ORTHOPAEDIC SURGEONS OF L.I., ASSOC.

410 Lakeville Road Suite 303 New Hyde Park, NY 11042
Tel: (516) 775-7898 www.ortho-md.com Fax: (516) 775-4796

Philip D'Ambrosio, M.D. F.A.C.S. Ronald Light, M.D. F.A.C.S. Neil Watnik, M.D. F.A.C.S.

PATIENT NAME:_____ SEX: M F
FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____ DATE OF BIRTH:_____ AGE:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

EMERG NAME & PHONE:_____ SS#:_____

PHARMACY NAME:_____

PHARMACY CITY: _____ STATE: _____ PHONE NUMBER:_____

REFERRING PHYSICIAN/PHONE NUMBER:_____

IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING:_____

PRIMARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____ PHONE #:_____

RELATIONSHIP TO INSURED:_____

POLICY HOLDER NAME & DATE OF BIRTH (IF DIFF. FROM PATIENT):_____

SECONDARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____ PHONE #:_____

POLICY HOLDER NAME & DATE OF BIRTH (IF DIFF. FROM PATIENT):_____

TERTIARY INSURANCE:_____

POLICY #:_____ GROUP #:_____

ADDRESS:_____ PHONE #:_____

POLICY HOLDER NAME & DATE OF BIRTH (IF DIFF. FROM PATIENT):_____

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO ORTHOPAEDIC SURGEONS OF L.I., ASSOCIATES FOR SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES INCLUDING REASONABLE ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT.
I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATIONS OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.
I AUTHORIZE THE PHYSICIANS AND ALLIED STAFF OF ORTHOPAEDIC SURGEONS OF LONG ISLAND, ASSOC. TO ADMINISTER AND TREAT ALL ORTHOPAEDIC CONDITIONS AS DEEMED NECESSARY FOR MYSELF, MY FAMILY AND/OR MY DESIGNATED HEALTHCARE PROXY.

SIGNED:_____ **DATE:**_____

PRINT NAME:_____

PLEASE ADVISE THE FRONT DESK STAFF IF YOU WERE INJURED IN A CAR ACCIDENT OR ON THE JOB

☐ **Yes** ☐ **No** **Patient Initials:**_____

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Your Insurance Company

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know, or keep up with, each program's provisions.

- Some programs require that a specific facility be used for your x-rays, ultrasounds, or blood tests.
- Some programs require pre-authorization, while others do not.
- Some companies require **patients** to notify them of hospital admissions or emergency room visits.
- Some programs require specific information regarding hospitalizations.

It is **your responsibility** (to know):

- To advise this office of your program's requirements in advance, each time we provide a service.
- Out of Network: will require any deductible or co-insurance payment
- Whether this office is participating with your particular plan and program
- We will do our very best to comply with any reasonable requirements that your program may have.

Please understand this if we have not been advised in advance of your programs requirements or conditions, and we provide a service or use a laboratory that is outside of the program, you will be responsible for the appropriate fees. In addition, there are times that we may not be able to obtain a consultant or laboratory that is participating with your program. It will be up to **you** to work this out with your insurance company.
These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may deny all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use if you have any questions about your coverage.

- **Assignment of benefits:** I authorize payment of medical benefits directly to Orthopaedic Surgeons of L.I. for services described. I understand that I am responsible to pay for services, including insurance co-payments as well as reasonable attorney fees and costs of collection in the event of default.

- I have been provided with a copy of the Orthopaedic Surgeons of L.I.'s **HIPPA Privacy Notice** and have been given an opportunity to read and ask questions about the notice.

- **Lastly, I authorize the following individual(s):** _____

to receive any medical information on my behalf. _____
Patient Signature

- **For patients insured by Medicare:** I authorize any holder of medical or any other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician, any information used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____	_____	_____
Signature	*Print Name*	*Date*

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PATIENT RESPONSIBILITY

Having the correct insurance information at all times is very important to us.

Most insurance companies have a timely filing period of 60 days. If we are given inaccurate information and bill the wrong insurance, it could affect the filing time limit with the correct carrier. **So please, anytime you have new information, let us know immediately.**

I am aware that all insurance information I have provided Orthopaedic Surgeons of LI is to be accurate and up to date. I am also aware that I am responsible to follow all the rules and regulations that are implemented by my insurance carrier. *This includes obtaining a proper referral form/authorization for my visits / MRI / X-Ray / PT / (if applicable), bring the referral form and/or referral number/authorization number with me to my appointments and any other rules I must follow with my insurance carrier. If my insurance does not cover my visits / MRI /X-Ray /PT / for any reason, I am responsible for the payment within 30 days of the denial.*

I understand that there will be a billing service charge of $10 for each statement mailed to me. I also understand that if I do not pay the balance in full within 60 days of the date of the statement, Orthopaedic Surgeons of LI may enter this balance on credit reporting registries, which will likely affect my overall credit rating.

PHYSICAL THERAPY: ***Appointment Cancellation /No Show Policy - If you cancel an appointment for physical therapy less than 24 hours in advance, or fail to show up for an appointment, you will be charged $25.00 for the allotted time.***

DOES YOUR INSURANCE REQUIRE A REFERRAL?

Please Initial: YES_____ NO_____

Print Patient Name:_____Date:_____

Patient Signature:_____

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Email Consent Form

OSLI would like to correspond with you via email communication. As a provider of care, we would like to be as efficient as possible and we believe this method of communication will allow us to do so.

Realizing that email communication is not completely secure, we would like to obtain your consent below giving us permission to contact you in this fashion. If you agree to have certain office correspondence, which may include requests for payment, scheduling updates, general office information, etc, please sign below and enter your primary email address.

Please Print:

_____
Full Name

_____
Primary Email Address

_____
Signature

_____
Date

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Musculoskeletal Orthopaedic Questionnaire

Name_____**Age**_____**Occupation**_____
Today's date_____**Your Date of Birth**_____**Social Security#**_____
Name of your referring physician_____
Name of your primary care physician_____

What brings you here?
CHIEF COMPLAINT:_____

HISTORY:
Date symptoms started/accident occurred:_____**Problem: Body part(s)**_____
Describe_____

List any treatments or tests you have had for this problem:

***PAST MEDICAL HISTORY:* (check if applies and explain)**

□Heart Disease_____ □Diabetes_____
□High Blood Pressure_____ □Circulation Problems_____
□Arthritis (type?)_____ □Stomach/intestine problems_____
□Neurological_____ □Cancer(type?)_____
□Bleeding/Clotting problems_____ □Hepatitis_____
□Breathing/Lung problems_____ □Broken bones_____
□Other Problems_____

List all past *SURGERIES* and dates:

MEDICATIONS: (list all)

ALLERGIES: (meds, environmental)

Have you ever had a Bone Densitometry test? □Yes, when:_____ **□No**

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SOCIAL HISTORY:

Living situation: (check if applies)

□Single □Married □Widowed □Separated □Divorced

PERSONAL HISTORY:

□ Drink Alcohol_____(amt/day) □ Smoke:_____(amt/day)

Your height: _____(Feet) _____(Inches) Your weight_____(lbs)

I am: □ Right hand dominant □ Left hand dominant □ Ambidextrous

DISABILITY:

Are you disabled? □Yes □No If yes, date last worked:_____

For Workman's Compensation / No-Fault Cases:

Date of injury_____ First date of disability_____ Are you out of work? □Yes □No

FAMILY HISTORY: **Please list any illness in family members living or deceased**

Mother: □ Alive □ Deceased **Father**: □ Alive □ Deceased #Siblings:_____ #Children:_____

_____

_____

_____

REVIEW OF SYSTEMS **(Circle words that apply to you)**

Gastrointestinal ------- bleeding ulcers, hiatal hernia, frequent indigestion, colitis

Genitourinary--------urination is: frequent, burning, painful, has blood

Neurologic --------- paralysis, weakness, numbness, tingling in arms or legs, seizures

Skin---------- rashes, frequent itching, sores that don't heal, infections or boils

Vascular & Hematologic &Lymphatic-----vein problems, phlebitis, clots, anemia bleeding problems, calf pain on exertion, bruise easily, swollen nodes

Cardiac & pulmonary----chest pain, shortness of breath, cough, enlarged heart, irregular heart beat, heart murmur, wheezing

Endocrine--thyroid problems, weight loss, weight gain, excessive sweating, tremor

Please give any other insights, information or concerns that you feel might be helpful in your care:_____

_____

_____

_____

If this is a work-related injury or motor vehicle accident, please inform staff

This is a confidential record of your medical history and will be kept in your chart.
Information contained here will not be released except when you have authorized us to do so.