WORKMANS COMPENSATION

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: ___/___/___

Address: _____

Home Phone: _____ Cell Phone: _____

EMPLOYER INFORMATION

Occupation: _____ Employer Phone: _____

Employer Name: _____

Employer Address: _____

WORKMANS COMPENSATION INFORMATION

Worker Compensation Carrier: _____ Carrier Phone Number: _____

Adjuster's Name: _____ Claim Number: _____

Carrier Address: _____

INJURY INFORMATION

Date of Injury: _____ Approximate Time: _____

Place of Injury: _____

Did you report the accident to your employer? ___ Yes ___ No

Name of person you reported accident to? _____

Description of how accident happened: _____

_____

_____

Have you lost time from work? ___ Yes ___ No

Have you seen other doctors for this condition? ___ Yes ___ No If yes, name of doctor: _____

Were X-rays taken? ___ Yes ___ No ___ N/A If yes, where? _____

Do you have the results? ___ Yes ___ No ___ N/A

Any previous Worker Compensation injuries? ___ Yes ___ No If yes, date(s): _____

Description previous injury: _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my claim for Workers Compensation benefits id denied.

Patient Signature: _____ Date: _____

First Name: _____ Last Name: _____

DOB: ___/___/_____ SSN: _____ Marital Status: _____ Gender: _____

Complete Address: _____

Mailing Address (if different): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ How did you hear about our office? _____

Occupation: _____ Employer (if this is an insurance case): _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____

Primary Insurance Address: _____ Phone: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ SSN: _____

Secondary Insurance: _____ Policy Number: _____

Secondary Insurance Address: _____ Phone: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ SSN: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

PHARMACY INFORMATION

Name/Address: _____ Phone: _____

CHIEF COMPLAINT

Describe the reason for your visit: _____

_____

When did your symptoms begin? (select one)

_____Today _____This week _____ 3 months to 6 months

_____Within last 3 months _____ 6 months to one year _____ More than one year

Which word describes the frequency of your discomfort? (select one)

_____ Constant _____ Occasional _____ Rare

Which phrases best describe changes in your discomfort during the day?

_____ Worse in the morning _____ Worse at night _____ Doesn't change

Please check which issues affect you **currently**: Current pain scale (**0 being pain free, 10 worst pain imaginable**)

Part of the body you have issues with	**Pain**	**Stiffness**	**Weakness**	**Difficulty of movement**	**Numbness and/or tingling**	**Other**
Head						
Neck						
Shoulders						
Upper Arms (left or right)						
Elbow (left or right)						
Forearms (left or right)						
Hands (left or right)						
Upper Back						
Mid Back						
Lower Back						
Hips (left or right)						
Upper Legs (left or right)						
Knees (left or right)						
Lower Legs (left or right)						
Ankles (left or right)						
Feet (left or right)						
Toes- please indicate which toes (left or right)						

What helps relieve your discomfort?

_____ Ice _____ Heat _____ Medication _____ Other (describe): _____

What activities are limited by your discomfort? (check all that apply)

_____Bending _____ BM/Urination _____ Walking _____ Daily Routine

_____ Driving _____ Getting Up _____Lifting _____ Reading

_____ Pushing/Pulling _____ Standing _____ Working _____ Sitting

_____ Sleeping _____ Exercising _____ Turning Head _____ Other

MEDICAL HISTORY

Are you currently pregnant? ___Yes ___ No ___N/A

Are you currently taking any blood thinners? ___Yes ___ No If yes, what? _____

Please list additional medications you may be taking:

Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____

Where applicable, specify the approximate date of your most recent:

Spinal X-Ray: _____ CT Scan: _____

MRI: _____ Other Scans/X-Rays: _____

SIGNATURE: _____ DATE: _____

(This form can be updated at any time by request of patient. Our office may ask you to update this form on a yearly basis.)

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation of your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health to all health professionals, who may provide treatment or who maybe consulted by staff members.

Payments: Your health information may be used to seek payment for your health plan, form other sources of coverage, such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of our facility. For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you to provide appointment reminders or information about treat alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Individual Rights: You have certain rights under Federal Privacy Standards. These include:

- The Right to request restrictions on the use and disclosure of your protected health information.
- The Right to receive confidential communications concerning your medical condition and treatment.
- The Right to inspect and copy your protected health information.
- The Right to receive an accounting of how and to whom your reported health information has been disclosed.
- The Right to receive a printed copy of this notice.

Our Facility: By law, we are required to maintain the privacy of your protected health information and to provide you with this notice of Privacy Practice.

This notice is effective as of May 1st, 2021, and we are required to abide by the terms of the notice of Privacy Practice currently in effect. We reserve the right to change the terms of our notice of Privacy Practice and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised notice of Privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filling a complaint.

Please contact us for more information:

Lauren Falco, Director of Operations

1717 Veterans Memorial Highway

Islandia, New York 11749

For more information about HIPPA, or to file a complaint:

US Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington D.C., 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____

Authorization for Treatment, Release of information, Assignment of Benefits & Acknowledgement of Receipt of Notice of Privacy Practices, Financial Policy and/or Medicare Financial Responsibility Disclosure Release of Information & Consent for Treatment

PATIENT NAME:_____ DATE OF BIRTH:_____

Release of Information & Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment from Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC and permit its employees and all other treatment providers to treat me as they deem beneficial to my condition. I consent to services, understand, acknowledge and affirm that services may involve bodily contact and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and multiple treatment modalities. No guarantees have been made to me about the outcome of this care.

I give permission to Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC to release information, verbal and written, contained in my medical record, to my insurance company, rehab curse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries, and all other relented person's as it relates to my treatment and/or payment for services provided. I authorize Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC to obtain medical records from other medical professionals/providers as it relates to my treatment.

Initial_____

This is my authorization to allow VERBAL discussion of my condition, care, or appointment reminders to the following:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

Notice of Privacy Practices (HIPAA Acknowledgment/Consent)

I hereby acknowledge that I have been given the opportunity to receive and/or review the office Notice of Privacy Practices. I have been made aware that the Notice of Privacy Practices is also posted in the lobby for my review. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations.

Initial_____

The following are AUTHORIZED to receive the patient's protected health information:

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____

Payment Guarantee

I agree to pay Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC for the services provided to me or any party, such as Worker's Compensation, or insurance contracts that prohibit payment for services. I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from a third-party payer. Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage, I acknowledge responsibility for payment of all services. I understand that my good faith payment may not be inclusive of all payments for which I am responsible, and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Spine and Sports Rehabilitation Pain Management and/or Jordan Sudberg MD PC.

Initial_____

SIGNATURE: _____ DATE: _____

(This form can be updated at any time by request of patient. Our office may ask you to update this form on a yearly basis.)

ASSIGNMENT OF BENEFITS

Dear Patients,

As a patient of Jordan Sudberg MD P.C. and/or Spine and Sports Rehabilitation Pain Management, we can accept your insurance for services performed. We will submit a claim for your treatment to your insurance company. While we are happy to provide this billing service to our patients, we do need your cooperation. By signing the assignment and release section below, you are authorizing your insurance company to send their payment directly to us instead of yourself. Should an insurance company send you a reimbursement check directly to you for services rendered here, you agree to send to us immediately after endorsing the back of the check as follows:

ENDORSEMENT: Pay to the order of:
Jordan Sudberg MD PC

Checks may be mailed to:
1717 Veterans Memorial Highway, Suite 1
Islandia, NY 11749

ASSIGNMENT and RELEASE: I hereby assign to the health care provider indicated above all rights, privilege, and remedies to payment for health care service provided by the assignee to which I am entitled under insurance law.

The assignee hereby certifies that they have not received any payment for or on behalf of the assignor (patient) and shall not pursue payment directly from the assignor (patient) for the services provided by said assignee. Notwithstanding any prior written agreement to the contrary, this agreement may be revoked by the assignee when benefits are not payable based upon the assignor's (patient) lack of coverage and / or violation of a policy condition due to the actions or conduct of the assignor (patient). I also authorize the release of any medical or other information necessary to process my claims.

Patient Name Printed: _____

Patient or Guardian Signature: _____

Date: _____