



Please check next to the name of the surgeon you have an appointment with:

- Jeffrey E. Rosen, MD Alexander Golant, MD Tony N. Quach, MD

DEMOGRAPHICS

Name:	Age:	Sex:
Social Security #: - -	Date of Birth:	
Street Address:		
City:	State:	Zip Code:
Marital Status : <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner		
Home Phone:	Cell Phone:	
Email Address:		
Emergency Contact Name:	Telephone Number:	

Employer Name:	Occupation:
Employer Address:	
City:	State: Zip Code:
Business Phone: ()	
Work Status?	If not, last date worked:

Referred By:	Phone: ()
Address:	
City:	State: Zip Code:

PRIMARY INSURANCE INFORMATION

NO INSURANCE (SELF PAY→SEE OUT OF NETWORK/FINANCIAL PRIVATE PAY SECTION FORM)

IS THIS CLAIM RELATED TO: (PLEASE CHECK)

WORKERS COMP. NO-FAULT

DATE OF ACCIDENT: _____

Insurance Carrier:		
Address:		
City:	State:	Zip Code:
Policy/ Claim #:	Group/ WCB#:	
Adjuster:	Tel:	Fax:
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____		
Insured's Name (if applicable):		
SS No.	DOB:	

SECONDARY INSURANCE INFORMATION

Insurance Carrier:		
Address:		
City:	State:	Zip Code:
Policy/ Claim #:	Group/ WCB#:	
Adjuster:	Tel:	Fax:
Relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other _____		
Insured's Name (if applicable):		
SS No.	DOB:	

FINANCIAL POLICY

We recognize the need for a definite understanding between you and your physician concerning healthcare and the financial arrangements for this medical care. Our commitment is to provide the very best healthcare to our patients while recognizing the need to limit services to only those medically necessary. The responsibility for payment of fees for these services is the direct obligation of the patient.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referral and establishes the limit on your coverage for medical services. For insurance plans we participate with, we will seek to obtain verification of your eligibility, however, even when such eligibility and/or benefits are verified by this office, your insurance plan will not guarantee the accuracy of their confirmation of coverage or benefits, and that you are eligible and that your benefits are in force.

It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments and/or coinsurance. You agree to accept responsibility for co-payments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your insurance plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan.

You will receive monthly statements. The first statement will show all charges, with subsequent statements showing any insurance payments (it takes 4-6 weeks for most insurance carriers to pay). You are responsible for any unpaid balances.

NOTE: Some procedures that are performed in our office involve sending specimens to the hospital laboratory department for analysis. When this occurs you may receive separate billings from the laboratory and/or hospital for their services.

Payment Policy Schedule*:

- Co-payments/Deductibles/Coinsurance: Full payment at the time of service.
- Medical materials: Full payment at the time of service.
- Non-covered service: Full payment at the time of service.
- Missed Appointments Fee: The office requires 48 hours notice (not including Saturday & Sunday) to cancel an appointment. Failure to provide this notice or for missed appointments will result in a \$25.00 charge to your account. This charge will not be covered by insurance, but will have to be paid by you personally.
- Collections: All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.
- Surgery payment: Surgery payment is handled on a case-by-case basis. Prepayment of 100% is due 14 days prior to surgery and only includes the surgeon's fee as well as the first post-operative visit.

Other charges/fees*:

- Returned check fee: \$25.00
- Completion of disability paperwork: \$25.00
- Copies of medical records: \$0.75/page
- Cancellation of surgery: \$300 (within 7 days of surgery other than for medical reason)
*subject to change at any time

We realize that temporary financial problems may affect timely payments on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any further questions about the information above or any uncertainty regarding our financial policy, please don't hesitate to ask us. We are here for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits to Jeffrey E. Rosen, MD when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize Jeffrey E. Rosen, MD to use or disclose any information for treatment, payment and health care operations. I authorize that the physicians and/or employees of Jeffrey E. Rosen, MD can contact me or leave me a message if they are unable to contact me directly. I authorize this office to release any medical information pertaining to medical history and/or information necessary to expedite insurance claims, and request direct payment of benefits to the above provider. I understand that I am responsible for all deductibles, co-pays and cost shares as determined by my insurance coverage.

Patient (or authorized) signature _____ Date _____

Print Name _____

Relationship (if not signed by patient) _____



56-45 Main Street, Flushing, NY 11355

RECEIPT OF:
HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

Effective Date 4/14/03

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
New York Hospital Queens is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our hospital, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our hospital. "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.

Signature _____ **Date** _____

Patient / Health Care Agent / Guardian / Relative Signature

(This signature indicates that you have received a copy of the Notice of Privacy Practices.)

Patient is unable to sign due to medical reasons Patient refuses to sign

Other (Please Explain) _____

This Acknowledgement Form will become a part of your permanent medical record.



ASSIGNMENT OF BENEFITS FORM

Patient Name:	SSN:
Employer:	Insurance ID:
Insurance Company Name:	

I, hereby authorize my insurance company listed above to make all payments to:

- Jeffrey E. Rosen, MD Alexander Golant, MD Tony N. Quach, MD

56-45 Main Street (4th Floor South)
Flushing, NY 11355

OR

If my current policy prohibits direct payment to the doctor, I hereby also authorize my above insurance company to make checks payable to me and mail it as followed to:

- Jeffrey E. Rosen, MD Alexander Golant, MD Tony N. Quach, MD

56-45 Main Street (4th Floor South)
Flushing, NY 11355

For professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current pay manner any balance of said professional service charges that my insurance does not cover due to my current policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature of Policyholder

Date

Signature of Claimant (if other than policyholder)

Date



Date of Service: _____ Amount: \$ _____

Type of Service Provided: _____

OUT OF NETWORK/FINANCIAL PRIVATE PAY INFORMATION

I have agreed to pay the above amount for the above named services that I will be receiving on ____/____/____. I understand that the following physician is a non-participating provider with my insurance carrier or I am a self-pay patient.:

- Jeffrey E. Rosen, MD Alexander Golant, MD Tony N. Quach, MD

I am aware that these services could be provided to me at a reduced fee and/or no cost from a provider who participates in my insurance carrier.

The entire fee is my entire responsibility and I agree to pay \$_____ as full payment.

I have read the above information and understand my financial obligations as a private pay patient.

Patient Name: _____

Patient Signature: _____

Date: _____



NYHQ Center for Orthopaedics & Rehabilitation Medicine

The Orthopaedic Faculty Practice of New York Hospital Queens

Patient Name: _____

Date: _____

REVIEW OF SYMPTOMS

Age: _____ Sex: M F Height: _____ Weight: _____ Dominant Hand: L R Latex Allergy: Y N

What is the reason for this visit? Pain Numbness Weakness Swelling Stiffness Other: _____

What body part is involved? (Please mark the table below)

SHOULDER	ELBOW	WRIST	HAND	HIP	KNEE	ANKLE	FOOT	NECK	BACK
<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/>	<input type="checkbox"/>

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years

Have you ever had a problem like this before? Y N

In this section, check the ONE BOX that best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

- NO INJURY (or onset was: Gradual or Sudden)
Please indicate why do you think it started>
- INJURY (Accident Sport) NOT Auto or Work
Date: _____ Please specify where and how it happened.
What sport? _____ School? _____
- INJURY AT WORK
From a: lift twist fall bend pull reach
- WORK RELATED (BUT NO INJURY)
Date: _____ How did your job cause the problem?
- AUTO ACCIDENT
Date: _____ How was your car hit?

COMMENTS:

On a scale of 0-10 (10 is the worst), how severe is your pain? (please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is Constant Comes and Goes (intermittent)

Does your pain wake you from your sleep? Y N

Do you have: Swelling Bruising Numbness Tingling Weakness Loss of control of bowel/bladder Locking/Catching Giving away

Since my problem started, it is: Getting better Getting worse Unchanged

What makes your symptoms worse: Standing Walking Lifting Exercise Twisting Lying in bed Bending Squatting
 Kneeling Stairs Sitting Other: _____

What makes your symptoms better: Rest Elevation Ice Heat Other: _____

Have you had any of these treatments? Injections: Y N Brace: Y N Physical Therapy: Y N Cane/Crutch: Y N

Are you here today as a result of an E.R. visit? Y N Who saw you in the E.R.? _____

What tests have you had for this problem? X-Rays MRI CAT Scan Bone Scan Nerve Test (EMG/NCV) Where? _____

Past Medical History

Have you had any of these symptoms? If no, mark none.

				NONE	YEAR
1. GI	<input type="checkbox"/> heartburn, ulcers	<input type="checkbox"/> nausea, vomiting	<input type="checkbox"/> blood in stool	<input type="checkbox"/>	_____
	<input type="checkbox"/> hepatitis	<input type="checkbox"/> liver disease		<input type="checkbox"/>	_____
2. ENDO	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> heat or cold intolerance		<input type="checkbox"/>	_____
3. CON	<input type="checkbox"/> weight loss	<input type="checkbox"/> loss of appetite		<input type="checkbox"/>	_____
4. EYE	<input type="checkbox"/> blurred vision	<input type="checkbox"/> double vision	<input type="checkbox"/> vision loss	<input type="checkbox"/>	_____
5. ENT	<input type="checkbox"/> hearing loss	<input type="checkbox"/> hoarseness	<input type="checkbox"/> trouble swallowing	<input type="checkbox"/>	_____
6. CV	<input type="checkbox"/> chest pain	<input type="checkbox"/> palpitations		<input type="checkbox"/>	_____
7. RS	<input type="checkbox"/> chronic cough	<input type="checkbox"/> shortness of breath		<input type="checkbox"/>	_____
8. GU	<input type="checkbox"/> painful urination	<input type="checkbox"/> blood in urine	<input type="checkbox"/> kidney problems	<input type="checkbox"/>	_____
9. SK	<input type="checkbox"/> frequent rashes	<input type="checkbox"/> skin ulcers	<input type="checkbox"/> lumps	<input type="checkbox"/>	_____
	<input type="checkbox"/> psoriasis			<input type="checkbox"/>	_____
10. NEU	<input type="checkbox"/> headaches	<input type="checkbox"/> dizziness	<input type="checkbox"/> seizures	<input type="checkbox"/>	_____
11. PSY	<input type="checkbox"/> depression	<input type="checkbox"/> drug/alcohol addiction	<input type="checkbox"/> sleep disorder	<input type="checkbox"/>	_____
12. HEM	<input type="checkbox"/> easy bleeding	<input type="checkbox"/> easy bruising	<input type="checkbox"/> anemia	<input type="checkbox"/>	_____
13. Are you HIV positive?	<input type="checkbox"/> Y <input type="checkbox"/> N				

Are you diabetic? Y N If yes, treatment: Insulin Oral Meds Diet None

Are you taking or have you ever taken blood thinners? Y (explain) _____ N

Have you ever had: Heart attack (year _____) High blood pressure Blood clots (year _____) Stroke

Heart Failure Ankle Swelling Kidney Failure Cancer (location and year _____)

Stomachache while taking anti-inflammatories (including Aleve/Advil). What anti-inflammatories have you already had a problem with? _____

Family History

Have any direct relatives had any of the following disorders? If so, which relative?

Have you or a family member ever had a reaction to anesthesia? Y (explain) _____ N

Diabetes _____ High Blood Pressure _____

Rheumatoid arthritis _____ NONE

Do any direct relatives have the same condition you are being seen for today? Y N

Work History

Current Work Status? Regular Light Duty (How long? _____) Not working due to this problem

Disabled Retired Student When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for: Disability Y N Worker's Comp Y N Unemployment Y N

Do you plan to be working 6 months from now? Y N

Patient Signature: _____

Date: _____