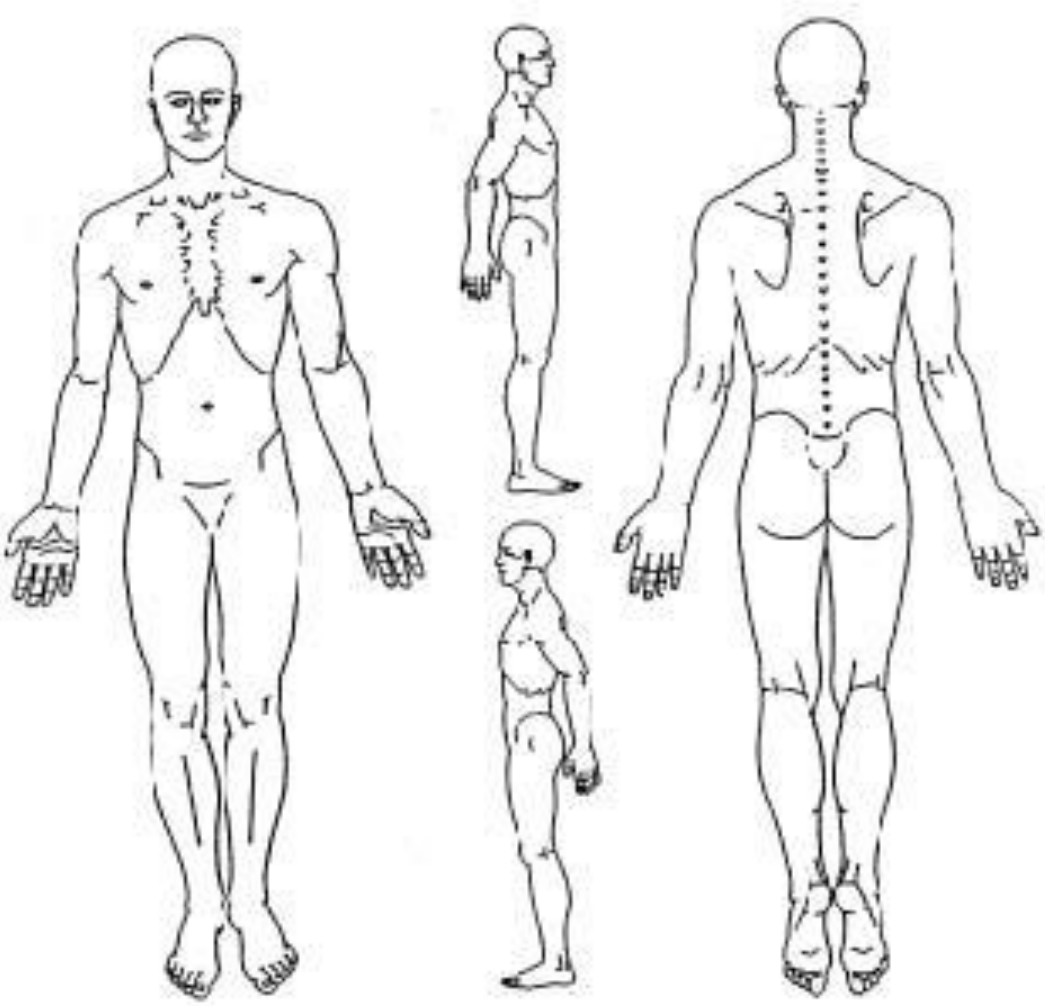
LONG ISLAND SPINE
REHABILITATION MEDICINE

NAME: _____ TODAY'S DATE: _____

PLEASE DRAW THE LOCATION OF YOUR SYMPTOMS BELOW
USE **XXXXX** FOR 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 your symptoms start (if known)? _____

What have you done for your symptoms (check all that apply):

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

☐ Medications: _____

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 average pain (check below: 1=least to 10=most):

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

Please list all current medications you are taking: _____

_____

Do you take Aspirin? ☐ Yes ☐ No

Please list all Medication Allergies: _____

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

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

Pleas list all of your Medical Conditions: _____

_____

Please list all past Surgeries (and approximate dates): _____

_____

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

Family Medical History: Is an **immediate family member** affected by any of these conditions?

☐ Diabetes ☐ Cancer ☐ Heart disease ☐ Kidney Disorder ☐ Lung disorder

☐ Other: _____

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: _____

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

Any difficulties with substance abuse (specify)? _____

Any history of: ☐ Car Accident ☐ Work injury **Date of injury**:_____

If yes, is the case open? ☐ Yes ☐ No

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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www.lispinemed.com

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 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.

I ALSO AUTHORIZE AND GUARANTEE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICES RENDERED. PAYMENTS INCLUDE DEDUCTIBLES, CO-PAYMENTS AND/OR CO-INSURANCE AMOUNTS OR ANY OTHER PATIENT RESPONSIBILITY DETERMINED BY MY INSURANCE CARRIER. I UNDERSTAND THAT PAYMENT IS MY OBLIGATION REGARDLESS OF INSURANCE OR OTHER THIRD PARTY INVOLVEMENT.

Patient Signature: _____ Date: _____

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Miranda B. Smith, M.D. Thomas P. Lione, D.O.

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: _____

<u>For Acupuncture & Complementary Medicine Appointments Only:</u>

- 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.

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 IT CAREFULLY.

Uses and Disclosures

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

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services 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 **Long Island Spine Rehabilitation Medicine**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information will be used to send you information on the treatment and management of your medical condition that you may find interesting. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the 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 amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Long Island Spine Rehabilitation Medicine Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit.

The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access to your records by contacting **[Privacy Official].** Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

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

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

The name and address of the person you may contact for further information concerning our privacy practice is:

Long Island Spine Rehabilitation Medicine
801 Merrick Avenue
East Meadow, New York 11554
(516) 393-8941

This notice is effective on or after 12/2006

In February, 2014, the Department of Health and Human Services (HHS) posted to its website new models of the notice of privacy practices in an effort to make the Notice of Privacy Practices (NPP) less cumbersome, and to improve patient's experience and understanding of their rights and how their PHI is managed. These notices are written in clear, user-friendly language and reflect the recent regulatory changes to HIPAA. There are two sets of notices available, one specific for health plans and one for health care providers. These are available to all covered entities and may be customized with an organization's specific information.

Each sample is provided in English and Spanish with three formatted options (booklet, layered, full page) and one text-only option. For detailed instructions on how to customize these "plain" language NPPs, go to the HHS website at http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html.