

Save this form to your own computer and then complete it. When finished, save your finished version, print it, and complete the pain diagram to bring to your appointment.

Long Island Spine Rehabilitation Medicine, P.C.
801 Merrick Avenue East Meadow, New York 11554

NAME _____ DATE ____/____/____

SEX _____ DATE OF BIRTH ____/____/____ SS# _____ - _____ - _____

ADDRESS _____ CITY _____ ZIP _____

TEL: HOME (____) _____ - _____ WORK (____) _____ - _____

CELL (____) _____ - _____ MARITAL STATUS: S M W D

REFERRING MD _____ PHONE (____) _____ - _____

PRIMARY INSURANCE _____ EFF. DATE ____/____/____

NAME OF INSURED _____ RELATIONSHIP TO PT _____

INSURED SS# _____ - _____ - _____ INSURED DATE OF BIRTH ____/____/____

INSURANCE ID # _____ GROUP# _____ PHONE(____) _____ - _____

DEDUCTIBLE: Y N AMOUNT _____ MET? Y N COPAY AMOUNT _____

SECONDARY INSURANCE _____ EFF. DATE ____/____/____

NAME OF INSURED _____ RELATIONSHIP TO PT _____

INSURED SS# _____ - _____ - _____ INSURED DATE OF BIRTH ____/____/____

INSURANCE ID # _____ GROUP# _____ PHONE(____) _____ - _____

DEDUCTIBLE: Y N AMOUNT _____ MET? Y N COPAY AMOUNT _____

CONDITION RELATED TO AN ACCIDENT? Y N DATE ____/____/____

IF YES, WORK RELATED? Y N AUTO RELATED? Y N

(IF THIS CLAIM IS RELATED TO WORKMAN'S COMPENSATION OR A NO-FAULT INJURY, PLEASE COMPLETE ALL REQUESTED INFORMATION ON THE BACK PORTION OF THIS FORM)

CAN PATIENT CALLS BE MADE TO HOME? Y N WORK? Y N
CAN MESSAGES BE LEFT ON VOICE MAIL HOME? Y N WORK? Y N

EMERGENCY CONTACT _____ RELATIONSHIP _____

PHONE(____) _____ - _____ ADDRESS _____

HOW DID YOU LEARN OF OUR PRACTICE? _____

ALL PATIENTS: PLEASE SIGN RELEASE AUTHORIZATION FOR TODAY'S VISIT AND ANY FUTURE TREATMENTS. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES. PLEASE REMEMBER THAT PAYMENT IS YOUR OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT. I AGREE TO RELEASE INFORMATION TO THIS FACILITY OF ANY MEDICAL PROBLEMS THAT ARISE DURING MY TENURE AS A PATIENT WITH THEM, AND I WILL OBTAIN MEDICAL CLEARANCE FROM MY PRIMARY PHYSICIAN AND PHYSIATRIST BEFORE RESUMING TREATMENT. I UNDERSTAND THAT I WILL NOT BE TREATED OTHERWISE.

PATIENT SIGNATURE _____ DATE ____/____/____

Long Island Spine Rehabilitation Medicine, P.C.
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Name _____ Date _____

TO ALL WORKERS COMPENSATION AND NO-FAULT INSURANCE CLAIMS:
THIS MUST BE COMPLETED THOROUGHLY.

WORKERS COMPENSATION ONLY:

EMPLOYER _____

ADDRESS _____

WCB CASE NO _____

CARRIER CASE NO _____

INSURANCE CARRIER _____

PHONE NUMBER _____

CONTACT NAME _____

ADDRESS _____

DATE / TIME OF INJURY _____

ADDRESS WHERE INJURY OCCURRED (CITY, TOWN, OR VILLAGE)

NO FAULT INSURANCE ONLY:

CARRIER _____

PHONE NUMBER _____

CONTACT NAME _____

ADDRESS _____

CLAIM/FILE NO _____

POLICY NO _____

POLICY HOLDER _____

DATE OF ACCIDENT _____

Long Island Spine Rehabilitation Medicine, P.C.

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HIPAA ACKNOWLEDGEMENT AND PATIENT PREFERENCES

HIPAA (The Health Insurance Portability and Accountability Act) provides protection to patients intended to limit the disclosure of protected health information (PHI). PHI is any data concerning your treatment in the office. We make every effort to comply completely with these HIPAA privacy regulations. At the same time, we do not want our patients to be inconvenienced when they wish to have a spouse or family member call us for test results of prescriptions from our office when it is inconvenient for you to do so.

Please provide answers to the following questions. Your answers should help us serve you better, while ensuring that your privacy is protected. This information may be changed by you at any time.

Name of Designee to Receive PHI

Relationship to Patient

Name of Designee to Receive PHI

Relationship to Patient

Name of Designee to Receive PHI

Relationship to Patient

Name of Designee to Receive Medical Records Only

I _____, acknowledge that I have been provided with a copy of Long Island Spine Rehabilitation, PC's privacy notice and have been given an opportunity to read and ask questions about the notice

Date: _____

Patients Signature