NF

New York
Orthopaedic & Comprehensive
Medical Services, P.C.

A **NYSI** Affiliate

NF

☐ Michael Friar ☐ James Gott ☐ Rohan Desai, MD ☐ ______________________

PLEASE WRITE YOUR DOCTORS NAME

Patient Demographic

Name: ______________________________ Date: ______________

Address: ______________________ City: ______________________ State: _______ Zip: __________

Please Provide Your Email Address: ______________________________________

Tel.#: (Home) ______________________ (Cell) ______________________

S.S.#: ______________________ Sex: ☐ Male ☐ Female D.O.B: ______________ Age: __________

Sex assigned at birth: ☐ Male ☐ Female Gender Identity ______________ Height: _______ Weight: ________

Race: ______________ Ethnicity: ______________ Preferred Language: ______________________

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Do You Have An Attorney? ☐ Yes ☐ No Attorney: ______________________________

Attorney Tel.#: ____

Emergency Contact Name: ______________________ Tel.#: ______________________

Primary Care Physician's Name: ______________________ Tel.#: ______________________

Address: ______________________ City: ______________________ State: _______ Zip: __________

Pharmacy Name: ______________________________ Tel.#: ______________________

Address: ______________________ City: ______________________ State: _______ Zip: __________

Please Indicate Below How You Were Referred To Our Office:

☐ Doctor ☐ Attorney ☐ By Patient ☐ Internet/Magazine Ad/Etc.

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NO FAULT INSURANCE INFORMATION

Please fill out in entirety

Insurance Carrier Name: ____

Carrier Address: ____

Carrier Telephone: ____

Adjusters Name: ____________________ Adjusters Phone: ____________________

Adjusters Fax: ____________________ Adjusters Email: ____________________

Claim #: ____________________ Carrier Case #: ____________________

Date of Injury: ____________________ Injured Body Parts: ____________________

List ALL Attorneys Representing You for ALL cases (Third Party/NF/WC etc...) ____________________

____

NEW YORK MOTOR VECHILE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM (FOR ACCIDENTS OCCURING IN AND AFTER 3/1/02)

I, ______________________________ **("Assignor")** hereby assign Michael Friar, DPT, James Gott, DPT, and Rohan Desai, MD

All rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (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 purse payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle which occurred on, notwithstanding any other agreement to the contrary.

Accident date: ______________________________

The 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 conducts 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 COMMERICAL 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 FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY 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)**

______________________________ **(Address of Patient)**

______________________________ **(Date of Signature)**

______________________________ **(Address of Patient)**

NEW YORK ORTHOPAEDIC & COMPREHENSIVE MEDICAL SERVICES, P.C.

☐ Michael Friar ☐ James Gott ☐ Rohan Desai, MD ☐ ______________________________
PLEASE WRITE YOUR DOCTORS NAME

______________________________ **(Signature of Provider)**

______________________________ **(Print Name of Provider)**

761 MERRICK AVENUE
WESTBURY, NEW YORK 11590
(Address of Provider)

______________________________ **(Date of Signature)**

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ASSIGNMENT OF RECOVERY PROCEEDS AND AUTHORIZATION TO

Patient: ____

Address: ____

Attorney: ____

I, ____, theundersigned, do hereby assign to **New York Orthopaedic & Comprehensive Medical Services, P.C.** any sums due and payable, received by me or on my behalf, from any source for any and all medical treatment and or fees for services rendered to me and/or my attorney.

I authorize and direct my attorney to deduct and immediately pay **New York Orthopaedic & Comprehensive Medical Services, P.C.** and such fees as may be due and payable for the assigned monies that may come into my hands or my attorney's hands in any recovery resulting from any claims or lawsuit. I further direct my attorney to contact **New York Orthopaedic & Comprehensive Medical Services, P.C.**, to determine the exact amount owed before any money is paid to me from any recovery resulting from any claim or lawsuit. I further direct my attorney to advise **New York Orthopaedic & Comprehensive Medical Services, P.C.**, upon request, of the status of my lawsuits and/or any claims which may result in a monetary recovery from which the fees due and payable to , may be satisfied. If my attorney is replaced by another attorney, I direct that the outgoing attorney not forward my file until written acknowledgement from my new attorney is signed and forwarded to the undersigned acknowledging the terms and conditions set forth in this assignment.

New York Orthopaedic & Comprehensive Medical Services, P.C., agrees to provide reasonable cooperation in connection with securing payment for all insurance claims to the extent required by law.In the event of any breach of this assignment by the patient and/or the patient's attorney, it is understood that the patient shall remain responsible for all legal fees required to either obtain insurance information and/or collect any monies owed to **New York Orthopaedic & Comprehensive Medical Services, P.C.**, plus the expense of litigation and/or arbitration.

It is understood that this agreement, in no manner whatsoever, makes the payment of the fees due and payable to **New York Orthopaedic & Comprehensive Medical Services, P.C.,** contingent upon securing a recovery in any lawsuit or in any insurance claim that I may have. I understand that I remain personally responsible for all fees for medical treatment, as well as for services rendered on my behalf to my attorney and that I am personally liable for payment of the same. Further, I acknowledge that this assignment does not, in any fashion, preclude or otherwise prevent, **New York Orthopaedic & Comprehensive Medical Services, P.C.,**from demanding payment at any time after such services, as embraced within this assignment, are rendered.

____
(Patient or Legal Guardian Signature)

____
Witness

THE TERMS AND CONDITIONS OF THE FOREGOING ASSIGNMENT ARE UNDERSTOOD AND AGREED TO, BY:

Attorney: ____

Address: ____

Attorney Signature: ______________________________ **Date:** ________________

New York
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MUST BE FILLED OUT IN ENTIRETY

Patient Name: ______________________________

Date Of The Accident: ______ / ______ / ______ Occupation: ______________________

Employer Name and Address: ______________________________

Chief Complaint: ______________________________

Where Is Pain? ☐ Neck ☐ Back ☐ Shoulder Rt/Lt ☐ Mid Back ☐ Knee Rt / Lt

How And Where Were You Injured?: ______________________________

Describe: ______________________________

Prior History Of Neck Or Back Pain? ☐ Yes ☐ No

Treatments You Have Received To Date: ______________________________

☐ Physical Therapy ☐ Chiropractic Care ☐ Acupuncture
☐ Diagnostic Imaging ☐ Epidural Injections ☐ Trigger Point Injection

Are You Currently Working? ☐ Yes ☐ No ☐ Limited Duty: ______________________

Which State did Injury Occur: ______________________ , ______________________

Work: ______________________ Car Accident: ______________________ Other: ______________________

How Are You Doing? ☐ Better ☐ Worse ☐ Same

Any Other Medical Problems?: ______________________________

Any Known Allergies?: ______________________________

Social History:

Smoke? ☐ No ☐ Yes, How Much?: ______________ Drink? ☐ No ☐ Yes, How Much?: ______________

List Any Operations And/Or Hospitalizations (With Dates): ______________________________

____

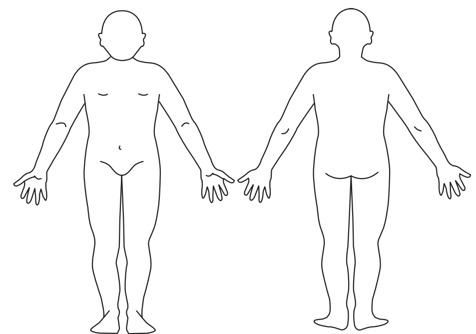
____

Current Medications?: ______________________________

____

Any Radiology Testing?: ______________________________

____



Pain Drawing & Scale Review

NEW YORK: **MANHATTAN** ■ **NASSAU** ■ **SUFFOLK** ■ **BROOKLYN** ■ **QUEENS** ■ **BRONX** ■ **WESTCHESTER** ■ **ORANGE**
NEW JERSEY: **PASSAIC** ■ **ESSEX**

PATIENT CONSENT FORM

Patient's Name: ____

I, the undersigned, do hereby authorize **New York Orthopaedic & Comprehensive Medical Services, P.C.** 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 Orthopaedic & Comprehensive Medical Services, P.C.** 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 Orthopaedic & Comprehensive Medical Services, P.C.** I understand that the Procedure(s) and any other treatment that I may receive appear indicated by the diagnostic and/or clinical observations performed by **New York Orthopaedic & Comprehensive Medical Services, P.C.** I attest that a medical staff member of **New York Orthopaedic & Comprehensive Medical Services, P.C.** 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 Orthopaedic & Comprehensive Medical Services, P.C.**

____ ____________________
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

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: ____

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which describes your rights and the Provider's legal duties with respect to the use and/or disclosure of your protected health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of **New York Orthopaedic & Comprehensive Medical Services, P.C.** of Privacy Practices which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information.

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______________________________ ______________________________

Patient/Designated Representative Signature   Print Name

______________________________ ______________________________

If designated representative, relationship to patient   Date

FOR PROVIDER USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices. We were unable to obtain such acknowledgment, however, because:

- ☐ Treatment was rendered in an emergency treatment situation. Efforts will be made to obtain the acknowledgment as soon as reasonable practicable after the emergency.
- ☐ We were unable to effectively communicate with the patient: Reason:

  ____

- ☐ Patient refused to sign: Reason Given:

  ____

- ☐ Other (please specify):

  ____