SOUTHERN WESTCHESTER ORTHOPEDICS AND SPORTS MEDICINE ASSOCIATES, P.C.

Please Print Clearly

Name:_____ **Sex:** M or F **Date Of Birth**_____

Social Security#:_____ **Marital Status:** S M D W

Address:_____Apt#_____City:_____State:_____

Zip:_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:** _____

Preferred Method Of Communication: Home( ) Work( ) Cellphone( )

Email:_____@_____

Emergency Contact/HIPAA Representative

Name:_____Phone#:_____Relationship:_____

Are you currently working: Yes( ) Full Time( ) Part Time( ) ( ) Self Employed Not working ( )

Reason: Retired( ) On Disability( ) Not Employed( ) Student( )

Employer

Name:_____Occupation:_____

Address:_____City:_____ State:_____ Zip Code:_____

Guarantor Information(to whom statements are sent)

Name:_____ Date Of Birth:_____ **Sex:** M or F Relationship to patient:_____

Address:_____City_____State_____Zip Code_____

Primary Insurance: _____ID#:_____Group#_____

Policyholder Name:_____ Date Of Birth:_____ **Sex:** M or F

Relationship To Policyholder: Self( ) Spouse/Partner( ) Child( ) Other_____

Secondary Insurance:_____ ID#:_____Group#_____

Policyholder Name:_____ Date Of Birth:_____ **Sex:** M or F

Relationship To Policyholder: Self( ) Spouse/Partner( ) Child( ) Other_____

Pharmacy Name(including any Mail Order Pharmacy):_____

Pharmacy Address: _____Pharmacy Phone #: _____

Family/Primary Physician: _____

Physicians Address: _____City:_____ State:_____ Zip Code:_____

Phone #:_____ Fax# _____

Were you referred to our office for a consultation by another physician? ___Yes ___No

Referring Physician Name: _____

Referring Physician Address: _____City:_____ State:_____ Zip Code:_____

Phone #:_____ Fax#: _____

To the best of my knowledge the above information is complete and accurate.

Signed:_____**Date:**_____

SOUTHERN WESTCHESTER ORTHOPEDICS AND SPORTS MEDICINE ASSOCIATES, P.C.

No Fault Claim Information

PATIENT NAME: _____

NO FAULT CARRIER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE_____

PHONE#: _____

NAME OF CLAIMS EXAMINER: _____

CASE/FILE#: _____

POLICY# _____

DATE OF INJURY: _____

ATTORNEY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIPCODE_____

PHONE#: _____

HOW DID ACCIDENT OCCUR:_____

WHAT BODY(S) PART WAS INJURED AS A RESULT OF THIS ACCIDENT:_____

_____

DO YOU HAVE A HISTORY OF SYMPTOMS RELATED TO INJURY? _____YES _____NO

ARE YOU CURRENTLY WORKING? YES_____ NO_____

IF NO, DATE YOU STOPPED WORKING?_____

WERE YOU TREATED IN EMERGENCY ROOM?_____WHERE_____WHEN_____

WERE X-RAYS TAKEN? _____ WHERE_____ WHEN_____

PAST MEDICAL HISTORY: _____

DO YOU HAVE ANY ALLERGIES? _____

HEIGHT_____ WEIGHT_____

MEDICATIONS YOU ARE CURRENTLY TAKING_____

_____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signed:_____Date:_____

Southern Westchester Orthopedics and Sports Medicine Associates, P.C.

Office Policy(Please read and sign below)

Thank you for choosing our office as your healthcare provider. We are committed to providing the best medical care possible. The following statement explains our financial policy which we ask you to read.

- All patients should provide accurate and complete personal and insurance information prior to be seen by the doctor. Also, you must notify us of any changes to your demographic or insurance information.
- All applicable copays, personal balances, both current and prior are due at the time of service.
- We accept cash, check(endorsed to Southern Westchester Orthopedics and Sports Medicine Associates, P.C.) or credit cards(Visa, Mastercard, American Express and Discover)

Referrals

Please keep track of your referrals. **It is your responsibility** to make sure that you have a current referral on file. Patients will not be seen without a valid referral.

Insurance Changes

You must notify us of any changes to your insurance. Medicare/Medicaid patients, we ask that you contact us **before** enrolling into a Medicare or Medicaid Managed Care Plan since our office may not participate in the plan you choose.

Past Due Accounts

Our office is willing to set up monthly payments for patients who cannot afford to pay balances upfront. However, patients who do not make an effort to pay their outstanding balances will be referred to a collection agency.

Copayments and Balances

By law we **MUST** collect your carrier designated co-pay. Payment for copays is expected at the time of service. If copay balances are not paid on the date of service a **$15.00 fee** will be charged to your account. This fee is not covered by your insurance, it will be your personal responsibility.

Returned Checks

For checks returned to us unpaid by your bank, **we will charge a $15.00** fee.

Forms

There is a $10.00 fee for each form to be filled out by our office with the exception of NYS disability forms. Certain forms that require extensive information will have a higher fee. All fees must be paid upfront and must be picked up. **Our office will not be responsible for faxing or mailing any forms.**

Xrays: There is a $10 fee for copies of xray pictures.

Workers Compensation/No Fault

If you register as a private patient and later want your case converted to a Workers' Compensation Claim or a No Fault Claim there will be a **$350.00** fee to you for all the administrative work involved.

HIPPA: I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

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 **Southern Westchester Orthopedics and Sports Medicine Associates,P.C.("Assignee")**
(Print patient's 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.
(Print accident date)

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)

Southern Westchester Orthopedics and Sports Medicine Associates, PC
970 North Broadway, Suite 204
Yonkers, NY 10701

_____
(Signature of Provider)

_____
(Date of signature)

NYS FORM NF-AOB *(Rev 1/2004)*

SOUTHERN WESTCHESTER ORTHOPEDICS AND SPORTS MEDICINE ASSOCIATES, P.C.
David Lent, M.D., Eric Spencer, M.D., Andrew Kirk, PA

Assignment of Benefits

I understand that I am financially responsible to pay Southern Westchester Orthopedics and Sports Medicine, P.C. its usual charges for all services received through Southern Westchester Orthopedics and Sports Medicine, P.C. practices, including any balances or charges not covered by my insurance carrier(s). I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Southern Westchester Orthopedics and Sports Medicine, P.C., and direct that payment of proceeds be made directly to Southern Westchester Orthopedics and Sports Medicine, P.C..

I authorize the release of medical record information or excerpts thereof to any Insurance company or third party payor for utilization management audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization, per HIPAA regulations.

I authorize Southern Westchester Orthopedics and Sports Medicine, P.C. to obtain/have access to my medication history.

I authorize the healthcare providers of Southern Westchester Orthopedics and Sports Medicine, P.C. to administer treatment as deemed necessary for my care. I certify that no guarantee has been made as to the results that may be obtained from the treatment. This authorization form will remain in effect for 1 year from signature date unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this authorization form is to be considered as valid as an original.

I also certify that I have read and have been given a copy of Southern Westchester Orthopedics & Sports Medicine Assoc., P.C.'s Notice of Privacy Practices describing how my medical information may be used and disclosed and how I can access my medical information.

Signed:_____ Date:_____

Practice's Requirements

Southern Westchester Orthopedics & Sports Medicine Assoc., PC:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of *04/15/03.*

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

PATIENT SIGNATURE_____ **DATE**_____