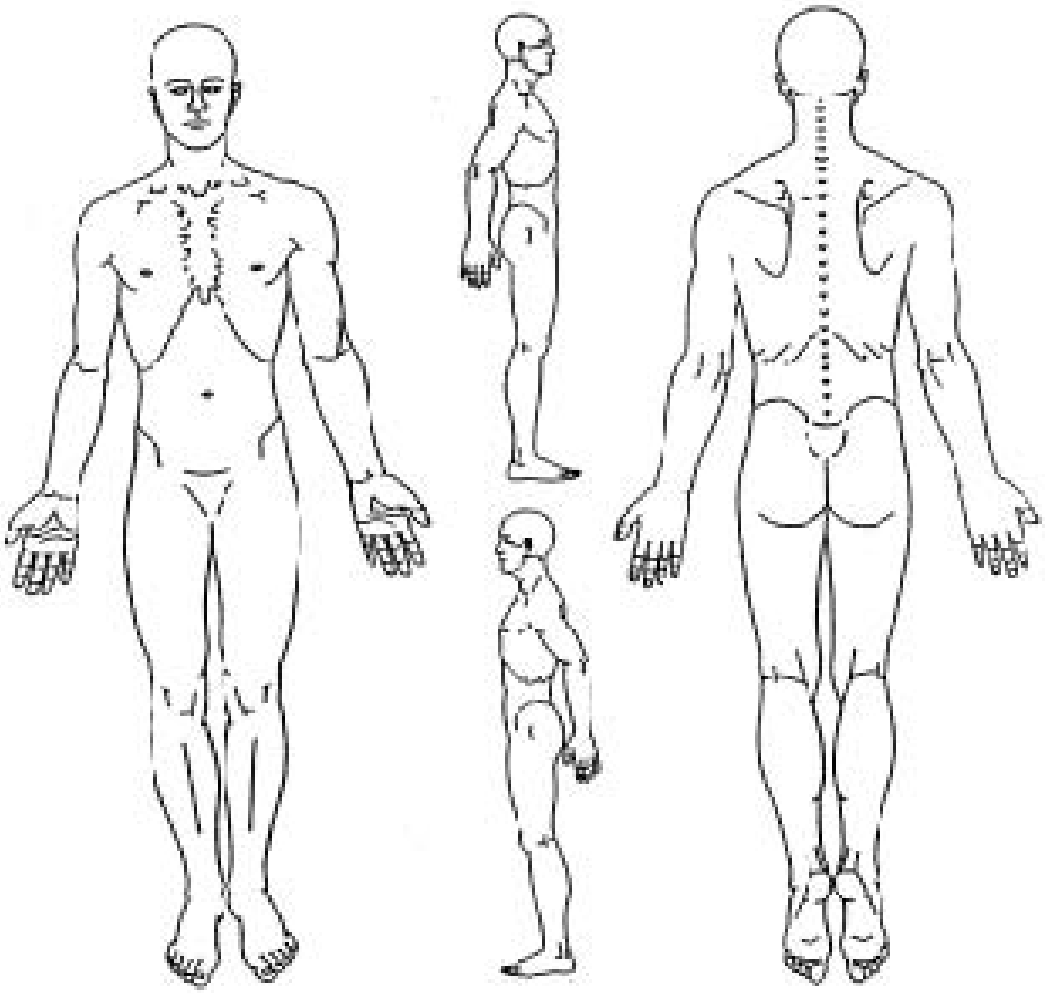
LONG ISLAND SPINE
REHABILITATION MEDICINE

NAME: _____ TODAY'S DATE: _____

PLEASE DRAW THE LOCATION OF YOUR COMPLAINTS BELOW, UTILIZING **XXXXX** FOR SYMPTOMS OF PAIN AND **00000000** FOR NUMBNESS OR TINGLING:



PLEASE GRADE YOUR PAIN INTENSITY BELOW:

0 **10**

No pain Worst possible pain

Name: _____ **Age**: _____ **Date of Birth**: _____

Family Physician: _____ **Referring Physician:** _____

When did your symptoms start (if known)? _____

How did this injury occur (if known)? _____

What have you done for this pain (check all that apply):

☐ Physical therapy ☐ Chiropractic ☐ Spinal injections/epidurals ☐ Acupuncture ☐ Surgery

☐ Other: _____

How do you describe your symptoms? ☐ Ache ☐ Burn ☐ Stab ☐ Pins and needles

☐ Other: _____

Positions or activities that <u>WORSEN</u> your pain: _____

Positions or activities that <u>RELIEVE</u> your pain: _____

Please grade your pain (check below: 1=least to 10=most):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

All current medications: _____

_____

Previous medications used for this condition: _____

Drug Allergies: _____

Are you allergic to: ☐ Seafood/shellfish ☐ Iodine ☐ Contrast dye ☐ Anesthetic

If yes to allergies, please specify what type of reaction: _____

Medical Conditions (include those you are on medications for): _____

_____

Past Surgeries: _____

_____

Name: _____ **Date of Birth:** _____

Family Medical History: _____

Mother: _____ Father: _____

Brother: _____ Sister: _____

Are you a smoker? ☐ Yes ☐ No ☐ Former smoker If yes, how much? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Do you have children? ☐ Yes ☐ No If yes, How many? _____

Current Employer/Job Description: _____

Highest level of education: _____

Do you drink alcohol? ☐ Non-drinker ☐ Socially ☐ History of alcohol abuse

Any difficulties with substance abuse in the past (specify)? _____

Are you currently involved in litigation (lawsuit)? _____

Height: _____ **Weight**: _____ **Recent blood pressure**: _____

Please circle / elaborate if you have difficulties/conditions with any of the following:

Weight change: _____ Fever/Chills: _____

Night Sweats: _____ Vascular/Circulation: _____

Breast: _____ Pulmonary/Breathing: _____

Heart: _____ Gastrointestinal/Bowel: _____

Urological/Bladder: _____ Joints/Arthritis:_____

Diabetes/Thyroid: _____ Sexual Function: _____

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PATIENT DEMOGRAPHICS FORM

NAME: _____ DATE: _____

SEX: ☐ MALE ☐ FEMALE SS#: _____-_____-_____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: HOME: (_____) _____-_____ WORK: (_____) _____-_____ CELL: (_____) _____-_____

EMAIL ADDRESS: _____

** NO PERSONAL HEALTH INFORMATION WILL BE TRANSMITTED UNLESS SPECIFICALLY REQUESTED. **

PREFERRED CONTACT: ☐ HOME ☐ WORK: ☐ CELL ☐ EMAIL ☐ TEXT

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW(ER)

PRIMARY MD: _____ PHONE: (_____) _____-_____

HOW DID YOU LEARN OF OUR PRACTICE? _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: (_____) _____-_____

PRIMARY INSURANCE_____ EFF. DATE: _____/_____/_____

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

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

INSURANCE ID#: _____GROUP #: _____ PHONE: (_____) _____-_____

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

SECONDARY INSURANCE _____ EFF. DATE: _____/_____/_____

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

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

INSURANCE ID#: _____GROUP #: _____ PHONE: (_____) _____-_____

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

PATIENT DEMOGRAPHICS FORM

DUE TO MANDATES BY THE FEDERAL AFFORDABLE CARE ACT,

WE ARE REQUIRED TO ASK THE FOLLOWING QUESTIONS:

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ FRENCH ☐ ITALIAN ☐ GERMAN ☐ PORTUGUESE
☐ JAPANESE ☐ CHINESE ☐ RUSSIAN ☐ OTHER

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ☐ OTHER

RACE: ☐ CAUCASIAN (WHITE) ☐ AFRICAN AMERICAN (BLACK) ☐ ASIAN ☐ INDIAN
☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ OTHER

DATE OF INJURY: _____

IS THE CONDITION RELATED TO: ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ NOT APPLICABLE

***** IF THIS CLAIM IS RELATED TO A WORKER'S COMPENSATION OR NO-FAULT INJURY, PLEASE HAVE THE ALL CLAIM INFORMATION AVAILABLE AT THE TIME OF THE VISIT. *****

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: _____

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Jason S. Lipetz, MD Jeffry R. Beer, MD Joseph K. Lee, MD Miranda B. Smith, M.D.

HIPAA ACKNOWLEDGEMENT & 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 or 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(s) to Receive Medical Records Only

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

_____ I also allow the providers at Long Island Spine Rehabilitation Medicine to review
(Initials) my eRx (electronic medication) history.

Patient Signature: _____ Date: _____

LONG ISLAND SPINE
REHABILITATION MEDICINE

Appointment Cancellation & No-Show Policy for all Physician Visits

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. In order to be respectful of the medical needs of all our patients, please be courteous and contact our office in a timely fashion if you are unable to show up for your appointment. This time will be re-allocated to someone who is in need of treatment.

Appointments are in high demand, and your timely cancellation will give another person access to timely medical care. If it is necessary to cancel your scheduled appointment with your physician, we require that you call at least 24 hours in advance. Appointments cancelled less than 24 hours before your appointment will result in a $50 fee that will be billed to your account and should be collected before or at your next scheduled visit.

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

Please print and sign your name below to acknowledge our cancellation and no-show policy.

Print Name: _____ Signature: _____ Date: _____

For Acupuncture & Complementary Medicine Appointments Only:

- A **one time** cancellation less than 24 hours before an appointment or a no show to your appointment will be recorded and discussed.
- A **second** cancellation less than 24 hours before an appointment / no show will incur a $90 charge **before** booking your next appointment.
- A **third** cancellation less than 24 hours before an appointment / no show will unfortunately result in not being able book any further acupuncture appointments.

Print Name: _____ Signature: _____ Date: _____

By this waiver and signature below, I hereby authorize LISRM to charge my credit card for $90 in the event I have missed two acupuncture or complementary appointments without notification.

Signature: X _____

Credit Card Type: _____ Number: _____

Expiration: _____ Security Code: _____

Thank you for your understanding. We appreciate your help in creating an efficient and enjoyable experience here at Long Island Spine Rehabilitation Medicine.