NEW YORK
SPORTS & JOINTS
ORTHOPAEDIC SPECIALISTS

WC

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: _____

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 (___)_____

Worker's Compensation Carrier: _____ Date of Injury: _____

Did you report this accident to your employer? YES / NO

WCC Number: _____ WCB Number: _____

Adjuster Name: _____ Adjuster Number: _____

Established Body Parts: _____

History of Injury (Please describe how the injury occurred): _____

_____

_____

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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Authorization, Assignment and Fee Agreement

In considering the amount of medical expenses to be incurred, I, the undersigned, hereby assign and convey directly to McCulloch Orthopaedic Surgical Services, PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor.
If I have, and do not pursue a Worker's Compensation claim, or if payment and benefits(s) under this type of claim is denied for any reason other than providers fees not meeting the applicable schedule, I understand that I am responsible for any amount not covered by insurance benefits, and all reasonable legal fees spent by providers to collect the amount I owe. I am responsible to provide insurance information and referrals, if needed to the provider. Providers can submit any dispute there may be under this authorization, assignment under the American Association New York office.

_____

(Patient Signature / Date)

Notice of Privacy Practice Policies

McCulloch Orthopaedic Surgical Services, PLLC is committed to protecting the privacy of its 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 McCulloch Orthopaedic Surgical Services, PLLC.

1. Makes its Notice of Privacy Practice's available upon request to any person.
2. Provides the Notice in person no 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 location where it is reasonable to expect the individual 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 be upon my request.

_____

(Patient 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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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 Services PLLC, 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 is as follows:
   Problem list
   Medication list
   All history 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 revoke this authorization at any time. I understand that if I revoke 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	Proccdure

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? YES / NO
If yes, how many packs per day? _____

Do you drink? YES / NO
If yes, how often? _____

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: _____

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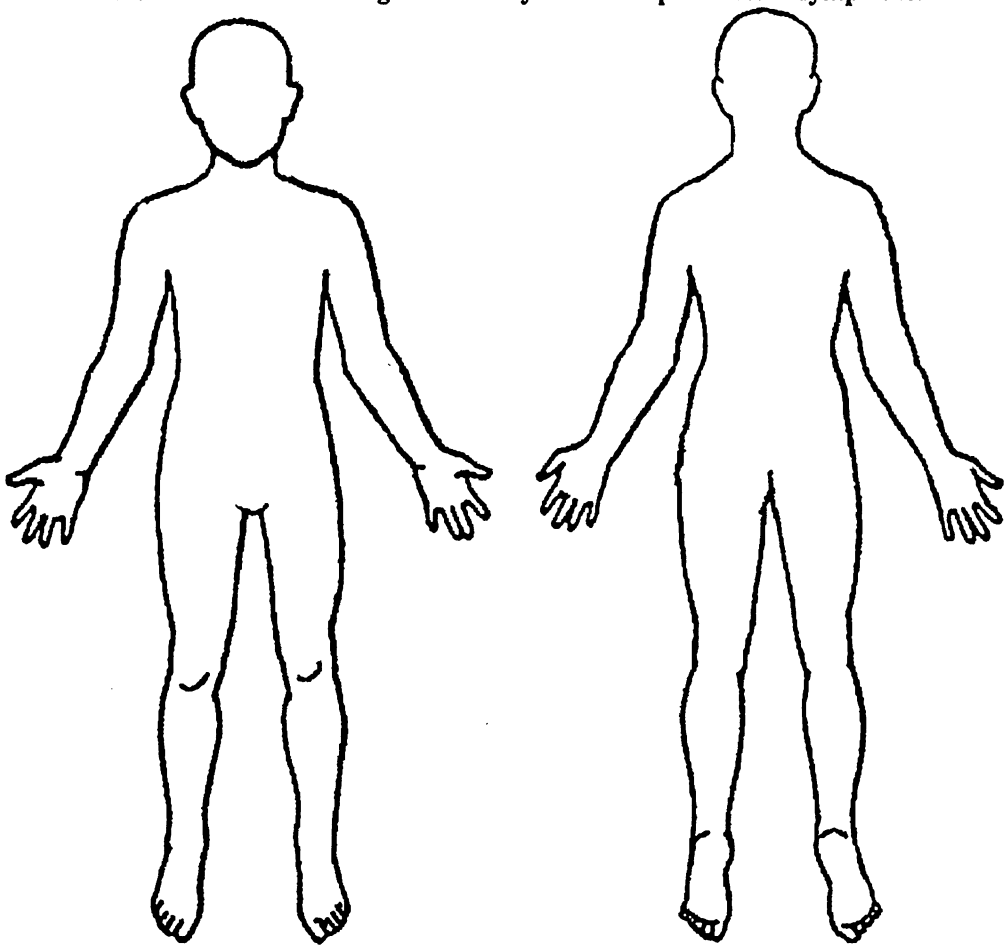
Please indicate on the diagram where you feel the pain and/or symptoms:



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:

4. What is the quality of the pain?

Sharp Shooting Stabbing Dull Aching Intermittent Constant

If other, please specify: _____

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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 McCulloch Orthopaedic Surgical Services, PLLC all medical insurance and health benefits. I understand that in the event that the services rendered are not covered, or if invalid, that I am responsible for any amount not covered by the insurance carrier.

I authorize the holder of medical information about me, to be released to the NY State Worker's Compensation Board, or any information needed to determine these benefits payable for related services.

_____
Print Name

_____
Signature

_____
Date