***Action Sports Medicine & Pain Management***


**1010 Sunrise Highway**
**Rockville Centre, NY 11570**
**(516) 678-0500**

**184 Old Country Road**
**Mineola, NY 11501**
**(516) 747-5042**

**131-04 Liberty Avenue**
**Richmond Hill, NY 11419**
**(718) 322-4145**


## PATIENT DEMOGRAPHICS

Date: ___/___/_____ Name: _____ _____ ___
Last First M.I.

SS# _____ Date of Birth ____/____/_____ Sex: M / F Marital Status: ____

Home Address: _____ Apt#: _____

_____ _____ _____
City State Zip
Cell #: _____ Home#: _____ Work #: _____

Email Address: _____

Referring Physician: _____ Specialty: _____
Address: _____ Telephone: _____

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**Primary Care Physician:** _____ **Tel:**_____

**Address:**_____

**Primary Insurance Information**

Policy Holder Name _____ Date of Birth ___/___/___ SS#_____
Insurance Name _____
Policy # _____ Group # _____
Relationship to Policyholder: Self_____Spouse_____Child_____Other_____
Employer Name _____
Address _____ City _____ State _____ Zip _____
**Referral Required from PCP** □ Yes □ No

**Authorization Required** □ Yes □ No □ Unsure

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**Secondary Insurance Information**
Policy Holder Name _____ Date of Birth ___/___/___ SS#_____
Insurance Name _____
Policy # _____ Group # _____
Relationship to Policyholder: Self_____Spouse_____Child_____Other_____
Employer Name _____
Address _____ City _____ State _____ Zip _____

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Name of Emergency Contact _____ Phone _____

Relationship _____ Not living with you _____

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Patient authorizes ASMR to release medical information which includes patient diagnosis, planned treatment, medical history and release of medical records to the following persons:

_____ _____ _____
Name Phone # Relationship

_____ _____
Patient Signature Date

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**Thank you for choosing our practice. Please tell us how you learned about our practice or whom can we thank?**

Your Name _____

☐ Referred by a friend Name _____

☐ Referred by a Doctor Name _____
City _____

☐ Outdoor Sign

☐ Yellow Pages

☐ Internet

☐ Website

☐ TV Commercial

☐ Insurance Company

☐ Insert in ***Shopper's Guide***

Newspaper Ad:

- ☐ ***Garden City Life***
- ☐ ***Rockville Centre Herald***
- ☐ ***Baldwin Herald***
- ☐ ***Mineola American***
  ***New Hyde Park Illustrated News***
- ☐ ***Hempstead Beacon***
- ☐ ***Other_____***

☐ Article in Newspaper, Newspaper name _____

PAIN HISTORY FORM

PATIENT'S NAME _____

ACCOUNT NUMBER _____

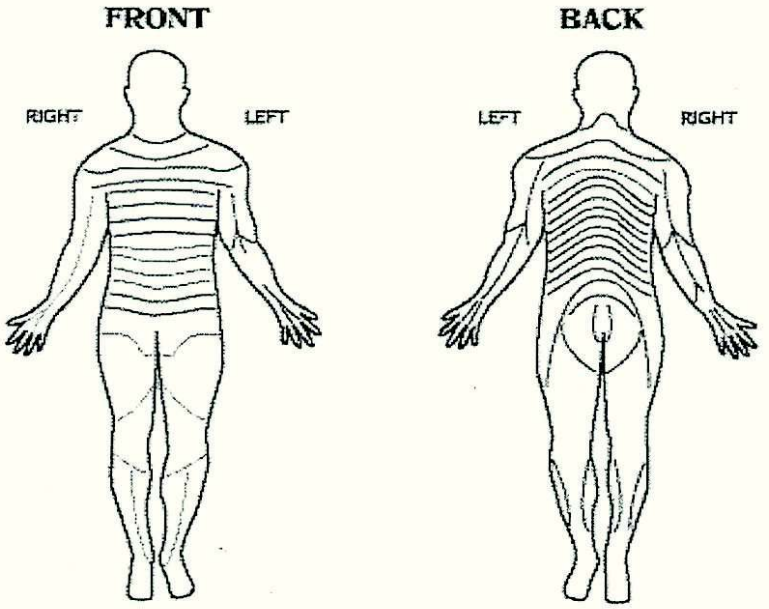
How and when did your pain begin? _____

Have you had any previous episodes of back/leg, arm/neck, or other pain?

o NO o YES - Describe _____

_____

Please shade areas of the body where you have pain:




HT: _____

WT: _____

Do you have any numbness, tingling, or burning in the leg/foot or arm/hand?

o NO o YES - Describe _____

_____

Have you experienced any weakness in the leg/foot or arm/hand?

o NO o YES - Describe _____

_____

What seems to aggravate your symptoms? _____

_____

How far are you able to walk? _____

Are you able to drive a car? o YES o NO

Are you able to put on your shoes and socks? o YES o NO

Does coughing, straining, or sneezing bother you? o YES o NO

Which position is the WORST? o SITTING o STANDING o LYING DOWN

PATIENT'S NAME _____

ACCOUNT NUMBER _____

**When is the pain WORSE?** o MORNING o NIGHT o VARIES

**Please indicate if you are:** o RIGHT HANDED o LEFT HANDED

**Have you had any TESTS for your current problems?** _____

o NO o YES - **When and what area of the body?** _____

CT SCAN _____ MYELO _____ DISCOGRAM _____

X-RAYS _____ EMG _____ OTHER _____

MRI _____ BONE SCAN _____ OTHER _____

**Your current:** Height _____ Weight _____

**What treatments have you had for your current problems?** Indicate what type of response you had to the treat-

| | NO Relief | SOME Relief | GOOD Relief |
|---|---|---|---|
| Bed Rest | | | |
| Physical Therapy | | | |
| Traction | | | |
| TENS Unit | | | |
| Spinal or Muscle Injection | | | |
| Chiropractic Treatment | | | |
| Soft Collar | | | |
| Lumbar Corset or Brace | | | |
| Application of o HEAT o ICE | | | |
| Medications (for Back or Neck) | | | |

**Please list the names of previous pain Physicians/Clinics you have seen:** _____

_____

_____

_____ o None seen in the past.

PATIENT'S NAME _____

ACCOUNT NUMBER _____

## MEDICAL CONDITIONS

| Have you, or your family ever had any of the following problems? | SELF | FATHER | MOTHER | SIBLINGS |
|---|---|---|---|---|
| Arthritis | | | | |
| Asthma | | | | |
| Bleeding Problems | | | | |
| Cancer (note type) | | | | |
| Colitis | | | | |
| Diabetes | | | | |
| Difficulty in Urinating | | | | |
| Emphysema | | | | |
| Glaucoma | | | | |
| Gout | | | | |
| Heart Attack | | | | |
| Heart Disease | | | | |
| Hepatitis | | | | |
| High Blood Pressure | | | | |
| HIV | | | | |
| Kidney, Bladder, Prostate problems | | | | |
| Lung Disease | | | | |
| Osteoporosis | | | | |
| Parkinson's Disease | | | | |
| Rheumatoid Arthritis | | | | |
| Seizures | | | | |
| Sickle Cell Anemia | | | | |
| Sleep Apnea | | | | |
| Thyroid Disorder | | | | |
| Ulcer | | | | |
| Other | | | | |

**Your current:** Height _____ Weight _____

## ALLERGIES

Please identify what you are allergic to and what type of reaction you have:

☐ MEDICATIONS _____ REACTION _____

☐ FOODS _____ REACTION _____

☐ IODINE (topical) _____ REACTION _____

☐ IODINE (injectable) _____ REACTION _____

☐ LATEX _____ REACTION _____

☐ ADHESIVES _____ REACTION _____

☐ OTHER _____ REACTION _____

☐ NO KNOWN ALLERGIES

PATIENT'S NAME _____

ACCOUNT NUMBER _____

MEDICATIONS I take the following medications:
(All prescriptions and over-the-counter, including aspirin and birth control pills):

_____ _____

_____ _____

_____ _____

_____ _____

**HERBAL SUPPLEMENTS** _____

OPERATIONS, TREATMENTS, HOSPITALIZATIONS
I have had the following Operations, Treatments and/or Hospitalizations:

_____ DATE _____

_____ DATE _____

_____ DATE _____

SOCIAL HISTORY

**Do you use any of the following assistive devices?** o GLASSES o CONTACTS o HEARING AIDES
o PROSTHETIC LIMBS o CANE o WALKER

**Smoking** (Complete if age 13 and greater)
o CURRENT SMOKER o FORMER SMOKER o NEVER SMOKED

**Current Smoker**

**How many cigarettes do you smoke per day?**
o 5 or less o 6-10 o 11-20 o 21-30 o 31 or more

**How soon after you wake up do you smoke your first cigarette?**
o Within 5 minutes o 6-30 min o 31-60 min o after 60 min

**Are you interested in quitting?**
o Ready to quit o Thinking about quitting o Not ready to quit

**Former smoker**

**How long has it been since you last smoked?**
o 1-3 months o < 1 month o 3-6 months o 6-12 months o 1-5 years o 5-10 years o > 10 years

**Do you use smokeless tobacco?** (Complete if age 13 and greater)
o NO If you quit smokeless tobacco, when did you quit? _____
o YES What do you use? _____ Number of years using smokeless tobacco? _____

**Do you drink alcoholic beverages?** o NO o YES—HOW OFTEN

o 1 DRINK PER MONTH o 1-2 DRINKS PER WEEK o 2-6 DRINKS PER WEEK o 6 DRINKS OR MORE PER WEEK

**Do you use recreational drugs?** o NO o YES (Please list) _____

**Evaluation for Falls.** (Complete if age 50 and greater)
o No falls, no injury?
o Fall in past year or fall with injury? How many? _____
o Screened for Osteoporosis (Bone Mineral Density Test, DEXA Scan)? When? _____

PATIENT'S NAME _____

ACCOUNT NUMBER _____

Are you currently pregnant? o NO o YES (Please list) _____

Are you planning a pregnancy? o NO o YES (Please list) _____

Have you experienced difficulty in sleeping due to your pain? o YES o NO

What type of mattress do you sleep on? o SOFT o MEDIUM o HARD o WATERBED

How many pillows do you use? _____

Have you lost weight because of your neck/back problems? o YES o NO

Have you suffered headaches in conjunction with your neck pains? o YES o NO
If yes, how often? _____

Do you have bowel or bladder problems? o YES o NO
If yes, what type? _____

Do you have any **UNUSUAL** visual problems? o YES o NO
If yes, what type? _____

Have you experienced any hearing loss? o RIGHT o LEFT o BOTH o NONE

Do you notice a buzzing/ringing in your ears? o RIGHT o LEFT o BOTH o NONE

Have you noticed any decrease in **TASTE** or **SMELL**? o YES o NO

What type of work do you do? _____

How long have you worked at your present job, or the job you last had? _____

If you have **NOT** been able to work because of your neck/back problem when was the FIRST DAY
of your disability? _____

What is the **MAIN** reason you are off work? _____

On a scale of 1-10 (1 being slight pain, 10 being severe pain) what number would you consider yourself?

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

Do you have any other problems or comments? _____

PATIENT'S NAME _____

ACCOUNT NUMBER _____

PLEASE PROVIDE:

Pharmacy Name: _____

Pharmacy Address: _____

Phone: _____ Fax: _____

Mail Order Pharmacy Name: _____

Mail Order Pharmacy Address: _____

Phone _____ Fax: _____

THE ABOVE LISTED INFORMATION IS CORRECT TO THE BEST OF MY ABILITY:

PATIENT SIGNATURE _____ DATE: _____

PHYSICIAN CO-SIGNATURE _____ DATE: _____

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## INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS

All co-payments are due to Action Sports Medicine & Pain Management at the time of service. Patient agrees to pay all deductibles, coinsurance, and services deemed patient responsibility as identified by the insurance carrier. Deductibles, coinsurance, and patient portions are billed monthly on receipt of the patients' insurance statement from the insurance carrier regarding your patient claim. **YOU**, the patient, are responsible to render payment once billed for the remainder. Patients are fully responsible for obtaining any necessary referral from another physician before the appointment time. Claim payments denied to lack of referral become the patient's responsibility. Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim. The insurance carrier makes final determination, based upon the plans level of coverage and associated policies, upon receiving the claim. Denied claims become the responsibility of the patient.

**I have read the above information and agree to the terms contained therein ____ Initial**

Patient's Signature _____

Patient's PRINTED Name _____

Social Security # _____

Date: _____

## SELF PAY PATIENT FINANCIAL LIABILITY FORM

Please understand that full payment of your account/bill is paid directly to Action Sports Medicine & Pain Management and considered part of your treatment and is required for all services rendered. Also, understand that payment of past services rendered and treatment given is required before all future services and treatment may be made. We expect full payments at the time services are rendered. This office accepts Visa, Mastercard, or cash with a valid photo ID. Extended payment plans may be offered with PRIOR credit approval and PRIOR patient request. All unpaid accounts are sent to collection after payment is not made in a reasonable time period and may adversely affect your credit. Non-emergent medical services can be denied for unpaid accounts.

**I have read the above information and agree to the terms contained therein ____ Initial**

Patient's Signature _____

Patient's PRINTED Name _____

Social Security # _____

Date: _____

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# INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Action Sports Medicine & Pain Management to furnish any and all records pertaining to medical history, services rendered or treatment given to me or my dependents to my insurance carriers when necessary for the processing of insurance claims.

I hereby assign to Action Sports Medicine & Pain Management all payments for medical services rendered to myself or my dependents. I understand that I am responsible for securing referrals from primary care physician and authorization from my insurance carriers when required for treatment. I further understand that payment due is not contingent on any settlement, judgment on any settlement or verdict by which I may eventually recover said fees.

_____ _____

Patient Signature Date

_____

Name of Patient

If signed by other than patient, print below:

Name and Address: _____

Relationship to the Patient:_____

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# HIPAA 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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to Object unless required by law.

You may revoke this authorization, at any time, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contract of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objection to this form, please as to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Patient Name: _____ Patient Signature: _____

Date: _____

☐ I authorize the doctor and staff members to leave messages on my home/cell/work answering machine for such purposes as: appointments and billing questions.

☐ I prefer to be reached at the following phone number _____, instead of my home phone number.

☐ I authorize the doctor and staff members to discuss my protected health information with the following people:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____