Orthopaedic & Sports Medicine Consultants of New York
Cary B. Chapman, M.D.

Last Name (Apellido): _____ **First Name** (Nombre): _____ **Middle** (Segundo Nombre): _____

Address (Direccion): _____ Apt#: _____ ☐ Male(Hombre)

City(Cuidad): _____ **State**(Estado): _____ **Zip**(Codigo Postal): _____ ☐ Female(Mujer)

Primary Phone#(Telefono primario): _____ **Secondary Phone#** (Telefono secundario): _____ **Other#**(Otro): _____

Email(Correo Electronico): _____ **DOB**(Fecha de Nacimiento): _____ **Social Security #** _____-_____-_____

How were you referred to us? (Como fue referido a nostoros?)

☐ NYU or SIUH Physician Referral
☐ Friend (Amigo)
☐ Commercial (Yellow Pages/ Magazine/ Internet)
☐ Dr. _____

	Yes	No
Is this visit due to a work injury?(es esta visita debido a una lesion en el trabajo?)	☐	☐
Were you in an automobile accident?(estabas en un accidente de caro?)	☐	☐
Do you have Litigation Pending?(usted tiene litigious pendientes?)	☐	☐

Primary Care Physician(Medico de Atencion Primaria) _____ **Phone #**(Numero Telefonico): _____

Reason for today's visit (Motivo de la vista de hoy): _____

If the patient is a minor/dependent, please complete the following (Si el paciente es menor de edad/dependientes rellene el siguiente

Legal Guardian/Parent(Tutor Legal/Padre): _____ **Relation to Patient**(Relacion con el paciente): _____

Address (Direccion): _____ **Phone #** (Telefono): _____

Employment(Empleo): ☐**Full Time**(completo) ☐**Part Time**(parcial) ☐**Unemployed**(desempleado) ☐**Self Employed**(Independiente) ☐**Retired**(Retirado)

Employer(Empleador): _____ **Occupation**(Ocupacion): _____

Address(Direccion): _____ **Phone**(telefono): (_____) _____

Emergency Contact(Contacto de emergencia):

Name(Nombre): _____ **Relationship to Patient**(Relacion con el paciente): _____

Home Phone #(Telefono de casa): _____ **Cell Phone #**(Telefono Cellular): _____ **Other#**(otro): _____

Primary Insurance(Seguro Primario): **(A copy of your insurance card is required/Se requiere un copia de sue tarjeta de seguro)**

Insurance Plan (Plan de seguro): _____ **ID#**: _____ **Group** (Grupo)#: _____

Insured's Name (Nombre del asegurado): _____ **Relationship to Patient**(Relacion con el paciente): _____

Secondary Insurance(Seguro secundario): **(A copy of your insurance card is required/Se requiere un copia de sue tarjeta de seguro)**

Insurance Plan (Plan de seguro): _____ **ID#**: _____ **Group**(Grupo)#: _____

Insured's Name(Nombre del asegurado): _____ **Relationship to Patient**(Relacion con el paciente): _____

Assignment and Release (Asignacion y Liberacion)

Authorization to treat and release information to insurance carrier for direct payment to the provider (Cary B. Chapman, MD, PLLC). Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and it is not a substitute for payment. I understand that I am financially responsible for all charges, whether or not paid by said Insurance, ***which includes deductible and co-insurance***. I authorize any holder of medical or other information about me to be released to my insurance company or to the Social Security Administration, any information needed for this or any related claim. I permit and request payment of medical benefits either to myself or to the party who accepts assignments. Regulations pertaining to the assignment of benefits apply. I understand that I am obligated to pay any charges deemed medically unnecessary or classified non-covered by Medicare.

Print Name(Nombre del paciente) : _____ **Signature**(Firma): _____ **Date:** _____

If patient is a minor or unable to sign: Guardian: _____ Signature: _____

Past Medical History (Historial Medico)

Asthma(Asma)	Yes No	**Mental Illness** (Enfermedad mental)	Yes No	**Sleep Apnea**	Yes No
High Blood Pressure(Hipertension)	Yes No	**Gastric Ulcer** (Ulcera Gastrica)	Yes No	**Cardiac Problems**	Yes No
Stroke(Carrera)	Yes No	**Cancer**	Yes No		
Seizure(Incautacion)	Yes No	**Rheumatism** (Reumatismo)	Yes No	Nature of _____	
Bleeding Disorder (Trastorno de la coagulacion)	Yes No	**Thyroid Disorder**(Trastorno de la tiroides)	Yes No		
Diabetes (la diabetes)	Yes No	**High Cholesterol** (Colesterol alto)	Yes No	Other _____	

Please list all surgeries (Por favor liste todas las cirugias que ha tenido):

Name(Nombre): _____ Date(Fecha): _____

Name(Nombre): _____ Date(Fecha): _____

Name(Nombre): _____ Date(Fecha): _____

Name(Nombre): _____ Date(Fecha): _____

Name(Nombre): _____ Date(Fecha): _____

Name(Nombre): _____ Date(Fecha): _____

Please list any medications you are taking (Por favor, indique todos los medicamentos que esta tomando):
CONSENT TO REVIEW MEDICATION HISTORY- _____ (Please Initial)

Name(Nombre): _____ Dose(Dosis): _____

Name(Nombre): _____ Dose(Dosis): _____

Name(Nombre): _____ Dose(Dosis): _____

Name(Nombre): _____ Dose(Dosis): _____

Name(Nombre): _____ Dose(Dosis): _____

Name(Nombre): _____ Dose(Dosis): _____

PREFERRED PHARMACY (Farmacia Preferida): All controlled substances must be obtained at the same pharmacy, where possible. Should the need to change pharmacies arise; our office must be informed ahead of time. Please choose one pharmacy near your home, work, or an alternative home address where you will be expected to fill any controlled substance prescription written by your practitioner at Orthopaedic & Sports Medicine Consultants of New York:

1. Pharmacy Name(Nombre de Farmacia): _____ Phone(Numbero): (_____) _____

Address(Direccion): _____ City: _____ State: _____ Zip: _____

Do you have any drug allergies? Please list below (Tienes alguna alergia a medicamentos?)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Social History (Historia Social): (please circle one – por favor circule uno)

Marital Status (Estado Civil): **Single** (Soltero) **Married** (Casado) **Widowed** (Viudo) **Divorced** (Divorciado)

Alcohol Use (Consumo de alcohol): **Never** (Nunca) **Rarely** (Raramente) **Moderate** (Moderado) **Daily** (Diario)

Tobacco Use (Consumo de Tabaco): **Never** (Nunca) **Quit** (Deje de fumar) **Current** (Actualmente) – Packs **per day** (Paquetes por dia) _____

Recreational Drug Use (Uso de drogas recreativas): YES NO **Type** (Tipo): _____

Please circle one off each that may apply to you (Por favor circule cada que pueden aplicarse a su caso):

Preferred Language (Idioma Preferido): English Spanish Chinese French Arabic German Russian Italian Other: _____

Ethnicity (Etnicidad) (Please select one): Hispanic Non- Hispanic Unknown/ Refuse to answer

Race (Raza) (Please select one): White Black/African American Asian Unknown/ Refuse to answer Other: _____

Questionnaire for Foot / Ankle Patients Only:
(Cuestionario para el Pie / Pacientes de Tobillo Solamente)

Pain (Dolor):
- ☐ **None** (Ninguno)
- ☐ **Mild,Occassional**(Ocasional)
- ☐ **Moderate, Daily** (Diario)
- ☐ **Severe, almost always present**
  (Grave,casi siempre presente)

Maximum Walking Distance:
(Distancia maxima caminando)
- ☐ **Greater than 6 blocks**
  (mas de 6 bloques)
- ☐ **4 - 6 blocks** (Bloques)
- ☐ **1 - 3 blocks** (Bloques)
- ☐ **Less than one** (menos de una)

Walking Surfaces (Superficie para caminar):
- ☐ **No difficulty, any surface** (ninguna dificultad)
- ☐ **Some difficulty on uneven terrain, stairs, inclines, ladders**
  (cierta dificultad en terrenos irregulares/escaleras)
- ☐**Severe difficulty on uneven terrain, stairs, inclines, ladders**
  (Difilcultad severa en terrenos irregulares)

Function (Funcion):
- ☐**No limitations on any activities** (No hay limtaciones en cualquier actividad)
- ☐**No limitations on activities of daily living/employment, with limitations on recreational activities**
  (No hay limitaciones en las actividades de la vida diaria/empleo,con limitaciones en las actividades recreativas)
- ☐**Limited daily and recreational activities; needs a cane to walk**
  (Limitado a diario y actividades recreativas; necesito un baston para caminar)
- ☐**Severe limitation of daily and recreational activities; needs crutches, walker, or wheelchair**
  (Limitacion severa de las actividades diarias y recreativas; necesito muletas o ando en silla de ruedas)

Footwear Requirements (Requisitos Calzado):
- ☐**Fashionable, conventional shoes, no insert (orthotic) needed**
  (De moda, zapato convencional, sin insercion (ortesis) necesario)
- ☐**Comfort footwear and/ or shoe insert**
  (Calzado Confort/ o insercion de zapatos)
- ☐**Modified shoes and braces**
  (Zapatos modifcados)

Pain Scale (please mark pain level over the past week)
(Scala de Dolor / Por favor marque el nivel de dolor durante la semana pasada)

0 1 2 3 4 5 6 7 8 9 10

(no pain)
(sin dolor)

(worst pain)
(peor dolor)

Assignment of Benefits

As a courtesy to the patient and their families, Cary B. Chapman, MD PLLC does submit claim to many third party payers. I request that payment of authorized Medicare or private benefits to be made Cary B. Chapman, MD PLLC for any covered services furnished by Cary B. Chapman, MD PLLC, if my insurance carrier pays me directly; I agree to forward all funds to Cary B. Chapman, MD PLLC within 10 working days.

Disclosure of Information

I understand that my medical records and billing information are made and retained by Cary B. Chapman, MD PLLC and are accessible to Cary B. Chapman, MD PLLC'S personnel, who may use disclosure medical information for Cary B. Chapman, MD PLLC operations and functions and to any other health care personnel, involved in my continuum of care for this admission.

Release of Records

I authorized Cary B. Chapman, MD PLLC to release to any governmental health care program and its agents, or to any private insurance company or its agents any information needed to determine my benefits payable for Cary B. Chapman, MD PLLC.

I hereby authorize my attending physician to release all medical records pertaining to my healthcare information to Cary B. Chapman, MD PLLC.

Acknowledgement of Notice of Private Practice

A complete description of how my medical information will be used and disclosed by Cary B. Chapman, MD PLLC has been Cary B Chapman, MD PLLC'S NOTICE OF PRIVATE PRACTICES. I have been given the opportunity and have been advised to read the notice prior to signing this consent form. If I have any questions, I know to contact the Compliance Officer whose information is provided to me in the Notice of Private Practices.

Consent for Care Treatment

I, the undersigned, do hereby agree and given consent to Cary B. Chapman, MD to furnish medical care and treatment to the patient listed below that is considered necessary and proper in diagnosing or treating his/her physical and/or mental condition.

_____

Patient Name (Nombre de paciente) Date of Birth (Fecha de nacimiento)

_____

Patient Signature (or Parent/ Guardian or Representative) (Firma) Date (Fecha de hoy)

_____

Relationship to Patient (Relacion con el paciente)

_____

Witness Date

This authorization permits Cary B. Chapman, MD PLLC to disclose identifiable health information about you. List any relatives/ personal representative who are authorized access to your medical records/ treatment plans:

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNITL I CHANGE OR CANCEL IT IN WRITING.

Patient Signature: _____ **Date:** _____

ORTHOPAEDIC SPORTS MEDICINE

CONSULTANTS of NEW YORK

TELEPHONE CONSENT

DATE: _____

I _____ hereby give Orthopaedic & Sports Medicine Consultants of New York and all its affiliate entities permission to leave messages regarding

- Medical information _____
- Billing information _____

on my answering machine at the following numbers:

- _____
- _____

_____

Patient Signature (Firma)

☐ Please check box and supply us with your full email address below if you would like access to **Patient Portal:** _____ (please print clearly)

A **patient portal** is a secure online website that gives **patients** convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, **patients** can view health information such as: Radiology Results.

☐ Please check box if you give permission to communicate by email with our office

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:

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:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, film referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — 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: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire: 3 years
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.

Practice name here: Cary B. Chapman, MD PLLC	HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM	Patient MRN:

Please Fax signed consents to: 917-829-2096

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Health System Health Information Exchange ("HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU Langone health providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the HIE. In order for a Care Everywhere Provider to know that information may be available through the HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staffs of NYU Langone Health System and affiliated entities to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization, a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Health System and affiliated entities program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling 877-695-4749. Upon request, your provider will print this list for you from this website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology. To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care". You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.
Your Consent Choices. You can fill out this form now or in the future. You have the following choices:

Please check one box ☑ below:

☐ 1. **I GIVE CONSENT** to ALL of the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access ALL of my electronic health information through the HIE and **I GIVE CONSENT** to ALL employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access ALL of my electronic health information through HEALTHIX in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT** to the HIE Participants **listed on the HIE website** and Care Everywhere Providers to access my electronic health information through the HIE and **I DENY CONSENT** to employees, agents and members of the medical staffs of NYU Langone Health System and affiliated entities to access my electronic health information through HEALTHIX for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the HIE and HEALTHIX. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

Print Name of Patient	Patient's Date of Birth	Date
Signature of Patient or Patient's Legal Representative	Print Name of Legal Representative and Relationship (if applicable)	