565 Jewett Avenue, Staten Island, New York 10302

SHAILESH S. PATHARE, M.D.

Advanced Spine Care &
Pain Management of New York

Tel: 718-701-6010
Fax: 718-447-7831

Social Security Number: - -	Last Name: First Name:	Date of Birth:
Home Telephone Number:	Address:	ZIP Code:
Sex: Male Female	Occupation:	Cell Phone Number
Is this work related? No Yes	Name/Address of Employer:	
Emergency Contact Name :	Relationship	Phone #

Referring Physician:	Primary Physician:
Address:	Address:
Telephone/Fax Number:	Telephone/Fax Number:

Primary Insurer:	Secondary Insurer:
Address:	Address:
Policy Number:	Policy Number:
Policy Holder:	Policy Holder:
Relationship to Patient: Self Spouse Child Other	Relationship to Patient: Self Spouse Child Other

I agree to follow my physician's treatment recommendations as specified. I will not adjust medication(s) or application(s) without first consulting with and obtaining permission of my physician. I hereby certify that, to the best of my knowledge, the above information is accurate. If reasonable payment for services rendered is not made to the provider by my insurance carrier(s), I agree to accept full financial responsibility for the payment of my physician's services. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Shailesh S. Pathare,, M.D. for any services furnished me by the physician.

Patient's or Authorized Person's signature _____ **Date** _____

How Did You Here About Us?

Newspaper Advertisement: ☐

Physician Booklet: ☐

Flyer: ☐

Friend/Relative: ☐

Referred By Doctor: _____

ADVANCED SPINE CARE

& Pain Management Of New York, P.C

DR. SHAILESH PATHARE

CONSENT TO AND ACKNOWLEDGEMENT OF TREATMENT

AND ASSIGMENT OF BENEFITS

I consent to undergo evaluation and treatment by Advanced Spine Care & Pain Management Of New York, P.C. I understand that in the course of diagnosis and therapy, the physicians or any of their agents and/or employees may assist or participate in my care.

I consent to the use and disclosure of protected health information (PHI) by Advanced Spine Care & Pain Management Of New York, P.C for the purpose of treatment, payment and health care operations.

I authorize my medical insurance benefits and/or Medicare/Medicaid benefits (for services rendered by Dr. Pathare in person or under their supervision) to be paid directly to Advanced Spine Care & Pain Management Of New York, P.C. (Dr. Pathare) realizing that I am responsible for non-covered services, coinsurance payments, and deductibles.

Paient Name:_____ **Date:**_____

Parent/Legal Guardian (if applicable):_____

Signature:_____

ADVANCED SPINE CARE

& Pain Management Of New York, P.C

DR. SHAILESH PATHARE

All patients are responsible for knowing their health insurance coverage

This office will bill your health insurance carrier on your behalf. However, it is ultimately your responsibility to know your health coverage and it is your responsibility to handle and discrepancies in claims processing.

All future services provided by our office are with the understanding that your previous recorded insurance information is correct and current. If anything changes with your insurance coverage, you must notify us immediately before services are provided. A referral or precertification may be required for services and may result in a denial of reimbursement from your insurance company. If you neglect to provide us with the new information, you will be financially responsible for the services rendered.

Thank you for your cooperation,

Advanced Spine Care & Pain Management Of New York, P.C

Patient Name:_____

Patient/Guardian Signature:_____

Relationship to Patient:_____

Date:_____

By signing this document, you are aware that there may be additional charges for your office visit and have been given the opportunity to check with your insurance company.

Advanced Spine Care

& Pain Management of New York, P.C

DR.SHAILESH PATHARE

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION PURSUANT TO HIPPA

NAME: _____ Date of Birth: _____

Social Security Number: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPPA) of 1996.

This office and its designated agents may share or disclose any part of your health record to other physicians or healthcare facilities that participate in your care. This may include any or all of the following: alcohol or drug abuse, mental health diagnoses and treatment, HIV (or AIDS) related information.

At times, it may become necessary to share portions of your medical records with other agencies that indirectly participate in your healthcare. Such an example would include billing, transcription, Insurance companies, law firms, medical testing centers, governmental agencies, etc. This information can include doctor's notes, blood or X-ray results, billing or insurance records, referrals, and information that we have received from other healthcare facilities.

By signing below, you or your authorized representative acknowledge that you have read this letter and agree. You have the right to restrict the release of any and all parts of your medical records to a particular healthcare or non-healthcare facility. If you choose to do so, please specify below. You have the right to change your preferences (i.e. revoke this authorization) at any time in the future.

Advanced Spine Care & Pain Management of New York will NOT be responsible for any health (or other) related problems that result from your refusal to have your health information shared with any physicians, health care facilities or any other agencies.

_____ I consent to release of ALL portions of my medical record to other physicians, healthcare facilities or agencies.

SIGNATURE _____ DATE _____

Relationship to patient if applicable _____

Please put your initial (not and X or check mark) on the appropriate "yes" or "no" line.

NO	YES	
_____	_____	We may send billing statements or letters to your home address
NO	YES	We may send clinical information (labs or xrays) to your home Address
_____	_____	
NO	YES	We may answer emails with any relevant clinical information
_____	_____	
NO	YES	We may call your home phone and identify ourselves.
_____	_____	
NO	YES	We may leave messages on your phone. If so list that number Here _____
_____	_____	
NO	YES	We may call your business phone number and identify ourselves As Advanced Spine Care & Pain Management of New York.
_____	_____	
NO	YES	We may call your cell and identify ourselves as Advanced Spine Care & Pain Management of New York.
_____	_____	

ADVANCED SPINE CARE & PAIN MANAGEMENT OF NEW YORK may speak with the following person/ people regarding any aspect of your healthcare (health records), billing, appointment scheduling if the listed person calls this office to speak to one of our personnel or alternatively if we reach this person when calling you.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT NAME _____

PATIENT SIGNATURE _____

The Pain Management Center
Richmond University Medical Center
355 Bard Avenue, Staten Island, New York 10310 – 1699
Tel # 718 818-4892
Fax# 718 818-3277

SHAILESH (SHAY) S. PATHARE, M.D.

Name:_____

Date of birth: _____ **Age:**_____ **Male:** _____ **Female:**_____

Marital status: (circle one)

Single Married Divorced Separated Widowed

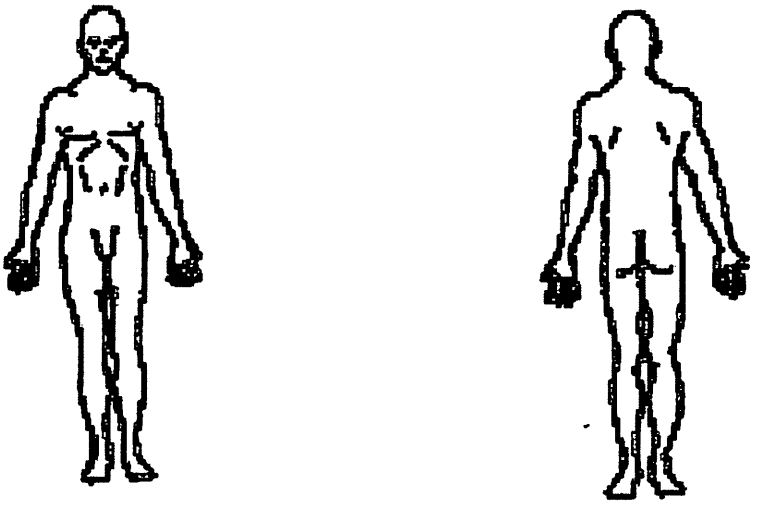
PLEASE ANSWER THESE QUESTIONS AS BEST AS YOU CAN. A THOROUGH RECORD IS IMPORTANT FOR THE BEST CARE:

Pain History

Where is the location of your pain?

_____
_____
_____
_____

On the drawing below, please shade in the areas in which you are having pain:



How long has the pain been present in this/these areas?

_____

_____

_____

Do you have any dizziness, weakness, and loss of bowel or bladder control?_____

_____

_____

Did an accident or other event precipitate your pain? Yes_____No ____
If yes please describe: _____

_____

_____

_____

Were you injured on the job? Yes_____No_____

Are you currently involved in litigation? Yes_____No_____

Are you currently working? Yes_____ No_____

If no, when did you stop?_____ Why?_____

If yes, Where and at what position?_____

How frequently do you have your pain? (Please circle)

Constantly	(About 80 to 100% of the time)
Often	(About 50 to 80% of the time)
Intermittently	(About 25 to 50% of the time)

How would you describe your pain symptoms? Please circle all that apply. Next to each, write in what area you feel this.

Burning _____	Sharp _____	Shooting_____
Dull _____	Aching _____	Throbbing_____
Cutting _____	Numbness_____	Cramps_____
Gripping_____	Electrical_____	Pins and needles _____
Weakness of limbs _____		Other_____

If pain limits your activities, please answer the following questions.

I can't tolerate walking more than _____blocks.
I can't tolerate sitting more than _____minutes.
I can't tolerate standing more than _____minutes
I can't tolerate lying down more than _____minutes.

What medications do you take ***now*** for pain? _____

_____

_____

Name of Physician prescribing these medications _____

What medications have you ***tried in the past*** for pain? _____

_____

_____

_____

_____

NO PAIN **HORRIBLE PAIN**

0 1 2 3 4 5 6 7 8 9 10

On the scale above put an:

"L" Where your pain is at your least.
"W" Where your pain is at its worst.
"N" Where your pain is right now.

When is the pain at its worst?

Morning Afternoon Evening Night Changing positions

Please circle the activities that your pain interferes with.

Appetite Sleep Social Activities Sex Working at Job / Home

Please circle the tests you have had. Put approximate date and name of facility where performed.

XRAY_____ CT SCAN_____

MRI _____ BONE SCAN_____

EMG _____ OTHERS _____

Please circle any treatment you have had for pain and give details:

	Dates	Was the treatment helpful
Surgery	_____	_____
Pain Injections	_____	_____
TENS	_____	_____
Physical Therapy	_____	_____
Psychotherapy	_____	_____
Biofeedback / Hypnosis	_____	_____
Chiropractor	_____	_____
Acupuncture	_____	_____
Other	_____	_____

GENERAL MEDICAL QUESTIONS

Do you or your family have a history of any of the following:
(Please check the appropriate boxes)

	Patient	Family		Patient	Family
Arhtritis	☐	☐	Heart disease	☐	☐
Diabetes	☐	☐	Hypertension	☐	☐
Lung Disease/asthma	☐	☐	Seasonal \ Allergies	☐	☐
Peptic Ulcer disease	☐	☐	Cancer	☐	☐
Other	☐	☐			

Check off if you have or if you have experienced any of the following in the recent past:

____Fever ____Weight loss _____Dysuria _____Spasticity
____Rashes ____Joint Swelling _____Joint Redness ____GYN problems
____Headaches ____Blurred Vision _____Sinus Congestion ____SOB
____ GI problems _____Night sweats _____Chest Pain ____Night sweats
____Trouble swallowing _____Ongoing Infection
____Incontinence _____Breast / Prostate problems _____ Chest Pain/palpitations
____Thoughts of harming yourself or others

Female – Last GYN / Breast _____ Male – Prostate History _____

Do you have any medical or psychiatric problems that you see a doctor for?

_____
_____
_____

List any surgeries you have had. What and when

_____
_____
_____
_____

Please list all medications that you take

_____
_____
_____
_____
_____

Please list any allergies to medications?

_____
_____

Do you have any allergy to shellfish or IV contrast?

_____
_____

Are you currently taking any antibiotics? Yes _____ No_____

If yes, list the name of medication and reason you are taking it.

_____

_____

_____

Do you currently use recreational drugs or IV drugs?

_____

_____

_____

Do you have a history of recreational drug or IV drug abuse?

_____

_____

_____

Do you smoke? If any, how many per day?

_____

_____

Current Height_____ Current Weight _____

Are you right handed?_____ Left handed _____

Your Signature _____

MOTOR VEHICLE INJURY PATIENTS ONLY

No – Fault Information

PATIENT NAME:_____

NAME OF INSURANCE CARRIER :

_____

_____

_____

ADDRESS OF INSURANCE CARRIER:

_____

_____

_____

_____

_____

DATE OF ACCIDENT: _____

NAME OF POLICY HOLDER: _____

POLICY NUMBER : _____

CLAIM NUMBER: _____

NAME OF INSURANCE REPRESENTATIVE: _____

PHONE # OF INSURANCE REPRESENTATIVE: _____

*** ALL INFORMATION MUST BE FILLED IN BEFORE WE BEGIN TREATMENT ***

MOTOR VEHICLE INJURY ONLY

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 03/01/2002)

I, _____, ("Assignor") hereby assign to _____,

(Print patients name) (Print hospital or health care provider name)

("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the NO-FAULT statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the assignor and shall not persue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, Not withstanding any other agreement to the contrary .

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/ or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMERCIAL INSURANCE OR A STATEMENT OF CLAIM OR ANY COMMERCIAL OR PERSONAL BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DEPARTMENT, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACTS, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FICE THOUSAND DOLLAR AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____

(PRINT PATIENTS NAME) **(SIGNATURE OF PATIENT)**

_____ _____

_____ **(DATE OF SIGNATURE)**

(ADDRESS OF PATIENT)

Shailesh Pathare _____

(PRINT NAME OF PROVIDER) **(SIGNATURE OF PROVIDER)**

565 Jewett Avenue _____ _____

Staten Island NY 10302 _____ **(DATE OF SIGNATURE)**

(ADDRESS OF PROVIDER)

NYS FORM NF-AOB (REV 1/2004)

WORKERS COMPENSATION

PATIENTS INJURY ONLY

PATIENT NAME: _____

EMPLOYER NAME : _____

OFFICE JOB TITLE : _____

NAME: _____

SOCIAL SECURITY NUMBER: _____

CARRIER: _____

ADDRESS OF CARRIER: _____

_____

_____

_____

WCB CASE # : _____

DATE OF ACCIDENT : _____

CARRIER ID: _____

CARRIER CASE # : _____

CASE MANAGER NAME: _____

CASE MANAGER PHONE NUMBER: _____

CASE MANAGER FAX NUMBER: _____

PLEASE NOTE THAT IT IS A REQUIREMENT BY THE WORKMANS COMPENSATION BOARD THAT WE SUBMIT ALL CLAIMS WITH YOUR SOCIAL SECURITY NUMBER.

Urine Toxicology Testing Informed Consent

Due to the nature of the field of Pain Management and Spine Care, Dr. Pathare has implemented urine toxicology screening and lab testing for all patients.

In keeping with a high standard of care in the field of Pain Management, urine toxicology testing adds valuable information to the doctor enabling him to determine a treatment plan that will address your pain problem. The testing provides information about the presence (or lack thereof) of certain medications and controlled substances, which will impact the treatment plan and goals.

Along with the ISTOP law for New York State, regular urine toxicology testing can help to ensure compliance with pain treatment programs and helps prevent doctor shopping for pain pills. This protocol also helps to prevent the use of illicit drugs and alcohol for patients requiring treatment of pain with narcotic medications.

Please note that refusing the urine testing may prevent the doctor from being able to treat you.

I understand and comply with urine toxicology testing:

Print Name _____

Signature _____

Date _____

PHARMACY INFORMATION FOR ELECTRONIC PRESCRIPTIONS

Advanced Spine Care and Pain Management

Of New York.

Patient Name:

Pharmacy Name:

Pharmacy Address:

Pharmacy Phone number:

Pharmacy Fax number: