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

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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5th Floor, Annex
New York, NY 10155

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PATIENT NAME: _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DOB: _____ **SOCIAL SECURITY NUMBER:** _____

HOME PHONE NUMBER: _____ **CELL NUMBER:** _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ **PHONE:** _____

NAME OF AUTO INSURANCE COMPANY: _____

CLAIM NUMBER: _____ **DOA:** _____

PIP COVERAGE LIMITS: _____ **HEALTHCARE PRIMARY: YES / NO (CIRCLE)**

NAME OF INSURED ON POLICY: _____

YOUR ATTORNEY NAME: _____ **PHONE NUMBER:** _____

DO YOU HAVE PRIVATE HEALTH INSURANCE? ☐ YES ☐ NO IF YES, NAME OF PRIVATE INSURANCE: _____

WERE YOU THE DRIVER OF THE AUTOMOBILE? ☐ YES ☐ NO
WERE YOU A PASSENGER IN THE AUTOMOBILE? ☐ YES ☐ NO
WERE YOU A PEDESTRIAN? ☐ YES ☐ NO
WERE YOU A MEMBER OF THE AUTOMIBLES OWNER'S HOUSEHOLD?
☐ YES ☐ NO
AS A RESULT OF THE ACCIDENT, WERE YOU INJURED? ☐ YES ☐ NO

ROAD CONDITIONS AT TIME OF ACCIDENT: ☐ ICY ☐ RAINY ☐ CLEAR ☐ DARK

THE CAR YOU WERE IN: ☐ HIT ANOTHER CAR ☐ WAS HIT BY ANOTHER CAR:
ON WHAT SIDE ☐ RIGHT ☐ LEFT ☐ REAR ☐ FRONT ☐ SIDE

TYPE OF ACCIDENT: ☐ HEAD-ON COLLISION ☐ BROADSIDE COLLISION ☐ REAR-END COLLISION ☐ FRONT IMPACT (CAR YOU WERE IN, REAR-ENDED CAR IN FRONT)

WAS THERE A SECONDARY COLLISION? ☐ YES ☐ NO

IF YES, IN THE SECONDARY IMPACT, THE CAR YOU WERE IN: ☐ HIT ANOTHER CAR ☐ WAS HIT BY ANOTHER CAR: ON WHAT SIDE ☐ RIGHT ☐ LEFT ☐ REAR ☐ FRONT ☐ SIDE

WERE YOUR PRE-WARNED THAT THE ACCIDENT WAS ABOUT TO HAPPEN? ☐ YES ☐ NO

DID YOU BRACE FOR THE IMPACT? ☐ YES ☐ NO
☐ I BRACED WITH MY HANDS ☐ I BRACED WITH MY FEET

WERE YOUR GRIPPING THE STEERING WHEEL? ☐ YES ☐ NO
IF YES: ☐ REGULAR GRIP ☐ TIGHT GRIP ☐ N/A

WERE YOU WEARING YOUR SEAT BELT? ☐ YES ☐ NO

WAS YOUR CAR STOPPED? ☐ YES ☐ NO
IF YES, WAS YOUR FOOT FIRMLY ON BRAKE? ☐ YES ☐ NO
IF NO, WAS YOUR CAR ☐ SLOWING DOWN ☐ MAINTAINING SPEED ☐ ACCELERATING

HEAD/BODY POSITION AT TIME OF IMPACT:
☐ HEAD TURNED ☐ LEFT ☐ RIGHT ☐ BODY STRAIGHT IN SITTING POSITION
☐ HEAD LOOKING BACK ☐ HEAD STRAIGHT FORWARD
☐ BODY ROTATED ☐ LEFT ☐ RIGHT ☐ LEGS CROSSED ☐ YES ☐ NO

WHICH WAY WERE YOU FACING AT THE TIME OF IMPACT: ☐ FORWARD ☐ LEFT ☐ RIGHT

AT THE TIME OF IMPACT, DID ANY PART OF YOUR BODY OR HEAD STRIKE ANYTHING IN THE VEHICLE? ☐ YES ☐ NO
IF YES, SPECIFY WHAT PART OF THE BODY STRUCK WHAT PART OF THE INSIDE OF THE CAR.
☐ STEERING WHEEL _____ ☐ DASHBOARD_____
☐ WINDSHEILD _____ ☐ ROOF_____
☐ LEFT SIDE DOOR _____ ☐ RIGHT SIDE DOOR _____
☐ LEFT SIDE WINDOW _____ ☐ RIGHT SIDE WINDOW _____
☐ OTHER _____

DID THE SEAT BACK BEND OR BREAK? ☐ YES ☐ NO

AS A RESULT OF THE ACCIDENT WERE YOU: ☐ RENDERED UNCONSCIOUS ☐ DAZED/DIZZY ☐ DISORIENTED ☐ NERVOUS ☐ NAUSEOUS ☐ UPSET ☐ WEAK ☐ OTHER: _____

COULD YOU MOVE ALL YOUR BODY PARTS? ☐ YES ☐ NO

IF NO, WHAT PARTS AND WHY?

_____

DID YOU GO TO THE HOSPITAL? ☐ YES ☐ NO WERE YOU ADMITTED? ☐ YES ☐ NO
IF YES, FOR HOW LONG WERE YOU ADMITTED? _____

WHEN DID YOU GO TO THE HOSPITAL? ☐ AT TIME OF ACCIDENT ☐ NEXT DAY ☐ OTHER _____

HOW DID YOU GET TO THE HOSPITAL? ☐ AMBULANCE ☐ PRIVATE TRANSPORTATION

NAME OF HOSPITAL YOU WENT TO FOR THIS ACCIDENT?

_____

ADDRESS: _____

WHICH OF THE FOLLOWING TREAMENTS/DIAGNOSIS WERE YOU GIVE AT HOSPIATL?
☐ NONE ☐ MRI ☐ X-RAYS ☐ CT-SCAN ☐ PLACED IN CERVICAL COLLAR
☐ STITCHES ☐ BANDAGED ☐ GIVEN PAIN MEDICATION
☐ GIVEN PRESCRITION FOR PHYSICAL THERAPY
☐ GIVEN INSTRUCTIONS REGARDING SPRAINS AND STRAINS
☐ INSTRUCTED TO CALL AN ORTHOPEDIC SURGEON
☐ INSTRUCTED TO CALL PRIMARY CARE PHYSICIAN ☐ OTHER: _____

HAVE YOU SEEN ANY OTHER DOCTOR'S AS A RESULT OF THIS ACCIDENT?
☐ PAIN DOCTOR: NAME: _____
☐ ORTHOPEDIC SURGEON: NAME: _____
☐ CHIROPRACTOR: NAME: _____
☐ PHYSICAL THERAPIST: NAME: _____
☐ NEUROLOGIST: NAME: _____
☐ PRIMARY CARE PHYSICIAN: NAME: _____

COMPLAINTS AND/OR SYMTOMS BECAUSE OF THE ACCIDENT:
[] NECK (CERVICAL) PAIN [] MID BACK (THORASIC) PAIN [] LOWER BACK (LUMBAR) PAIN [] LEFT SHOULDER [] LEFT SHOULDER [] LEFT LEG [] RIGHT LEG [] LEFT ARM [] RIGHT ARM [] LEFT FOOT [] RIGHT FOOT [] LEFT WRIST [] RIGHT WRIST

IN YOUR OWN WORDS, PLEAE DESCRIBE YOUR SYMTOMS AND COMPLAINTS BECAUSE OF THIS ACCIDENT:

_____

_____

HAVE YOU LOST ANY TIME FROM WORK DUE TO YOUR INJURIES? []YES []NO
IF YES, HOW MUCH TIME? _____

AT THE TIME OF THE ACCIDENT, WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? [] YES [] NO

Release of information: I hereby authorize Brain and Spine Institute of NY and NJ to disclose to my insurance company(s) copies of my medical record(s) to obtain payment for services or as part of a payment review of medical services, or in the case of Workers' Compensation or Motor Vehicle claims, to my present or past employer(s). Additionally, I authorize Brain and Spine Institue of NY and NJ to release copies of my medical record(s) to my attorney and to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that federal and/or state law may protect the information disclosed, and I specifically consent to disclose such information.

_____ _____
Patient Signature **Date**

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT, MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, SUBJECT TO CRIMINAL PROSECUTION AND CIVIL PENALATIES"
THIS STATEMENT IS REQUIRED BY THE NEW JERSEY FRAUD PREVENTION ACT OF 1983

BRAIN AND SPINE INSTITUTE OF NY AND NJ
614 CRANBURY ROAD – SUITE 413
EAST BRUNSWICK, NEW JERSEY 08816

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

I hereby assign benefits and authorize payment directly to **BRAIN AND SPINE INSTUTITE OF NY AND NJ, LLC** and/or its staff (hereinafter collectively "You") of any insurance benefits made as payment to me (or a minor for whom I am guardian) as reimbursement for services provided to me (or a minor for whom I am the guardian) for their services. I agree to immediately forward to this office any insurance payments that are made directly to me.

I, _____, irrevocably assign to you, **BRAIN AND SPINE INSTUTITE OF NY AND NJ, LLC**, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your mane on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code. I request that the insurance carrier consent to my assignment of benefit s within 10 days of receipt otherwise it is deemed consented to.

As medical provider I agree to attempt to reasonably comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize the attorney to file directly against that carrier I my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care providers(s) to release all such information to you about me, including medical reports, X-rays reports, narrative reports, and any other report or information regarding my physical condition.

INSURANCE COMPANY: _____ **DATE OF ACCIDENT**: _____

CLAIM NUMBER: _____

CLAIMANT NAME (PRINTED): _____ **DATE:** _____

CLAIMANT SIGNATURE: _____

PROVIDER NAME: ARIEN J. SMITH, M.D. **TIN:** 81-2033666

DATE: _____ **PROVIDER SIGNATURE:** _____

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New York, NY 10155

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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 Mail Text Phone Email

Email Address	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	Phone #
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

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5th Floor, Annex
New York, NY 10155

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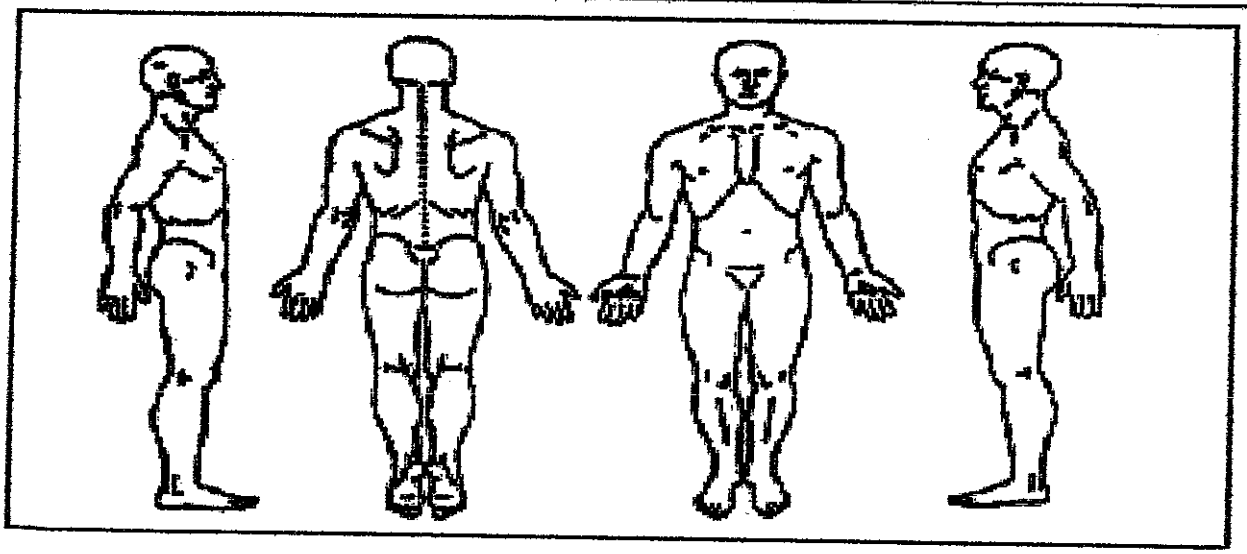
Patient Name: _____ DOB: _____

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:_____ **Latex:** Yes No **Contrast Dye:** Yes No

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

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 withouthelp.

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 minuteswithout 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. Mypain is gradually worsening.
5. My pain israpidly 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 25% Of The Day	Intermittent Pain 50% Of The Day	Frequent Pain 75% Of The Day	Constant Pain 100% Of The Day

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

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

4. Travel (Driving, Riding, etc.)

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

5. Work

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

6. Recreation

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

7. Sleeping

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

8. Lifting

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

9. Walking

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

10. Standing

(0)	(1)	(2)	(3)	(4)
No Pain After Several Hours	Increased Pain After Several Hours	Increased Pain After One Hour	Increased Pain After Half Hour	Increased Pain 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 confidentially 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 that 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.

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: _____

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

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

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)

_____ DOB:_____
Patient Name (Please print)

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

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

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

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 INSTITUE 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

25 Kennedy Boulevard Suite #850
East Brunswick, NJ 08816

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

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

www.bsinynj.com

BRAIN AND SPINE INSTITUTE OF NY AND NJ, LLC ASSIGNMENT OF BENEFTIS, 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 FUDCIARTY 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 ELIGIBLEE 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

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

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 abound 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