



Corporate Office  
25 Kennedy Boulevard Suite #850  
East Brunswick, NJ 08816

New York Office  
150 East 58th Street  
5th Floor, Annex  
New York, NY 10155

[www.bsinynj.com](http://www.bsinynj.com)

Welcome to the Brain and Spine Institute of NY and NJ. Our goal is to provide you with the most comprehensive and compassionate treatment for your condition.

For your initial office consultation, please bring the following:

- Medical insurance card and a picture form of identification (driver's license)
- Referring physician and/or primary care physician's contact information
- All diagnostic studies- MRI, CT scan, or X-rays films, CD's, and reports (**PLEASE BRING THE ACTUAL CD OF THE MRI TO THE VISIT**)

If you are being seen for the following reason below please provide the following information in addition to the above:

#### **MOTOR VEHICLE ACCIDENT**

Claim number and claims adjuster contact info  
Declaration page of your insurance policy  
Police Report  
Attorney name and contact information  
Private medical insurance card (**To cover co-pays and deductibles from PIP or you have chosen PIP as primary**)

#### **WORKERS' COMPENSATION:**

Authorization if applicable  
Insurance company name, address, and telephone number Claim number  
Date of injury  
Attorneys name, address and telephone number  
Adjuster or nurse case manager's name and contact information including fax number

We appreciate the opportunity in being involved in your care!

Sincerely,

Brain and Spine Institute of NY and NJ



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Today's Date: \_\_\_\_\_

### Patient Information

Patient Number: \_\_\_\_\_

First Name		Middle Name		Last Name	
Sex	Marital Status		Date of Birth	Social Security Number	
Patient's Address			City	State	Zip
Home Phone	Cell Phone		Work Number	Ok to call at work?	
Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This will reduce the need for you to return our call if you do not have any additional questions. This should be a phone number where only you, or anyone that you are comfortable with hearing your medical information, has access to.					
Phone number that it is ok to leave message on			Initials _____		
Ethnicity	Race	Preferred Language			
Occupation	Employer		How Did You Hear About Us?		
Preferred Pharmacy	Pharmacy Cross Streets			Pharmacy Phone Number	
How May We Contact You? Please Select All That Apply					
Email Address		Mail	Text	Phone	Email
				Phone Number we can text to	

### Parent/Guardian/Spouse/Domestic Partner

First Name		Middle Name		Last Name	
Sex	Marital Status		Date of Birth	Social Security Number	
Address			City	State	Zip
Home Phone	Cell Phone		Work Number	Ok to call at work?	
Primary Medical Insurance/Work Comp Insurance/Auto Insurance					
Insurance Company Name			ID #	Group #	
Street Address			City, State, Zip		Phone #
Name of Subscriber, (MUST HAVE name, SSN, DOB to bill)			Social Security #		Subscriber's Date of Birth

**Secondary Medical Insurance**

Secondary Insurance Name		ID#	Group #
Street Address		City, State, Zip	
Name of Policy Holder		Social Security #	Date of Birth

**Emergency Contact Information**

Name	Relationship		Phone #
Address	City	State	Zip

\*\*\*\*\*

**RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER**

I, hereby authorize Brain and Spine Institute of NY and NJ, LLC, and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Arbor Family Medicine, PC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

\_\_\_\_\_  
Patient Signature/Authorized Representative

\_\_\_\_\_  
Date

**CONSENT FOR TREATMENT**

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

\_\_\_\_\_  
Patient Signature/Authorized Representative

\_\_\_\_\_  
Date



Corporate Office  
 25 Kennedy Boulevard Suite #850  
 East Brunswick, NJ 08816

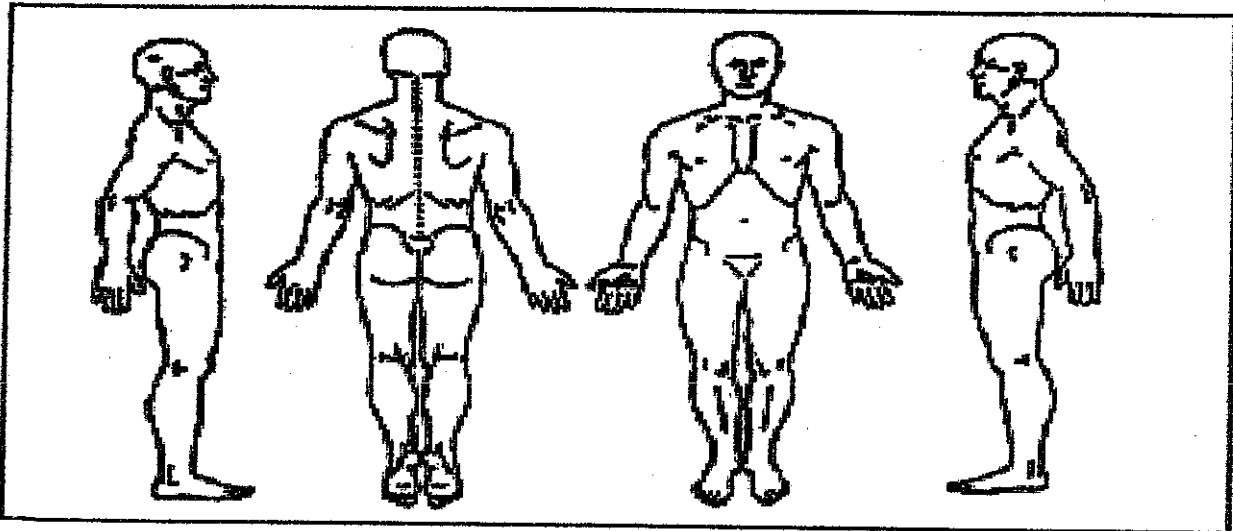
New York Office  
 150 East 58th Street  
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 New York, NY 10155

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Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Please Indicate the Location(s) of Your Pain: \_\_\_\_\_



Chief Complaint: \_\_\_\_\_

Pain Level:(Mild) 0 1 2 3 4 5 6 7 8 9 10 (Severe) Occasional / Frequent / Constant

How and when did pain begin? \_\_\_\_\_

If your pain is the result of an accident, briefly describe details: \_\_\_\_\_

Associated Symptoms:	YES	NO	Where and how often?
Numbness /Tingling			_____
Weakness			_____
Bladder Incontinence			_____
Bowel Incontinence			_____
Balance Problems			_____
Fever / Chills			_____
Joint Stiffness			_____
Weight Loss			_____

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Is pain aggravated by?      Sitting      Standing      Walking      Bending forward / backward

Is pain alleviated by?      Sitting      Standing      Walking      Bending forward / backward

Pain Description:      Dull/Aching      Burning      Sharp      Shooting      Throbbing      Tightness  
   Spasm      Electrical      Cramping

Pharmacy Name and Phone Number: \_\_\_\_\_

**Medical History**

**Medical Conditions:**

**Cardiac:**

Heart Attack  
Coronary Artery Disease  
Heart Valve Disorder Arrhythmia  
High Blood Pressure  
Other: \_\_\_\_\_

**Endocrine:**

Diabetes  
Hyperthyroidism  
Hypothyroidism  
Other: \_\_\_\_\_

**Gastro Intestinal:**

Acid Reflux  
GI Bleeding  
Gastric Ulcer  
Other: \_\_\_\_\_

**Renal:**

Kidney Disease  
Kidney Stones  
Disease  
Urinary Incontinence Dialysis  
Dialysis  
Other: \_\_\_\_\_

**Respiratory:**

Asthma  
COPD  
Other: \_\_\_\_\_

**Vascular:**

Stroke/TIA  
Peripheral Vascular  
Other: \_\_\_\_\_

**Neurological:**

Multiple Sclerosis  
Seizures  
Headaches  
Migraines  
Other: \_\_\_\_\_

**Cancer: Type**

\_\_\_\_\_

Allergies: \_\_\_\_\_  
No

Latex: Yes No      Contrast Dye: Yes

Previous Surgery(s): \_\_\_\_\_

Social History: Occupation: \_\_\_\_\_ Last Date Worked: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Substance Use: Alcohol Tobacco Marijuana IVDrugs Cocaine Other: \_\_\_\_\_  
How Often: \_\_\_\_\_

Review of Systems: Circle all that apply:

- Trouble Sleeping
- Fatigue
- Dizziness
- Ringling in Ears
- Lungs/Breathing
- Nausea
- Psychiatric
- Neurological
- Vomiting
- Skin
- Chest pain
- Bleeding
- Joints/Bones
- Headaches
- Vision
- Urinary
- Thyroid
- Memory
- Muscles

Family History:	Age	Diseases	Alive/Deceased
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

**Current and previous treating physicians for your current pain complaint:**

Please list Name/Address/Specialty

- 1: \_\_\_\_\_
- 2: \_\_\_\_\_
- 3: \_\_\_\_\_
- 4: \_\_\_\_\_
- 5: \_\_\_\_\_
- 6: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature/Authorized Representative

\_\_\_\_\_  
Date

# Low Back (Lumbar) Pain and Disability Questionnaire

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Read:** This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please just circle the one choice which closely describes your problem right now.

## SECTION 1--Pain Intensity

- 0. The pain comes and goes and is very mild.
- 1. The pain is mild and does not vary much.
- 2. The pain comes and goes and is moderate.
- 3. The pain is moderate and does not vary much.
- 4. The pain is severe but comes and goes.
- 5. The pain is severe and does not vary much.

## SECTION 2--Personal Care

- 0. I would not have to change my way of washing or dressing in order to avoid pain.
- 1. I do not normally change my way of washing or dressing even though it causes some pain.
- 2. Washing and dressing increase the pain, but I manage not to change my way of doing it.
- 3. Washing and dressing increase the pain and I it necessary to change my way of doing it.
- 4. Because of the pain, I am unable to do any washing and dressing without help.
- 5. Because of the pain, I am unable to do any washing or dressing without help.

## SECTION 3--Lifting

- 0. I can lift heavy weights without extra pain.
- 1. I can lift heavy weights, but it causes extra pain.
- 2. Pain prevents me from lifting heavy weights off the floor.
- 3. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
- 4. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- 5. I can only lift very light weights, at the most.

## SECTION 4 --Walking

- 0. Pain does not prevent me from walking any distance.
- 1. Pain prevents me from walking more than one mile.
- 2. Pain prevents me from walking more than one mile.
- 3. Pain prevents me from walking more than 1/2 mile.
- 4. I can only walk while using a cane or on crutches.
- 5. I am in bed most of the time and have to crawl to the toilet.

## SECTION 5--Sitting

- 0. I can sit in any chair as long as I like without pain.
- 1. I can only sit in my favorite chair as long as I like.
- 2. Pain prevents me from sitting more than one hour.
- 3. Pain prevents me from sitting more than 1/2 hour.
- 4. Pain prevents me from sitting more than ten minutes.
- 5. Pain prevents me from sitting at all.

## SECTION 6 -- Standing

- 0. I can stand as long as I want without pain
- 1. I have some pain while standing, but it does not increase with time.
- 2. I cannot stand for longer than one hour without increasing pain.
- 3. I cannot stand for longer than Yi hour without increasing pain.
- 4. I can't stand for more than 10 minutes without increasing pain.
- 5. I avoid standing because it increases pain right away.

## SECTION 7--Sleeping

- 0. I get no pain in bed.
- 1. I get pain in bed, but it does not prevent me from sleeping.
- 2. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- 3. Because of pain, my normal night's sleep is reduced by less than one-half.
- 4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
- 5. Pain prevents me from sleeping at all.

## SECTION 8--Social Life

- 0. My social life is normal and gives me no pain.
- 1. My social life is normal, but increases the degree of my pain.
- 2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- 3. Pain has restricted my social life and I do not go out very often.
- 4. Pain has restricted my social life to my home.
- 5. Pain prevents me from sleeping at all.

## SECTION 9--Traveling

- 0. I get no pain while traveling.
- 1. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- 2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- 3. I get extra pain while traveling which compels me to seek alternative forms of travel.
- 4. Pain restricts all forms off travel.
- 5. Pain prevents all forms of travel except that done lying down.

## SECTION 10--Changing Degree of Pain

- 0. My pain is rapidly getting better.
- 1. My pain fluctuates, but overall is definitely getting better.
- 2. My pain seems to be getting better, but improvement is slow at present.
- 3. My pain is neither getting better nor worse.
- 4. My pain is gradually worsening.
- 5. My pain is rapidly worsening.

# NECK (Cervical) DISABILITY INDEX

Patient Name: \_\_\_\_\_ MR#: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Read:** This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem right now.**

## SECTION 1--Pain Intensity

0. I have no pain at the moment
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain is severe but comes and goes.
5. The pain is severe and does not vary much.

## SECTION 2--Personal Care (Washing, Dressing etc.)

0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help, but manage most of my personal care.
4. I need help every day in most aspects of self-care.
5. I do not get dressed; I wash with difficulty and stay in bed.

## SECTION 3--Lifting

0. I can lift heavy weights without extra pain.
1. I can lift heavy weights, but it causes extra pain.
2. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

## SECTION 4 --Reading

0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

## SECTION 5--Headache

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come in-frequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

## SECTION 6 -- Concentration

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.
5. I cannot concentrate at all.

## SECTION 7--Work

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

## SECTION 8--Driving

0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

## SECTION 9--Sleeping

0. I have no trouble sleeping
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

## SECTION 10--Recreation

0. I am able engage in all recreational activities with no pain in my neck at all.
1. I am able engage in all recreational activities with some pain in my neck.
2. I am able engage in most, but not all recreational activities because of pain in my neck.
3. I am able engage in a few of my usual recreational activities because of pain in my neck.
4. I can hardly do any recreational activities because of pain in my neck.
5. I cannot do any recreational activities at all.



# ACTIVITIES OF DAILY LIVING ASSESSMENT

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please circle the number which most closely describes your chief complaint(s) today:

**1. Pain Intensity**

----- (0)----- (1)----- (2)----- (3)----- (4)----- (5)----- (6)----- (7)----- (8)----- (9)----- (10)-----  
 No Pain Worst Possible Pain

**2. Frequency Of Pain**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 No Pain      Occasional Pain      Intermittent Pain      Frequent Pain      Constant Pain  
                  25% Of The Day      50% Of The Day      75% Of The Day      100% Of The Day

**3. Personal Care (Washing, Dressing, etc.)**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 No Pain      Mild Pain      Moderate Pain      Moderate Pain      Severe Pain  
 No Restrictions      No Restrictions      Need to go slowly      Need some assistance      Need 100% Assistance

**4. Travel (Driving, Riding, etc.)**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 No Pain      Mild Pain      Moderate Pain      Moderate Pain      Severe Pain  
 On Long Trips      On Long Trips      On Long Trips      On Short Trips      On Short Trips

**5. Work**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 Can Do Usual Work      Can Do Usual Work      Can Do 50%      Can Do 25%      Cannot Work  
 Plus Extra Work      No Extra Work      Of Usual Work      Of Usual Work

**6. Recreation**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 Can Do All      Can Do Most      Can Do Some      Can Do A Few      Cannot Do Any  
 Activities      Activities      Activities      Activities      Activities

**7. Sleeping**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 Perfect      Mildly      Moderately      Greatly      Totally  
 Sleep      Disturbed      Disturbed      Disturbed      Disturbed

**8. Lifting**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 No Pain      Increased Pain      Increased Pain      Increased Pain      Increased Pain  
 With Heavy Weight      With Heavy Weight      With Mod Weight      With Light Weight      With Any Weight

**9. Walking**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 No Pain      Increased Pain      Increased Pain      Increased Pain      Increased Pain  
 Any distance      After One Mile      After Half Mile      After Quarter Mile      With All Walking

**10. Standing**

----- (0)----- (1)----- (2)----- (3)----- (4)-----  
 No Pain      Increased Pain      Increased Pain      Increased Pain      Increased Pain  
 After Several Hours      After Several Hours      After One Hour      After Half Hour      With Any Standing

What would you like to be able to do again that you presently cannot? \_\_\_\_\_

# BRAIN AND SPINE INSTITUTE OF NY AND NJ

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Brain and Spine Institute of NY and NJ is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### **Disclosure of Your Health Care Information**

#### **Treatment**

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

*"On occasion, it may be necessary to seek consultation regarding your condition from other healthcare providers associated with to Brain and Spine Institute of NY and NJ "*

*"It is our policy to provide a substitute healthcare provider, authorized by to Brain and Spine Institute of NY and NJ to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider 's absence due to vacation, sickness, or other emergency situation."*

#### **Payment**

We may disclose your health information to your insurance provider for the purpose of payment or healthcare operations.

#### **Workers' Compensation**

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

#### **Emergencies**

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

#### **Public Health**

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

#### **Judicial and Administrative Proceedings**

We may disclose your health information in the course of any administrative or judicial proceedings.

### **Law Enforcement**

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### **Deceased Persons**

We may disclose your health information to coroners or medical examiners.

### **Organ Donation**

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

### **Research**

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### **Public Safety**

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

### **Specialized Government Agencies**

We may disclose your health information for military, national security, prisoner and government benefits purposes.

### **Change of Ownership**

In the event that Olivieri Chiropractic and Rehabilitation Center is sold or merged with another organization, your health information/record will become the property of the new owner.

### **Your Health Information Rights**

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Brain and Spine Institute of NY and NJ is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Brain and Spine Institute of NY and NJ amend your protected health information. Please be advised, however, that Brain and Spine Institute of NY and NJ is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Brain and Spine Institute of NY and NJ.

- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. "If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

### **Changes to this Notice of Privacy Practices**

Brain and Spine Institute of NY and NJ reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Brain and Spine Institute of NY and NJ is required by law to comply with this Notice.

Brain and Spine Institute of NY and NJ is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

### **Complaints**

Complaints about your Privacy Rights or how Brain and Spine Institute of NY and NJ has handled your health information should be directed to Michael A Falcon, by calling this office at (732) 742-1590. If Michael A Falcon is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

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If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights  
200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, DC 20201

This notice is effective as of July 1, 2016

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Brain and Spine Institute of NY and NJ with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and healthcare operations as described in the Privacy Notice.

Patient's Name (print): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Facility Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**NO FAULT INSURANCE-** Any patient who is being seen for a No Fault injury needs to provide our front desk with their private medical insurance and/or attorney information. It is the responsibility of the patient to ensure that your accident insurance company has authorized your office visit/procedure. If the insurance company denies the claim, we will bill your private healthcare insurance. If you do not have healthcare insurance, you will be responsible for the bill.

If you are seeing us for a Motor Vehicle Injury, please initial \_\_\_\_\_

**WORKERS COMPENSATION INSURANCE-** Please provide our front desk staff with your Workers Compensation claim number, adjuster's information and insurance information. Should you have an attorney, we will need to have your attorney's name, address and telephone number.

If you are seeing us for a work related injury, please initial \_\_\_\_\_

**MEDICARE** –We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to Manhattan Spine and Pain Medicine, P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Please check the appropriate box below:

I am entitled to benefits under Medicare Hospital Insurance Part A YES NO

I am entitled to benefits under Medicare Hospital Insurance Part B YES NO

**ACCOUNT BALANCES & COLLECTIONS-** Any account balance past due after 3 invoices will be sent to the collection department unless there is a written payment arrangement in place. In the event that the provider's charges are outstanding, I hereby authorize the provider to file such a claim or appeal and/or action on my behalf so that the provider may receive payment of their charges. I understand that if the provider does not receive payment from the insurer, I will remain responsible for provider's charges. If you believe you qualify for financial hardship please contact the Billing Department for more information.

**Initial**

**FEES**

**Forms.** Effective May 1, 2012, there will be a \$10.00 fee for Social Security, disability and work related forms. Forms will be completed within 4 business days from the time the form is dropped off. It is your responsibility to provide a fax number and/or mailing address for us to forward the claims to.

**Missed Appointments.** Office Hours and Procedures: The care we provide our patients is a priority at Brain and Spine Institute of NY and NJ. Should you be unable to attend a scheduled appointment, we require a twenty-four hour (24 Hr.) notification. Without appropriate notification, you will incur a \$30.00 no-show fee for office visits.

**Returned Checks.** Subject to any bank fees and an additional \$50.00 service fee.

I have read, understand and agree to the Financial Policies and Procedures of Brain and Spine Institute of NY and NJ.

\_\_\_\_\_  
Patient/Financial Responsible Signature

\_\_\_\_\_  
Date



**Corporate Office**  
25 Kennedy Boulevard Suite #850  
East Brunswick, NJ 08816

**New York Office**  
150 East 58th Street  
5th Floor, Annex  
New York, NY 10155

[www.bsinynj.com](http://www.bsinynj.com)

**Disclosure of Physician Affiliation NOTICE TO PATIENTS**

Please carefully review the information contained in this notice.

Pursuant to the new Emergency Medical Services and No Surprise Bill law, in order to allow you to make a fully informed decision about your health care, the physicians of BRAIN AND SPINE INSTITUTE OF NY AND NJ, LLC (the "Practice") would like to advise you that we participate with the following health plans:

(i) Medicare; (ii) Workers Compensation, and (iii) No Fault insurance

Please note that the amount or estimated amount for your procedure or services is available upon request. If you have any questions concerning this notice, please feel free to ask your physician or any representative of our office. We welcome you as a patient and value our relationship with you.

**BY SIGNING THIS DOCUMENT, I ASKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS**

BY: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient/Patient Representative Signature)

\_\_\_\_\_  
Patient Name (Please print)      DOB: \_\_\_\_\_



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**Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws**

**Legal Assignment Of Benefits And Designation Of Authorized Representative**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider, *Brain and Spine Institute of NY and NJ*, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

---

Signature of Member or Legal  
Guardian/Representative

---

Date





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### PATIENT FINANCIAL POLICY

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

We are committed to providing you with the best possible care. We look forward to assisting you in receiving your maximum allowable benefits. All billing questions should be addressed to our billing department.

**REGISTRATION** - Upon arrival at our office, you will be required to bring your insurance card(s), and a picture form of identification (ex. driver's license). If you do not have the above form of ID available we will be unable to verify your insurance coverage. At that point you will have the option to reschedule your appointment, or you can pay for the services rendered that day. We will then submit the claim to your insurance company on your behalf. It is your responsibility to inform our office of any changes in your insurance plan or coverage.

**CO-PAYMENTS** -By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. We accept Cash and Checks only. ***Returned checks will be charged a return check fee of \$50.00 plus balance owed.***

**OUT OF NETWORK PLANS** -You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days; you will be responsible for the full amount due. In the event that the insurance company mails you the payment, it is your responsibility to contact our office. You will need to endorse the payment, and forward the checks to **BRAIN AND SPINE INSTITUTE OF NY AND NJ** within five (5) business days. In the event that the payment is not sent to BSI NY NJ within the time frame listed above, the entire billed amount will become the patient or the subscriber responsibility. (Please see our Assignment of Benefits form.)

**SELF-PAY PATIENTS** -Payment is expected at the time of service unless financial arrangements have been made prior to your visit. We accept Cash or Check only.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



**Corporate Office**  
25 Kennedy Boulevard Suite #850  
East Brunswick, NJ 08816

Phone: (732) 875-3814  
Fax: (732) 354-0091

**New York Office**  
150 East 58th Street  
5th Floor, Annex  
New York, NY 10155

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**BRAIN AND SPINE INSTITUTE OF NY AND NJ, LLC ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PERSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND/OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE**

I hereby assign and convey directly to the above-named health care billing provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement. If any, otherwise payable to me for services, treatment, therapies, and/or medications rendered or provided by the above-named health care billing provider, regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care billing administrator fiduciary, insurer, and /or attorney to release to the above-named health care billing provider any and all plan documents summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care billing provider or its attorneys in order to claim such medical benefits.

I intend by this assignment and designation of authorized representative to convey to the above-named billing provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or medications provided by the above-named health care billing provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named billing provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

Pursuant to the provisions of the Patient Protections and Affordable Care Act, our commitment is to ensure that we provide the highest quality of care with affordable prices. In addition, we would like to protect our patients from unexpected bills. In making sure services are available to as many patients as possible at affordable prices, our financial policy is outlined below. Please read this carefully and sign prior to your treatment.

▶ **WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE**

▶ **WE MAY OFFER FINANCIAL ASSISTANCE UNDER OUR FINANCIAL POLICY TO ELIGIBLE PATIENTS ON A CASE BY CASE BASIS**

**Insurance**

We accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, and telephone/verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by our office. However, you are personally responsible for your account balance in the event your insurance company does not pay the full amount of your claims, unless your eligible for a reduction in the amount owed under our Financial Policy.

**Discounts or Reductions in Bill**

We may offer a discount, reduction or waiver of the deductible, coinsurance or co-pay to eligible patients based on medical needs and ability to pay on a case-by-case basis under our Financial Policy in accordance with applicable federal and state laws.

**Your Responsibility and Cooperation**

If we accept your insurance assignment as a payment from your insurance company, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquiries, requests for additional information, claims status verification or any inquires for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provide us with a copy of any documentation received from the insurance company or submitted to the insurance company from you.

**I have read the Financial Policy, I understand and agree to this Financial Policy.**

X \_\_\_\_\_

Signature of Responsible Party

Print Name

Date



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### HIPPA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_  
Signed (Patient or Legal Representative for Patient)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Legal Representative's Relationship to Patient