NEW PATIENT REGISTRATION FORM

DATE	APPOINTMENT WITH	MR #

PATIENT INFORMATION

PATIENT'S LAST NAME/Apellido Del Paciente	FIRST NAME/Primer Nombre	DOB	AGE/Edad	SOCIAL SECURITY #

STREET ADDRESS/Direccion	APT. #	CITY/Ciudad	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE) M F

HOME PHONE NO /Telephono	WORK PHONE NO	MARITAL ST/ S M W D SP	SPOUSE'S NAME	SPOUSE'S WORK NO EXT
( )	( )			( )

PATIENT EMPLOYER/Patron Del Paciente'	F/T STUDENT Y N	ALLERGIES

EMPLOYER'S ADDRESS/Direccion Del Patron	CITY/Ciudad	STATE/Estado	ZIP CODE

EMERGENCY CONTACT PERSON/Contacto De Emergencia	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO	CONTACT'S WORK PHONE EXT
		( )	( )

REFERRING MD NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO
					( )

PRIMARY DOCTOR NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO
					( )

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY	DOB	HOME PHONE NO
					( )

GUARANTOR'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE) M F

GUARANTOR'S EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE NO
					( )

INSURANCE INFORMATION

MEDICARE	EFF. DATE	MEDICAID #	EFF. DATE

PRIMARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #	CERTIFICATE #

ADDRESS	CITY	ZIP CODE	STATE	ZIP CODE	PHONE NO
					( )

NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB	SEX/Sexo (CIRCLE ONE) M F

INSURED'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	HOME PHONE NO
						( )

INSURED'S EMPLOYER	WORK PHONE NO
	( )

SECONDARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #	CERTIFICATE #

ADDRESS	CITY	ZIP CODE	STATE	ZIP CODE	PHONE NO
					( )

NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB	SEX/Sexo (CIRCLE ONE) M F

INSURED'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	HOME PHONE NO.
						( )

INSURED'S EMPLOYER	WORK PHONE NO.
	( )

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to Shuriz Hishmeh, MD any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature of Patient/Legal Guardian: _____ Date: _____

MEDICAL INFORMATION FORM

Date of Initial Visit: _____/_____/_____

Last Name _____ **First Name** _____

Age: _____ **Date of Birth** _____/_____/_____ **Sex:** _____ **Weight:** _____ **Height:** _____

Phone: Home_____ **Work** _____ **Mobile**_____

Email:_____

Who referred you to the Spine Institute?

_____ _____

Referring Physician Name **Referring Physician Telephone #**

_____

Referring Physician Address **City** **State** **Zip Code**

Please describe your main problem/complaint. _____

_____

_____

_____

PLEASE PUT AN "X" NEXT TO THE BEST ANSWER FOR EACH QUESTION

SOCIAL HISTORY

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

Highest Education Level Completed:

☐ (0, 1 2 3 4 5 6 7 8) Grade school ☐ (9 10 11 12) High school

☐ (13 14 15 16) College, Technical ☐ (> 16 YEARS) Graduate, Professional

Do you currently use Tobacco? ☐ Yes ☐ No **Started Age/Yr.**_____ **Stopped Age/Yr.**_____

Indicate quantity per day: **Cigarettes**_____ **Cigars**_____ **Chewing Tobacco**_____

Do you currently consume Alcohol? ☐ Yes ☐ No

Indicate quantity per day: **Beer**_____ **Wine**_____ **Distilled Spirits**_____

WORK STATUS

Occupation _____

Are you currently?

☐ Working Full time ☐ Working Part time

☐ Unemployed ☐ Retired

☐ Disabled, Temporarily ☐ Disabled, Permanently

☐ Housewife ☐ Other _____

If you are currently NOT working:

How long have you been off work due to your back/neck pain? _____

PAST MEDICAL HISTORY - Check below if you have had any of the following:

- ☐ Heart Disease
- ☐ Asthma
- ☐ Migraine Headaches
- ☐ Emotional Disorder
- ☐ OTHER _____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Hepatitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ HIV
- ☐ NONE

Current Medications (include Non-Prescription): _____

_____

Medicine / Substance Allergies (include Reaction): _____

_____

CURRENT MEDICAL CONDITION:

Do you have:

- ☐ Only back pain
- ☐ Back and leg pain
- ☐ Only shoulder pain/arm pain
- ☐ Only leg pain
- ☐ Only neck pain
- ☐ Neck, shoulder and arm pain
- ☐ Other _____

Which is worse:

- ☐ Back pain
- ☐ Neck pain
- ☐ Leg pain
- ☐ Shoulder/arm pain

I have had back/neck pain:

- ☐ Less than 1 month
- ☐ 3 - 6 Months
- ☐ 1 - 3 Years
- ☐ Greater than 5 years
- ☐ 1 - 3 Months
- ☐ 6 Months - 1 Year
- ☐ 3 - 5 Years

My pain came on:

- ☐ Gradually, over time
- ☐ Quickly

My pain was brought on by:

- ☐ No specific incident
- ☐ Following an accident or incident at work
- ☐ Following an accident or incident NOT at work

Describe the accident/incident: _____

_____

Do you have:

- ☐ NUMBNESS Where _____
- ☐ TINGLING Where _____
- ☐ WEAKNESS Where _____

What time of the day is your pain worse: ☐ Morning ☐ Late in the day ☐ The middle of the night

My pain pattern is:

- ☐ A Single attack of pain
- ☐ Continuous pain
- ☐ Attacks of pain with pain free intervals
- ☐ Continuos pain with attacks of severe pain

I experience pain:

- ☐ The entire day
- ☐ Most of the day (16-20 HOURS)
- ☐ A Good part of the day (8-15 HOURS)
- ☐ A Fair amount of the day (2-7 HOURS)
- ☐ A Small amount of the day (1 HOUR OR LESS)
- ☐ Less than once per day

How long does a pain attack last: ☐ Seconds ☐ Minutes ☐ Hours ☐ Constant

For how long can you walk: ☐ Less than 15 minutes ☐ 15 - 30 Minutes ☐ 30 - 60 Minutes ☐ NO Restrictions

How long can you sit: ☐ Less than 15 minutes ☐ 15 - 30 Minutes ☐ 30 - 60 Minutes ☐ NO Restrictions

How long can you stand: ☐ Less than 15 minutes ☐ 15 - 30 Minutes ☐ 30 - 60 Minutes ☐ NO Restrictions

What position/activity make the pain worse or better?

	Better	Worse	Comments		Better	Worse	Comments
Standing				Bending			
Sitting				Lifting			
Walking				Coughing			
Stairs				General Activity			
Lying Down				Bowel Movement			

Pain Rating Scale: **How would you rate your pain today: (Circle One Number)**

No Pain 0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*
None Mild Moderate Severe

Where have you sought help for your pain: (Check all that apply)

☐ Family Doctor ☐ Orthopedic Doctor ☐ Spine Surgeon ☐ Physical Therapist ☐ Neurologist ☐ Psychiatrist / Psychologist ☐ Physiatrist ☐ Chiropractor ☐ Pain Clinic ☐ OTHER _____

Have any of the above decreased your pain: ☐ NO ☐ YES **Specify**_____

My pain now seems to be: ☐ Getting better ☐ Staying the same ☐ Getting worse

Have you noticed any change in your bowel or bladder habits:

☐ NO ☐ YES **Describe:** _____

Have you had previous Surgery:

☐ YES **WHEN:** ____/____/____ **TYPE:** _____

☐ NO **WHEN:** ____/____/____ **TYPE:** _____

WHEN: ____/____/____ **TYPE:** _____

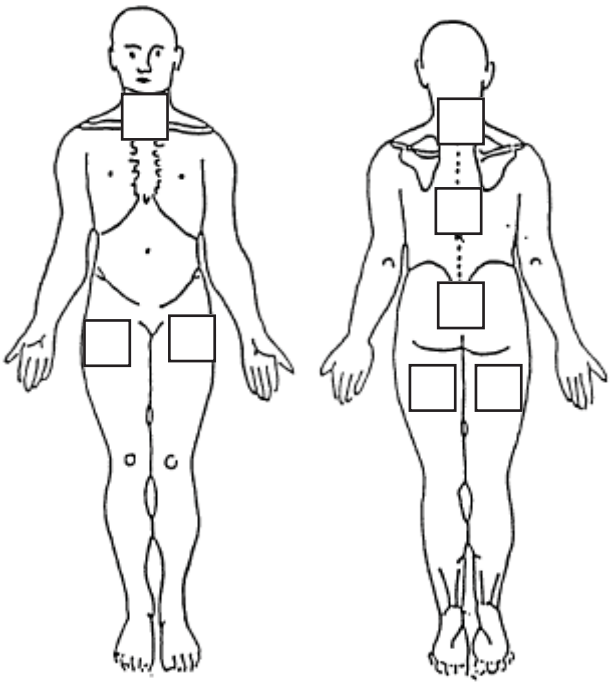
If you had previous spine surgery, did the surgery make the pain better: ☐ YES ☐ NO

Have you, or are you planning to apply for disability or workmen's compensation: ☐ YES ☐ NO

Is there a lawsuit or litigation pending in relationship to your pain? ☐ YES ☐ NO

- - FOR OFFICE USE ONLY - -

Patient/Family Education Record:
Learner: π Patient π Family π Other _____ **Learning Needs:** πTreatments π Medications π Disease Process π Pain π Other _____
Barriers: π None π Physical π Language π Cultural/Religious π Financial π Cognitive π Psychosocial
Methods: πDiscussion π Demonstration π Handout π Other _____ **Follow Up Plan:** π Review π Other _____
Comprehension: πVerbalized Understanding πReturn Demonstration π Other _____ **Signature:** _____



PAIN DIAGRAM:
Please use the following diagrams to show us where you are experiencing pain and numbness:

Pain: x x x x x x
Numbness: o o o o o o o
Aching: / / / / / /

Please circle all of the following adjectives which describe your pain:

DULL BURNING
COLD SHOOTING
TIGHT THROBBING
ELECTRIC TINGLING
OTHER_____

Patients with Scoliosis or Kyphosis, please complete the next section.

SCOLIOSIS / KYPHOSIS SECTION

Year deformity was first noticed: _____

Your age at the time deformity was first noticed: _____

Family history of Scoliosis/ Kyphosis:
None **Parent**
Brother/ Sister **Cousin**
Other _____

Previous non-operative treatment:
None **Exercise**
Brace **Observation only**
Other _____

First operative event: _____/_____/_____ **Second operative event:** _____/_____/_____

Current concerns:
None **Feel imbalance**
New or increased back pain **Painful rod**
Unhappy with my appearance

If you have back pain, then where: **Upper back** **Mid back** **Lower back**

Do you feel that your curves have increased or decreased over time: **Yes** **No**
Do you feel you have lost height in the last few years: **Yes** **No**

***** END OF QUESTIONNAIRE *****

No-Fault Intake Form

☐ I require translation assistance
☐ J'ai besoin de l'aide de traduction
☐ Я нуждаюсь в помощи переводчика
☐ Requiero ayuda de la traduccion

Translator Information

Date of translation: _____
Print Name: _____
Signature: _____

Date of Accident _____

Accident State _____

INSURANCE

INSURANCE NAME			
INSURANCE ADDRESS	CITY	STATE	ZIP
POLICY NUMBER	**CLAIM NUMBER**	**POLICY HOLDER**	
CLAIM ADJUSTER NAME	INSURANCE PHONE NUMBER		

PATIENT

LAST NAME	FIRST NAME	MIDDLE NAME		
ADDRESS	SEX	DATE OF BIRTH	SOCIAL SECURITY #	
CITY	STATE	ZIP CODE	PHONE NUMBER	ALT.PHONE NUMBER
REFERRING PROVIDER	ADDRESS	PHONE NUMBER		

Description of Accident:

Date of Symptoms First Appeared: _____

Date of First Consultation: _____

Do you have a history of same or similar condition? ☐ YES ☐ NO ☐ DON'T KNOW
If YES , state when and describe:
Patient MUST initial

Is Condition Solely a Result Of This Auto Accident? ☐ YES ☐ NO ☐ DON'T KNOW
If NO , please explain:
Patient MUST initial

Is Condition Due To Injury Arising Out Of Patient's Employment? ☐ YES ☐ NO ☐ DON'T KNOW
If YES , please explain:
Patient MUST initial

Will Injury Result in Disfigurement or Disability? ☐ YES ☐ NO ☐ DON'T KNOW
If YES ,please describe:
Patient MUST initial

Did you miss any IME (Independent Medical Examination)? ☐ YES ☐ NO
If YES ,please provide date(s):
Patient MUST initial

_____ _____
Patient Signature Date

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor")** hereby assign to
(Print patient's name)

_____**, ("Assignee")**
(Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement to the contrary.
(Date of Accident)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) **(Signature of Provider)**

_____ _____
(Date of signature)

_____
(Address of Provider)

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

PATIENT NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:
PATIENT ADDRESS:		

PROVIDER NAME AND ADDRESS:

I hereby authorize the Healthcare Provider indicated above to furnish copies of all information they have regarding my condition while under their observation or treatment, including the history obtained, diagnostic tests and images such as x-rays and MRIs and physical findings, diagnosis and prognosis. The Healthcare Provider indicated above is authorized to provide this information in accordance with the New York Comprehensive Motor Vehicle Insurance Reparations Act (No-Fault Law).

Patient or Guardian Signature: _____

Relationship, if patient is a minor: _____

Date: _____

MEDICAL LIEN

To Attorney: _____
_____
_____

RE: Reports and Lien for: _____
(Patient Name)
Date of Accident: _____

I do hereby authorize the above doctor/medical facility to furnish, you, my attorney, with a full report, diagnosis, treatment plan, prognosis, etc. for myself in regard to the accident in which I was involved.

I hereby authorize and direct, you, my attorney, to pay directly to said doctor/medical facility such sums as may be due and owing said doctor/medical facility for medical services rendered to me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility. I further give a lien on my case to said doctor/medical facility against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or to myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor/medical facility for all medical bills submitted by said doctor/medical facility for services rendered to me and that this agreement is made solely for said doctor/medical facility's additional protection and in consideration of said doctor/medical facility awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover said fee.

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date: _____ Patient's Signature: _____
(Guardian Signature if Patient is a Minor)

The undersigned, being the attorney of record for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility above named.

Date: _____ Attorney's Signature: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

I hereby give my consent for Shuriz Hishmeh, MD, PLLC to use and disclose protected health information ("*PHI*"), as that term is defined by the Health Insurance Portability and Accountability Act ("*HIPAA*"), about me to carry out treatment, payment and healthcare operations ("*TPO*") (Shuriz Hishmeh, MD, PLLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Shuriz Hishmeh, MD, PLLC reserves the right to revise its Notice of Privacy Practices at any time without prior notice to you. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Shuriz Hishmeh, MD, PLLC at 175 Jericho Turnpike, Suite 120, Syosset, New York 11791.

With this consent, Shuriz Hishmeh, MD, PLLC may call my home, cell phone, or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. Calls may be made by a live person or automated system.

With this consent, Shuriz Hishmeh, MD, PLLC may mail to my home or ether alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Shuriz Hishmeh, MD, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Shuriz Hishmeh, MD, PLLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Shuriz Hishmeh, MD, PLLC 's use and disclosure of my PHI to carry out TPO. I may only revoke my consent in writing except however cannot restrict the practice's disclosures made in reliance of my prior consent. If I do not sign this consent, or later revoke it, Shuriz Hishmeh, MD, PLLC may decline to provide treatment to me.

_____ _____

(Print name of Patient) (Signature of Patient)

_____

(Date of signature)

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PATIENT FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION AND ASSIGNMENT FORM

You are responsible for all professional services rendered by Shuriz Hishmeh, MD, PLLC. If we do not accept your insurance plan, the necessary forms will be completed by our office to help expedite insurance carrier payments. However, as the patient, you are ultimately responsible for all of our fees. By signing this form, you hereby authorize the doctors at Shuriz Hishmeh, MD, PLLC, its agents, employees or assigns, including its billing company, to diagnose, treat and manage the medical condition(s) presented at the time of your visit and to furnish any information to the insurance carriers concerning your illness and treatments. You hereby assign all insurance payments to Shuriz Hishmeh, MD, PLLC for medical services rendered to you personally or to your dependents and understand that you are responsible for any amount that is not a covered service under my insurance.

I understand and agree that health and accident policies are a contract between the insurance carrier and me. I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

While it is customary to pay when services are rendered unless other arrangements have been made in advance with our office, as a courtesy to you, Shuriz Hishmeh, MD, PLLC will allow you to make payment for your treatment once checks have been issued by your insurance company are received by you. Please note that although the checks are for services that were rendered by Shuriz Hishmeh, MD, PLLC, payment from the insurance carrier may be issued in your name, or the name of the primary policy holder. Should that occur, all you need to do is bring the checks and accompanying paperwork to this office. Please direct family members or others who may have access to your mail not to deposit or cash the checks. By signing this form you agree to bring all payments from your insurance company received for services/treatment rendered by Shuriz Hishmeh, MD, PLLC to our office.

If we are required to refer your account to a collection agency for any reason, your account balance will be charged a fee of twenty-five (25%) percent. In the event that your account is referred to an attorney, you will pay all legal fees and third-party expenses charged by the attorney.

I _____ affirm that I have read, understand and agree to the following the above policies of Shuriz Hishmeh, MD, PLLC.

Signature: _____ Date: _____