716 ORTHOPAEDICS AND SPINE SURGERY

2914 Elmwood Avenue, Kenmore NY 14217-----4855 Camp Rd, Suite 400, Hamburg, NY 14075-----5875 South Transit Road, Lockport, NY 14094
PHONE: (716) 447-6310 FAX: (716) 775-6288

PATIENT NAME: _____
ADDRESS: _____
EMAIL:_____TELEPHONE: HOME: _____CELL: _____
DATE OF BIRTH: _____SEX: MALE:_____FEMALE:_____
SOCIAL SECURITY NUMBER: _____
EMERGENCY CONTACT:_____ TELEPHONE: _____

Workers' Compensation Patients

Understand that without majority of the below information, you or your back-up insurance may be billed in lieu of missing information about your Workers' Compensation claim. The more information we have, the more timely we are able to process any requests for additional testing, surgery, braces, etc that the physician may/may not wish to order at your appointment. If you are unsure how to obtain the below information, before you arrive at our office, contact your Human Resources representative at your company. They will assist you.

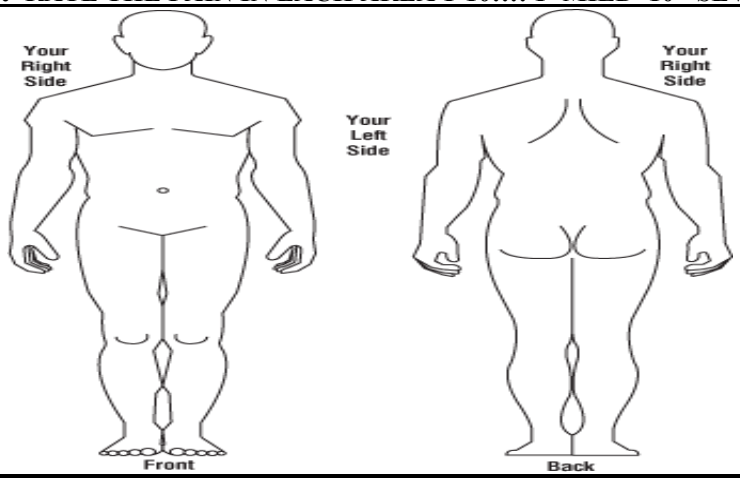
WC Carrier Name:	
WC Carrier Address:	
WC Carrier Phone:	
WC Carrier Fax:	
WC Carrier ID NUMBER	**W** ___ ___ ___ ___ ___ ___
Date of Injury:	
WC CASE/Claim Number:	
WC Board Number:	___ ___ ___ ___ ___ ___ ___ ___
WC Claim Examiner/Adjuster:	
Examiner/Adjuster Phone #:	
Examiner/Adjuster Fax #:	
Employer's Name:	
Employer's Address:	
Job Title:	
Employment Status:******	
Brief Description of how accident occurred:	
Did you receive treatment immediately after the accident? If no, when was the first time you sought medical treatment:	
Have you had ANY previous injury? *(due to a car accident or workers' compensation)* **YES OR NO** If yes, please describe and include date of injuries, body part, and type of injury:	
Since the onset of your pain, is it:	**Better Unchanged Worse**

I,_____ authorize my physician/Health Care Solutions of WNY, LLC to release any information pertaining to my work related injury to my employer, Workers' Compensation insurance carrier and the Workers' Compensation Board (for the duration of my treatment for this incident) You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Signature:_____ Date:_____

Mark the areas where you feel pain and/or discomfort- RATE THE PAIN IN EACH AREA 1-10:::: 1=MILD 10= SEVERE

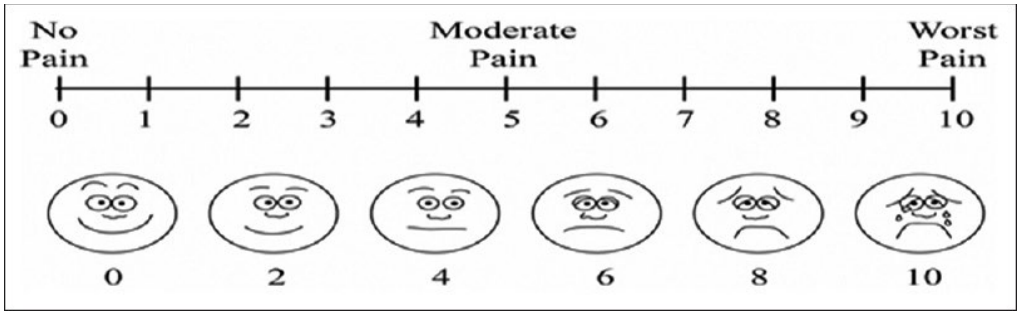
_____Neck
_____Mid Back
_____Low back
_____Shoulder (Left/Right)
_____Arm (Left/ Right)
_____Elbow (Left/Right)
_____Wrist (Left/Right)
_____Hand (Left/Right)
_____Hip (Left/Right)
_____Leg (Left/Right)
_____Knee (Left/Right)
_____Ankle (Left/Right)
_____Foot (Left/Right



PLEASE DESCRIBE THE TYPE OF PAIN YOU ARE HAVING? *(CIRCLE ALL THAT APPLY)*

Sharp Aching Shooting Burning Cramping Throbbing Stabbing Itchy Sore Dull Tight Stinging

PLEASE RATE YOUR LEVEL OF PAIN



Do you have any of the following?

***Body/muscle stiffness Yes No Circle which applies: Mild----------Moderate----------Severe**
Radiating pain?** ***(Pain that shoots from one area to another) **Yes No Describe:_____**
***Tingling, pins and needles or burning sensations? Yes No Describe:_____**
***Feelings of muscle weakness? Yes No Describe:_____**
***Any bowel/bladder changes? Yes No Describe:_____**
***Increased pain from coughing or sneezing? Yes No Describe:_____**

What makes the pain worse? *(Circle all that apply)*

Any/all activity Bending Running Reaching Lifting Weight Prolonged Walking Lying down/sleeping
Prolonged Sitting Prolonged Standing Changing Positions Twisting/Rotation

What makes the pain better? *(Circle all that apply)*

Rest Movement Heat Therapy Elevation Medication Changing Positions Nothing

---

Are you currently attending therapy? No -- Yes If yes, where & with which Dr._____
for how long?_____

Has the therapy helped? Yes No **If no, why & when did you stop therapy?_____**

What type of therapy? (Circle all that apply)

Chiropractic Therapy: Physical and/or Occupational Acupuncture Modalities-Ultrasound, Electrical Stim, Hot/Cold packs

Have you had any type of injections for this problem? Yes No

If so, what type of injections did you have? ***(Circle all that apply)*** **Did the injections help?** Yes No

Epidural Injection:_____Trigger Point Injections; Location:_____Facet Injections_____Other:_____

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GENERAL INFORMATION***

***(You do NOT have to fill out GENERAL INFORMATION portion, if this insurance is secondary to NF/WC)**

****

PATIENT NAME : _____

ADDRESS : _____

TELEPHONE : HOME : _____CELL : _____

EMAIL ADDRESS:_____

DATE OF BIRTH : _____SEX : MALE :_____FEMALE :_____

SOCIAL SECURITY NUMBER : _____

CHIEF COMPLAINT:_____

EMERGENCY CONTACT INFORMATION

NAME : _____

RELATIONSHIP: _____

TELEPHONE: HOME : _____**CELL :** _____

****

PRIVATE INSURANCE INFORMATION

PRIMARY INSURANCE : _____

ID# :_____Suffix:_____GROUP# :_____

Responsible Party:_____ **DOB:**_____

SECONDARY INSURANCE : _____

ID# :_____Suffix:_____GROUP# :_____

Responsible Party:_____ **DOB:**_____

CORRESPONDENCE INFORMATION

**********IMPORTANT INFORMATION NEEDED**********

PRIMARY MEDICAL DOCTOR: _____

Address: _____Telephone: _____

ATTORNEY INFORMATION:_____

Address: _____Telephone: _____

INSURANCE AUTHORIZATION:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIANS. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL MEDICAL SERVICES RENDERED UNTIL SUCH AUTHORIZATION IS REVOKED BY ME. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN LIEU OF THE ORIGINAL.

NO SHOWS:

Please be advised that a fee of $75.00 will be charged to patients who fail to show for a scheduled appointment without giving us one business day's notice by phone {716-447-6310}. The patient must speak with someone in the office to cancel his/her appointment.

*PLEASE NOTE THAT YOUR INSURANCE COMPANY WILL NOT COVER THIS CHARGE –
THIS POLICY IS INTENDED TO FACILITATE BEST SCHEDULING PRACTICES AND ENABLE OUR PROVIDERS AND OUR STAFF TO MAXIMIZE THE TIME AVAILABLE FOR PATIENT CARE

_____ _____

Patient name Printed Date

_____ _____

Patient Signature Date

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HEIGHT:_____ **WEIGHT:**_____

~*~*~*ALLERGIES:**_____~*~*~***

MEDICATIONS: Please list your most current medications

MEDICATION:: **DOSAGE:** **PRESCRIBER:**

_____

_____

_____

_____

SOCIAL HISTORY:

ALCOHOL: DO YOU DRINK? **Y OR N** IF YES, HOW MUCH AND HOW OFTEN: SOCIAL / OCCASIONAL / MODERATE

SMOKING AND CHEWING TOBACCO: DO YOU SMOKE? Y or N < PACK A DAY___1-2 PACKS A DAY___ >3 PACKS A DAY___

CHEWING TOBACCO____ PREVIOUS SMOKER: Y or N WHEN DID YOU QUIT? _____

Surgical History & The Date Performed:_____

_____

PRESENT MEDICAL CONDITIONS: Please check any medical conditions you are being treated for or have been in the past

MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBER	MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBER
Asthma			Dialysis or Kidney Failure		
Emphysema			Urinary tract infections		
COPD			Diabetes		
Pneumonia			Thyroid problems		
Tuberculosis			Osteomyolitis		
Pulmonary Embolism			Bleeding disorders		
Respiratory Arrest			Anesthesia problem / Malignant hyperthermia		
Sleep Apnea			Peripheral Vascular Disease (PVD)		
High Cholesterol/Lipids			Deep Vein Thrombosis (DVT)		
High Blood Pressure			Cerebral Palsy		
Stroke / TIA			Polio		
Mitral Valve Prolapse			Parkinson's		
Congestive Heart Failure			Multiple Sclerosis		
Angina (Chest Pain)			Ulcers skin/pressure		
Coronary Heart Disease			Psoriasis		
Heart Attack (Myocardial Infarction)			Tooth abscess		
Arrhythmia (Irregular heart beat)			Gingivitis		
Inflammatory Bowel (Diverticulitis/losis)			Rheumatoid Arthritis		
Acid Reflux (GERD)			Gout		
Gastric / Stomach Ulcer			Lupus		
GI Bleed			Scleroderma		
Hepatitis or liver disease			Depression		
Kidney problems			HIV/AIDS		
Drug OR Alcohol dependency			CANCER		

AUTHORIZATION AND RELEASE: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature:_____ **Date:**_____

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Narcotic Medication Agreement

I,_____ understand that:

- **I will call the office FIVE (5) business days ahead of my refill date. P# 716-447-6310.**
- The overuse of narcotic medication can result in serious health risks.
- You should not drive or operate machinery while taking narcotic medications.
- All prescriptions must be filled at one (1) pharmacy only and prescribed by one (1) doctor only, this includes emergency department prescriptions.
- You agree to a random urine drug testing.
- **This medication will be strictly monitored and ALL of the medications will be filled at the SAME pharmacy.**

  The pharmacy I have chosen is: _____

  Phone #: _____ **Address:**_____
- **Early refill requests will not be honored & I will take my medication ONLY as prescribed.**
- I am responsible for MAKING & KEEPING scheduled appointments. I understand that I will need to be seen approximately EVERY month while I am being prescribed narcotic medications.
- I understand that if I am not able to keep my appointments my medications will **not** be refilled.
- I WILL NOT obtain narcotic medication from any provider while obtaining medications from 716 Orthopaedics and Spine Surgery and/or associates. If it is found that other providers are prescribing for me, Dr. Rogers and/or his associates reserve the right to discontinue prescribing medications and/or discharge me.**
- Your prescription or medications WILL NOT be replaced if they are lost, destroyed, stolen, get wet, misplaced etc. under any circumstances.
- Early refill requests will NOT be honored & I will take my medication **ONLY** as prescribed.
- Notify us immediately if you become pregnant.

I have read the Narcotic Medication Agreement and by signing I affirm that I have read, understand, and accept all of the terms of this agreement.

**PAIN MANAGEMENT PROVIDER:_____

Patient Signature:_____ Date:_____

Witness Signature: _____ Date:_____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6 **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
716 Orthopaedics and Spine Surgery, PLLC

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

O Medical Record from (insert date) to (insert date)

U Entire Medical Record, including patient histories, office notes referrals, consults, billing records, insurance records, and records (except psychotherapy notes), test results, radiology studies, films, sent to you by other health care providers.

Include: *(Indicate by Initialing)*

Authorization to Discuss Health Information

Mental Health Information

HIV-Related Information

(b) **O** By initialing here Initials I Name of individual health care provider to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:
O At request of individual
O Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

*** Human Immunodeficiency Virus that** causes **AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

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DATE: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

General Information:

Information about your treatment and care, including payment for care, is protected by two federal laws:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Confidentiality Law. Under these laws the practice must obtain your written consent before it can disclose information about you for payment purposes. For example, the practice must obtain your written consent before it can disclose any Personal Health Information (PHI). In addition, you must also sign a written consent before the practice can share information for any and all treatment purposes. However, federal law permits the practice to disclose information in the following circumstances without your written permission:

1. To practice staff for the purposes of maintaining the clinical records
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, your insurance company)
3. For research, audit or evaluations (e.g. State licensing review, or accreditation as required by the State and/or Federal government);
4. To report a crime committed on the practice's premises or against practice staff
5. To medical personnel in a medical/psychiatric emergency
6. To appropriate authorities to report suspected child abuse or neglect
7. To report certain infectious illnesses as required by state law
8. Information that is requested per a court order

Before the practice can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Disclosure of Medical Information

I give my permission to the office of 716 Orthopaedics and Spine Surgery , PLLC to disclose medical information regarding my treatment/diagnosis to the following family members or friends whom you may speak with:

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to 716 Orthopaedics and Spine Surgery PLLC . (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice 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 the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

Signature:_____ **Date:** _____