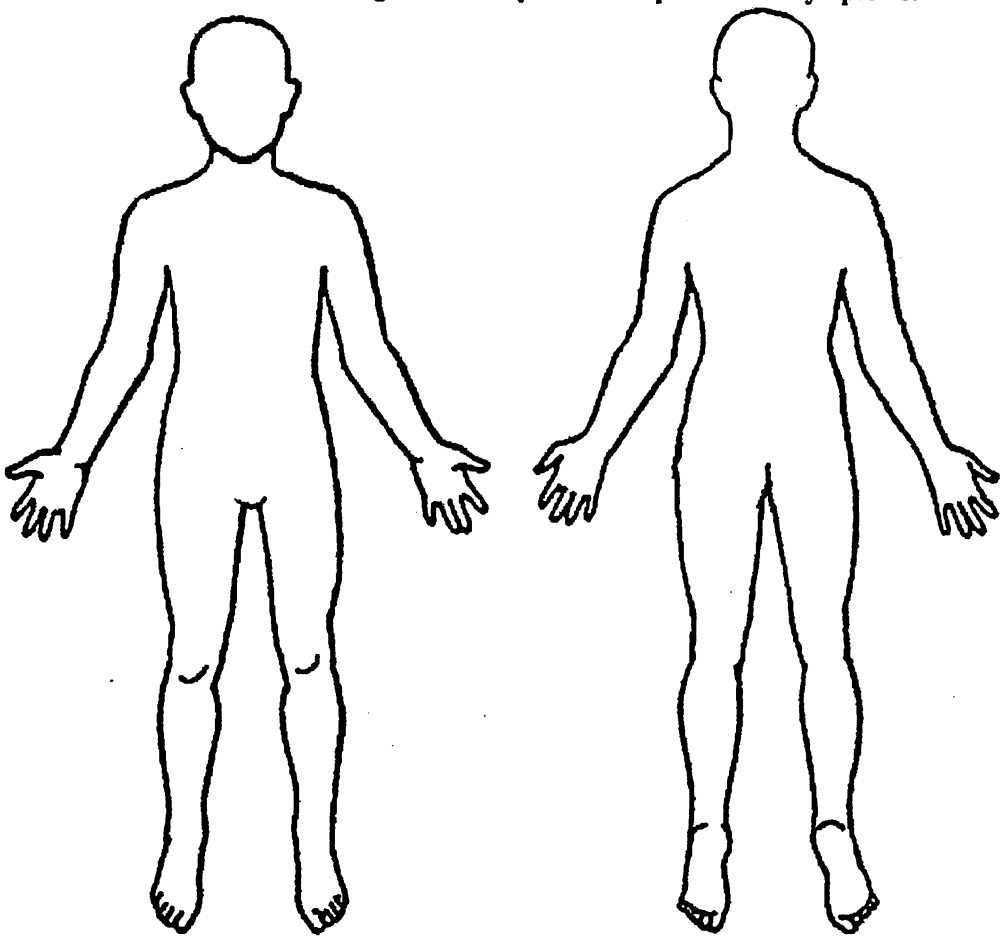
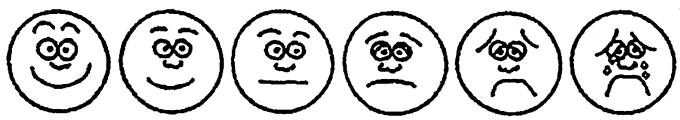
Please indicate on the diagram where you feel the pain and/or symptoms:



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:



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4. What is the quality of the pain?

Sharp Shooting Stabbing Dull Aching Intermittent Constant

If other, please specify: _____

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 Kenneth McCulloch M.D. 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

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