New York BRAIN SPINE & JOINT

nybsj.com | (631) 600-9400

Patient Demographics

Today's Date: _____

Patient Name (Last): _____ (First): _____(Middle)_____

Date of Birth: _____ Age: _____ SSN: _____-_____-_____ ☐ Male ☐Female

Race/Ethnicity: _____ Preferred language: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different): _____ City: _____State: _____ Zip: _____

Home Phone: (_____) _____ ☐ Ok to leave message Cell Phone: (_____) _____ ☐ Ok to leave message

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Employer/Company Name: _____ Employer/Company Address: _____

Occupation: _____

Emergency Contact Name: _____ Phone: (_____) _____

Relationship to patient: _____ Language: _____

How did you hear about us? _____

Responsible Party Information (if the patient is a minor)

Parent or Legal Guardian Name: _____ SSN: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____ Relationship to Patient _____

Address (if different from patient):
_____

City: _____ State: _____ Zip: _____

New York BRAIN SPINE & JOINT

*MANDATORY

nybsj.com | (631) 600-9400

Insurance Information

Is this a **Worker's Compensation** or **No-Fault** claim? _____ No ____ Yes (if yes go to the corresponding section).

Primary Insurance: _____ Phone: (_____) _____

Policy Holder's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance: _____ Phone: (_____) _____

Policy Holder's Name: _____ Date of Birth: _____

Policy #: _____ Group #: _____ Effective Date: _____

Worker's Compensation

If yes, what is your WCB claim number? _____ Date(s) of Injury: _____

Carrier: _____

Carrier case _____ Adjuster Name: _____

Phone: _____ Fax: _____

Claims submission address: _____

No-Fault

If yes, what is your claim number? _____ Date(s) of loss/Injury: _____

Policy number_____ Carrier: _____

Adjuster name: _____ Phone: _____

Claims submission address_____

Are you represented by an attorney for this visit? _____ Yes _____ No If yes, name of firm_____

Attorney phone: _____ Attorney name: _____

Referring Physician

Name: _____ Phone: (_____) _____ Fax: (_____) _____

Primary Care

Name: _____ Phone: (_____) _____ Fax: (_____) _____

I certify that the above information is true and correct to the best of my knowledge.
As the responsible party, I agree that unless otherwise stated, any amount not covered by my insurance will be my responsibility.

Patient Signature: _____ Date: _____

nybsj.com | (631) 600-9400

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ / _____ / _____

Height: ____ ft _____ in Weight: _____ lbs

Smoking Status: ☐ Never ☐ Former ☐ Current Everyday ☐ Current Some Days ☐ Unknown

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No If yes, what is the manufacturer? _____

Do you have any other implanted medical devices? ☐ Yes ☐ No If yes, please list: _____

Do you have any allergies? ☐ Yes ☐ No If yes, list allergies and reactions: _____

REVIEW OF SYSTEMS (ROS)

(Please check all that apply. If none, indicate "None" or "Negative")

CONSTITUTIONAL: ☐ Fever ☐ Chills ☐ Weight loss ☐ Fatigue ☐ Night sweats ☐ Malaise ☐ Weakness ☐ None

HEENT: ☐ Headache ☐ Vision changes ☐ Double vision ☐ Hearing loss ☐ Tinnitus ☐ Nasal congestion ☐ Sore throat ☐ None

RESPIRATORY: ☐ Shortness of breath ☐ Cough ☐ Wheezing ☐ Chest tightness ☐ Sleep apnea ☐ None

CARDIOVASCULAR: ☐ Chest pain ☐ Palpitations ☐ Leg swelling ☐ Hypertension ☐ Orthopnea ☐ None

GASTROINTESTINAL: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Acid reflux ☐ Abdominal pain ☐ None

GENITOURINARY: ☐ Urinary frequency ☐ Urgency ☐ Incontinence ☐ Painful urination ☐ Erectile dysfunction ☐ None

MUSCULOSKELETAL: ☐ Joint pain ☐ Muscle aches ☐ Stiffness ☐ Back pain ☐ Neck pain ☐ Swelling ☐ None

NEUROLOGICAL: ☐ Numbness ☐ Tingling ☐ Weakness ☐ Dizziness ☐ Seizures ☐ Memory loss ☐ Balance issues ☐ Headaches ☐ None

PSYCHIATRIC: ☐ Depression ☐ Anxiety ☐ Mood swings ☐ Sleep disturbances ☐ Suicidal ideation ☐ None

ENDOCRINE: ☐ Excessive thirst ☐ Frequent urination ☐ Heat intolerance ☐ Cold intolerance ☐ Weight changes ☐ None

HEMATOLOGIC/LYMPHATIC: ☐ Easy bruising ☐ Bleeding tendency ☐ Swollen lymph nodes ☐ Anemia ☐ None

New York BRAIN SPINE & JOINT
nybsj.com | (631) 600-9400

Authorization Disclosure of Protected Information

Patient Name: _____ DOB: _____/_____/_____

I hereby authorize the above-named medical practice to use, disclose, or obtain the following protected information:

- **All Medical Records**
- **Specific Medical Records – specify**_____
- **Medical Imaging (CD) – specify**_____
- **Other - specify**_____

These records may be obtained from:

Please Mail/Fax or Email to New York Brain Spine & Joint

- **1175 Montauk Highway Suite 3, West Islip, NY 11795**
- **Fax: 631-500-9444**
- **Email: medicalrecords@mneurosurgery.com**

- **Right to Revoke:** You have the right to revoke this Authorization in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.
- **HIPAA Compliance:** The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- **Redisclosure:** I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- **Voluntary Signing:** I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- **Copies:** I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Expiration: This authorization will remain in effect for **one year** from the date of signature unless otherwise specified here:

_____ (Date or Event).

Signature: _____ Print: _____ Date_____

nybsj.com | (631) 600-9400

Consent for Treatment

1. CONSENT FOR CARE AND TREATMENT

I hereby voluntarily consent to receive medical care, treatment, and services deemed necessary or advisable by the physicians, nurse practitioners, physician assistants, nurses, and other healthcare professionals affiliated with New York Brain, Spine & Joint. This may include, but is not limited to:

- Laboratory testing and imaging studies
- Administration of medications
- Minor medical procedures

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of treatments or examinations.

2. ACKNOWLEDGEMENT OF RISKS

I understand that all medical treatments and procedures may involve risks, including but not limited to adverse reactions, complications, or unforeseen outcomes. I have the right to ask questions and receive additional information regarding any proposed treatment.

3. FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all services rendered, whether or not they are covered by my insurance. I authorize New York Brain, Spine & Joint to release information necessary to process insurance claims and request payment directly from my insurance carrier where applicable.

4. HIPAA & PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been offered or received a copy of New York Brain, Spine & Joint's Notice of Privacy Practices, which explains how my medical information may be used and disclosed in accordance with state and federal law, including the Health Insurance Portability and Accountability Act (HIPAA)

5. CONSENT FOR COMMUNICATION

I consent to New York Brain, Spine & Joint contacting me via phone, voicemail, email, text message, or mail regarding appointments, test results, billing matters, and other healthcare-related communications, unless I provide written notice otherwise.

6. RIGHT TO REFUSE OR WITHDRAW

I understand that I have the right to refuse any treatment or procedure and may withdraw this consent at any time in writing, except to the extent that action has already been taken in reliance on this consent.

7. AUTHORIZATION

By signing below, I confirm that I have read and understand this consent form, have had the opportunity to ask questions, and agree to the terms outlined above.

Patient/Legal Guardian Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____ Date: _____

CREDIT CARD AUTHORIZATION & FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Guarantor/Responsible Party (if different): _____

Financial Responsibility Acknowledgment

____ I understand that I am financially responsible for any charges incurred for medical services provided by New York Brain, Spine & Joint/Link Medical Services PLLC that are not paid by my insurance carrier or other third-party payer.

____ I authorize New York Brain, Spine & Joint/Link Medical Services PLLC to charge the credit/debit card listed below for patient financial responsibility, including but not limited to:

- Co-payments
- Deductibles
- Coinsurance amounts
- Non-covered or excluded services
- Denied insurance claims determined to be patient responsibility
- Balances remaining after insurance processing
- Missed appointment (“No-Show”) fees
- Late cancellation fees
- Surgery cancellation fees in accordance with clinic policy
- Other patient-authorized charges related to services rendered

____ I understand that New York Brain, Spine & Joint/Link Medical Services PLLC will submit claims to my insurance carrier as a courtesy when applicable. I remain ultimately responsible for all charges deemed my responsibility after insurance adjudication.

____ I understand that late payment may result in collection review, and I will be responsible for any related collection or legal fees. Charges for the visit and related procedures will be collected at the time of service based on the best information available to the practice.

Co-payments are collected at the time of service when they can be anticipated. All returned checks will incur a $50.00 service fee in addition to any fees assessed by our banking institution.

Accounts with unresolved balances may be subject to collection efforts consistent with applicable law. The patient may be responsible for reasonable costs of collection where permitted by law.

Insurance Authorization Responsibility

I understand that certain insurance plans require referrals, prior authorizations, or approvals for services.

While the practice may assist when possible, obtaining required authorizations remains my responsibility unless otherwise agreed in writing. If authorization is denied, unavailable, or benefits are not available, I understand I may be financially responsible for services rendered.

Authorization for Card on File

____ I authorize New York Brain, Spine & Joint/Link Medical Services PLLC to securely maintain my credit/debit card information on file and process charges related to my account for amounts I am responsible to pay.

Whenever reasonably practical, the practice may provide notice prior to processing non-routine charges; however, failure to provide advance notice shall not invalidate this authorization for amounts properly owed.

If a charge cannot be processed, I understand I remain responsible for payment and may be billed directly.

This authorization shall remain in effect until revoked in writing by me. I understand that revocation does not relieve me of financial responsibility for charges incurred before the revocation date.

Credit / Debit Card Information

Cardholder Name (as shown on card):

Billing Address:

Card Type:
☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX ☐ Other _____

Card Number:

Expiration Date (MM/YY): _____

CVV/Security Code: _____

Billing ZIP Code: _____

Acknowledgment

By signing below, I acknowledge that:

1. I have read and understand this authorization.

2. I accept financial responsibility for charges not paid by insurance or otherwise owed under clinic policy.
3. I authorize New York Brain, Spine & Joint/Link Medical Services PLLC to process payment using the card listed above for authorized charges.
4. I acknowledge receipt of the practice's Appointment, No-Show, and Surgery Cancellation Policy.

Patient / Responsible Party Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

ACKNOWLEDGMENT OF RECEIPT / ACCESS TO OFFICE POLICIES & DISCLOSURES

Patient Name: _____

Date of Birth: _____

I acknowledge that I have been provided with access to, or offered the opportunity to review, the following documents and disclosures maintained by this practice:

- **Notice of Privacy Practices (NPP)**
- **No-Show / Cancellation Policy**
- **Physician/Provider Self-Referral Disclosure (PHL §18 / Self-Referral Notice, if applicable)**

I understand that these documents describe important information regarding privacy practices, office policies, patient rights, scheduling expectations, and provider disclosures. I understand that I may request a copy of these documents at any time and may ask questions regarding their contents.

By signing below, I acknowledge receipt of, or access to, these materials and understand that it is my responsibility to review them.

Patient/Legal Representative Signature: _____

Printed Name: _____

Relationship to Patient (if applicable):

☐ Self ☐ Parent ☐ Guardian ☐ Other (specify): _____

Date: _____