NEW YORK SPINE INSTITUTE
Medical solutions for spine disorders

ALEXANDRE B. DEMOURA, MD PC
PATIENT DEMOGRAPHIC

NAME: _____ DATE____/____/____

ADDRESS: _____CITY: _____STATE: _____ ZIP: _____

PHONE: (HOME) _____(CELL) _____ (OTHER) _____

S.S.# _____SEX ___M / F___ D.O.B. _____AGE _____

ALLERGIES TO MEDICATION: _____

OTHER MEDICAL ISSUES: _____

IS THE PATIENT WORKING? YES / NO LIMITED DUTY: _____

DO YOU HAVE AN ATTORNEY? YES / NO

DID INJURY OCCUR AT: WORK: _____ CAR ACCIDENT: _____OTHER _____

HOW DID INJURY/ILLNESS OCCUR? _____

_____

_____

PLEASE INDICATE BELOW HOW YOU WERE REFERED TO OUR OFFICE:

DOCTOR: _____PHONE # (____) ____ - _____

ATTORNEY: _____PHONE # (____) ____ - _____

BY PATIENT: _____ INTERNET/MAGAZINE AD/OTHER _____

EMAIL ADDRESS: _____

HISTORY: PLEASE DESCRIBE YOUR PAIN AS BEST YOU CAN ON THE DRAWINGS BELOW:

LOCATION OF PAIN OR OTHER SYMPTOMS:

_____

_____

_____

ON A SCALE FROM 0-TO-10, HOW SEVERE IS THE PAIN, (10 BEING THE WORST)
1 2 3 4 5 6 7 8 9 10 _____

HOW OFTEN IS THE PAIN

_____

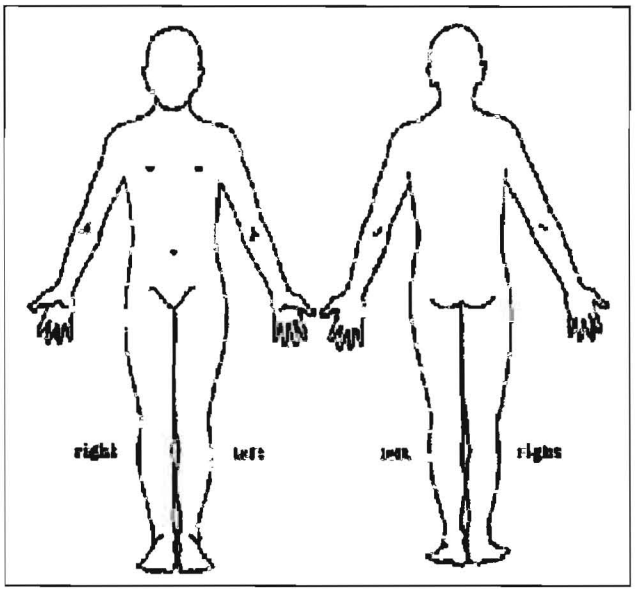
IS THE PAIN REFERRED TO ANOTHER PART OF YOUR BODY?

_____

SENSATION:

_____

PAIN DRAWING & SCALE REVIEW



HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHAT KIND OF NON-SURGICAL TREATMENT HAVE YOU HAD TO DATE? _____

_____

PHYSCIAL THERAPY? YES / NO , **IF YES HOW OFTEN?** _____

CHIROPRATIC CARE? YES / NO , **IF YES HOW OFTEN?** _____

ACCUPUNCTURE? YES / NO , **IF YES HOW OFTEN?** _____

MEDICATIONS? _____

NONE: _____

ANTI-INFLAMMATORY: _____ **WHICH?** _____

MUSCLE RELAXANTS: _____ **WHICH?** _____

PAIN KILLERS: _____ **WHICH?** _____

ANTI-DEPRESSANTS: _____ **WHICH?** _____

EPIDURAL STERIOD INJECTIONS: _____ YES / NO _____ **HOW MANY TIMES?** _____

Insurance Information

Commercial Insurance:

Primary Insurance			
Insurance Comp.	Insurance ID #	Policyholder Name	Date of Birth

Secondary Insurance			
Insurance Comp.	Insurance ID #	Policyholder Name	Date of Birth

No Fault Insurance:

Insurance Carrier	Date of Accident	NF Claim Number	Policy Number	Adjustor Name	Phone Number

Workers Compensation Insurance:

WCB Case #	Carrier Case #	Date of Injury	Nature of Injury/Illness	Insured Person's SSN	Workers Comp Code #

Insurance Carrier	NAME:	ADDRESS:
Employer	NAME:	ADDRESS:

I IRREVOCABLY ASSIGN TO ALEXANDRE B. DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE ALL MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY ANY MEDICAL SERVICES PROVIDER EMPLOYED BY ALEXANDRE B DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE. I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIMS BY ALEXANDRE B. DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE TO BE RELEASED TO ALEXANDRE B. DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE. I IRREVOCABLY AUTHORIZE ALEXANDRE B. DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO ALEXANDRE B. DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE. I IRREVOCABLY AUTHORIZE ALEXANDRE B. DE MOURA, MD, PC AND THE NEW YORK SPINE INSTITUTE TO ACT ON MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPRT CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION AND I UNDERSTAND ITS NATURE AND EFFECT.

Patient Signature_____ Date_____

Provider Name & Address: Alexandre B. de Moura, MD, PC and New York Spine Institute

761 Merrick Avenue Westbury, NY 11590

NEW YORK SPINE INSTITUTE
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I irrevocably assign to Alexandre B. deMoura, MD, PC and the New York Spine Institute all my rights and benefits under any insurance contracts for payment for services rendered to me by any medical service provider employed by Alexandre B. deMoura, MD,PC and the New York Spine Institute.

I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Alexandre B. deMoura, MD, PC and the New York Spine Institute to be released to Alexandre B. deMoura, MD, PC and the New York Spine Institute.

I irrevocably authorize Alexandre B. deMoura, MD, PC to file insurance claims on my behalf for services rendered to me.

I direct that all such payments go directly to Alexandre B. deMoura, MD, PC and the New York Spine Institute , I irrevocably authorize Alexandre B. deMoura, MD, PC and the New York Spine Institute to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Signature of Patient: _____ **Date:** ____/____/____

Signature of Parent or Guardian: _____

NYU Hospital for Joint Diseases
Orthopaedic Surgery

Nassau County ■ 761 Merrick Avenue • Westbury, NY 11590 • (516) 357-8777 • Fax (516) 357-0087
Manhattan ■ 530 1st Avenue, Suite 8U • New York, NY 10016 • (212) 213-5470
Queens ■ 111-20 Queens Boulevard Forest Hills, NY 11375 • (718) 261-0480
Suffolk County ■ One Corporate Drive • Bohemia, NY 11716 • (631) 218-7616
www.nyspine.com

NEW YORK SPINE INSTITUTE
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I understand that **"The NEW YORK SPINE INSTITUTE"** is participating only with the following insurance:

- **MEDICARE**
- **WORKERS COMPENSATION**
- **NO FAULT**

All other **NEW YORK SPINE INSTITUTE** providers, including **MRI**, Pain Management, Physical Therapy, Chiropractic and X-ray **DO NOT** participate with any insurance companies other than **MEDICARE, WORKERS COMPENSATION, NO FAULT.**

I understand that if my insurance is not listed above, I will be utilizing my **OUT-OF-NETWORK** benefits for services rendered by the New York Spine Institute.

I understand it is the policy of the New York Spine Institute to accept my insurance payments as payment in full, and I will only be held responsible for my deductible, co-payment and co-insurance. **The New York Spine Institute** will accept the percentage paid by the insurance after the deductible met.

I understand that if my insurance does not provide **OUT-OF-NETWORK** benefits, I will be responsible for payment, in full unless other arrangements have been made with the billing department.

I, _____, understand that I may receive the payment(s) directly from my insurance carrier for services rendered to me at New York Spine Institute. In such event, I will immediately forward such payment(s) to New York Spine Institute. If I fail to do so, I will remain responsible for the payment(s) in full. Payments turned over in excess of thirty (30) days of receipt of payment(s) from the insurance carrier will be subject to monthly finance charges of 1.5%. I acknowledge that New York Spine Institute may seek remedies in recovering payment(s) for services rendered.

X_____ _____/_____/_____

SIGNATURE DATE

PATIENT CONSENT FORM

Patient's Name: _____

I, the undersigned, do hereby authorize New York Spine Institute to provide me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic X-Rays or Magnetic Resonance Imaging, Physical Therapy or Chiropractic services, the administration and/or injection of medications and pharmaceutical products, including, but not limited to tripper point injections, and the drawing of blood (the "Procedure(s)"), as in the judgment of personnel and/or physicians of New York Spine Institute deems necessary.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at New York Spine Institute. I understand that the Procedure(s) and any other treatment that I may receive appears indicated by the diagnostic and/or clinical observations performed by New York Spine. I attest that a medical staff member of New York Spine has explained to me the nature of the recommended Procedure(s), the purpose of and need for the recommended Procedure(s), the possible risks and complications of the recommended Procedure(s) and the alternatives, if any, to the recommended Procedure(s). I understand all explanations given to me and give this consent voluntarily. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of New York Spine Institute.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Date

I declare that I have personally explained the above information to the patient or the patient representative.

_____ _____
Provider's Signature Date

FOR FEMALE PATIENTS ONLY:

I understand that in the course of my treatment I may have x-rays or other diagnostic tests. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Relationship to Patient Date

_____ _____
Witness Date

HIPAA BOOKLET AVAIALBE AT THE FRONT DESK

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us.

No retaliatory action will be taken against you for any complaints you may make.

New York Spine Institute has made available for review a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) with regard to the use and/or disclosure of certain protected health information about me.

I authorize my medical information to be released to the following:

1. Primary Care Physicians, and other Physicians & Medical Staff involved in my care.
2. Physical Therapists & Occupational Therapists involved in my care.
3. School Nurses and Physicians involved in my care.
4. Orthotics involved in my care.
5. Attorneys involved in my care.
6. Athletic Trainers and coaches involved in my care.
7. OTHER _____

I make the following special request for confidential communications:

_____

_____