NEW YORK SPINE INSTITUTE

Medical solutions for spine disorders

ALEXANDRE B. DEMOURA, MD PC

PATIENT DEMOGRAPHIC

NAME: _____ DATE: ____/____/____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PLEASE PROVIDE YOUR EMAIL ADDRESS: _____

PHONE: (HOME) _____ (CELL) _____ HEIGHT _____ WEIGHT _____

S.S.# _____ SEX: ☐ M / F ☐ D.O.B:. _____ AGE: _____

RACE: _____ ETHNICITY: _____ PERFERRED LANGUAGE: _____

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ PARTNER

ALLERGIES TO MEDICATION: _____

OTHER MEDICAL ISSUES: _____

ARE YOU CURRENTLY WORKING? ☐ YES ☐ NO ☐ LIMITED DUTY: _____

DO YOU HAVE AN ATTORNEY? ☐ YES ☐ NO ATTORNEY: _____

ATTORNEY PHONE #: _____ ATTORNEY EMAIL: _____

WHERE DID INJURY OCCUR: WORK: _____ CAR ACCIDENT: _____ OTHER _____

HOW DID INJURY/ILLNESS OCCUR? _____

EMERGENCY CONTACT NAME: _____ TEL# _____

ADDRESS _____

PRIMARY CARE PHYSICIAN'S NAME: _____ TEL# _____

ADDRESS _____

PLEASE INDICATE BELOW HOW YOU WERE REFERRED TO OUR OFFICE:

DOCTOR: _____ PHONE # (____) ____-_____

ATTORNEY: _____ PHONE # (____) ____-_____

BY PATIENT: _____ INTERNET/MAGAZINE AD/OTHER _____

Pharmacy Name: _____

Address: _____ Tel: _____

NEW YORK SPINE INSTITUTE

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ALEXANDRE B. DEMOURA, MD PC

PATIENT DEMOGRAPHIC

NAME: _____ DATE: ____/____/____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (HOME) _____ (CELL) _____ HEIGHT _____ WEIGHT _____

S.S.# _____ SEX ☐ M / F ☐ D.O.B:. _____ AGE: _____

RACE: ETHNICITY: PERFERRED LANGUAGE:

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ PARTNER

ALLERGIES TO MEDICATION: _____

OTHER MEDICAL ISSUES: _____

ARE YOU CURRENTLY WORKING? ☐ YES / NO ☐ LIMITED DUTY: _____

DO YOU HAVE AN ATTORNEY? ☐ YES / NO ☐ ATTORNEY: _____

ATTORNEY PHONE #: _____ ATTORNEY EMAIL: _____

WHERE DID INJURY OCCUR: WORK: _____ CAR ACCIDENT: _____ OTHER _____

HOW DID INJURY/ILLNESS OCCUR? _____

EMERGENCY CONTACT NAME: TEL#

ADDRESS

PRIMARY CARE PHYSICIAN'S NAME: TEL#

ADDRESS

PLEASE INDICATE BELOW HOW YOU WERE REFERRED TO OUR OFFICE:

DOCTOR: _____ PHONE # (____) ____-____

ATTORNEY: _____ PHONE # (____) ____-____

BY PATIENT: _____ INTERNET/MAGAZINE AD/OTHER _____

PLEASE PROVIDE YOUR PERSONAL EMAIL ADDRESS: _____

Pharmacy Name: _____

Address: _____ Tel: _____

NO FAULT INSURANCE INFORMATION

Insurance Carrier Name: _____

Carrier Address: _____

Carrier Telephone #: _____

NF Claim #: _____ Policy #: _____

Date of Accident: _____ Auto Accident State: _____

Adjuster Name: _____ Adjuster Phone #: _____

Adjuster Fax #: _____

Did another health provider treat this injury/illness including hospitalization and/or surgery? **Please Circle:** YES ☐ NO ☐

If yes, please explain: _____

_____

_____

_____

List ALL Attorneys Representing You for ALL cases (Third Party/NF/WC etc.…) _____

_____

PRIVATE INSURANCE INFORMATION (incase NF benefits are denied/closed)

Insurance Carrier Name: _____ Ins. Telephone #: _____

Member ID #: _____ Group #: _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____

**Please also provide the front desk with a copy of your insurance card*

PATIENT CONSENT FORM

Patient's Name: _____

I, the undersigned, do hereby authorize New York Spine Institute to provide me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic X-Rays or Magnetic Resonance Imaging, Physical Therapy or Chiropractic services, the administration and/or injection of medications and pharmaceutical products, including, but not limited to tripper point injections, and the drawing of blood (the "Procedure(s)"), as in the judgment of personnel and/or physicians of New York Spine Institute deems necessary.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at New York Spine Institute. I understand that the Procedure(s) and any other treatment that I may receive appear indicated by the diagnostic and/or clinical observations performed by New York Spine. I attest that a medical staff member of New York Spine has explained to me the nature of the recommended Procedure(s), the purpose of and need for the recommended Procedure(s), the possible risks and complications of the recommended Procedure(s) and the alternatives, if any, to the recommended Procedure(s). I understand all explanations given to me and give this consent voluntarily. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of New York Spine Institute.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Relationship to Patient Date

I declare that I have personally explained the above information to the patient or the patient representative.

_____ _____

Provider's Signature Date

FOR FEMALE PATIENTS ONLY:

I understand that in the course of my treatment I may have x-rays or other diagnostic tests. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Relationship to Patient Date

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

(FOR ACCIDENTS OCCURING IN AND AFTER 3/1/02)

New York Spine Institute

I, _____ **("Assignor")** hereby assign Dr. Alexandre B. de Moura, Dr. Adam Landskowsky, Dr. Peter G. Passias, Dr. Angel Macagno, Dr. John Ventrudo, Michael Friar DPT, Dr. Timothy Roberts and Dr. Alan Greenfield **("Assignees")** (Print Hospital or Health Care Provider Name)

All rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (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 purse payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle which occurred on _____, notwithstanding any other agreement to the contrary.
(Print accident date)

The 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 conducts of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERICAL OR PERSONAL INSURANCE 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 FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Address of Patient) **(Date of Signature)**

_____
(Address of Patient)

NYSI - NEW YORK SPINE INSTITUTE
Dr. Alexandre B. de Moura, Dr. Peter G. Passias,
Dr. John Ventrudo, Dr. Angel E. Macagno,
Dr. Alan Greenfield, Dr. Adam Landskowsky,
Dr. Timothy Roberts and Michael Friar, DPT _____
(Print name of Provider) (Signature of Provider)

761 MERRICK AVENUE _____
(Date of Signature)

WESTBURY, NEW YORK 11590
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

Alexandre B. Demoura, M.D., P.C d/b/a New York Spine Institute

Patient Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which describes your rights and the Provider's legal duties with respect to the use and/or disclosure of your protected health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of Alexandre B. De Moura, M.D., P.C. d/b/a New York Spine Institutes of Privacy Practices which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information.

_____ _____

Patient/Designated Representative Signature Print Name

_____ _____

If designated representative, relationship to patient Date

FOR PROVIDER USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices. We were unable to obtain such acknowledgment, however, because:

- Treatment was rendered in an emergency treatment situation. Efforts will be made to obtain the acknowledgment as soon as reasonable practicable after the emergency.
- We were unable to effectively communicate with the patient: Reason:
- Patient refused to sign: Reason Given:
- Other (please specify):

Alexandre de Moura, M.D., PC, DBA, New York Spine Institute
761 Merrick Ave.
Westbury, New York 11590
516-357-8777

ASSIGNMENT OF RECOVERY PROCEEDS AND AUTHORIZATION TO ALEXANDRE DE MOURA, M.D., PC, DBA, NEW YORK SPINE INSTITUTE

PATIENT: _____

ADDRESS: _____

ATTORNEY: _____

I, _____, the undersigned, do hereby assign to **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, any sums due and payable, received by me or on my behalf, from any source for any and all medical treatment and or fees for services rendered to me and/or my attorney.

I authorize and direct my attorney to deduct and immediately pay **Alexandre de Moura, M.D., PC, DBA New York Spine Institute**, and such fees as may be due and payable for the assigned monies that may come into my hands or my attorney's hands in any recovery resulting from any claims or lawsuit. I further direct my attorney to contact **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, to determine the exact amount owed before any money is paid to me from any recovery resulting from any claim or lawsuit. I further direct my attorney to advise **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, upon request, of the status of my lawsuits and/or any claims which may result in a monetary recovery from which the fees due and payable to **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, may be satisfied. If my attorney is replaced by another attorney, I direct that the outgoing attorney not forward my file until written acknowledgement from my new attorney is signed and forwarded to the undersigned acknowledging the terms and conditions set forth in this assignment.

Alexandre de Moura, M.D., PC, DBA, New York Spine Institute, agrees to provide reasonable cooperation in connection with securing payment for all insurance claims to the extent required by law.

In the event of any breach of this assignment by the patient and/or the patient's attorney, it is understood that the patient shall remain responsible for all legal fees required to either obtain insurance information and/or collect any monies owed to **Alexandre de Moura, M.D, PC, DBA, New York Spine Institute**, plus the expense of litigation and/or arbitration.

It is understood that this agreement, in no manner whatsoever, makes the payment of the fees due and payable to **Alexandre de Moura, M.D., PC, DBA**, **New York Spine Institute** contingent upon securing a recovery in any lawsuit or in any insurance claim that I may have. I understand that I remain personally responsible for all fees for medical treatment, as well as for services rendered on my behalf to my attorney and that I am personally liable for payment of the same. Further, I acknowledge that this assignment does not, in any fashion, preclude or otherwise prevent **Alexandre de Moura, M.D., PC, DBA, New York Spine Institute**, from demanding payment at any time after such services, as embraced within this assignment, are rendered.

_____

(Patient or Legal Guardian Signature)

_____

Witness

THE TERMS AND CONDITIONS OF THE FOREGOING ASSIGNMENT ARE UNDERSTOOD AND AGREED TO, BY:

ATTORNEY: _____

ADDRESS: _____

_____

ATTORNEY'S SIGNATURE: _____

DATED: _____

NEW YORK SPINE INSTITUTE
Medical solutions for spine disorders

Patient Agreement for Controlled Substances

1. **Interdisciplinary Treatment;** I, _____ agree to actively participate in all aspects of my treatment, as recommended by Dr. Deborah Mottahedeh, D.O or any physician employed by The New York Spine Institute, including psychological testing and therapy, follow-up, physical therapy, occupational therapy, chemical substance evaluation. If I fail to do so, I understand my treatment at The New York Spine Institute may be terminated.

2. **Lifestyle;** I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of that goal, and that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits, specifically involving exercise, weight control and the use of tobacco and alcohol. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

3. **Physical tolerance and addiction;** I have been fully informed by my physician about the physical dependence on medications. I understand that if I have been on a medication for several weeks or more, I will become physically dependent on certain medications. When I stop such medication, I must do so slowly, and under the supervision of my physician to minimize withdrawal symptoms. I know that some persons may develop psychological dependence (addiction) to a medication.

4. **Effects of medications;** I understand the side effects of the medications may include dizziness, sleeplessness, severe sweating and altered consciousness. I understand that my ability to drive and/or operate heavy machinery may be affected, and I will not perform potentially hazardous tasks before understanding how I will be affected by the medication. I understand that his may cause injury to me or others.

   (***Males Only)*** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(***Females Only)*** I am aware that chronic opioid use has been associated with low levels of sex hormones and may lead to decrease in fertility. If I plan to become pregnant or believe that I am pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always possibility that my child will have a birth defect while I am taking an opioid.

5. **Obtaining controlled substances** from physicians only at New York Spine Institute; I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medication from my doctors at New York Spine Institute. I am not to obtain controlled substances from other physicians, friends or family members. The only exception is if it is prescribed while I am admitted in a hospital.

6. **Taking medications as prescribed;** I will not increase, alter or stop my dose of controlled substance medication without approval of a New York Spine Institute physician. If I overuse my medication and run out of medication early, I will experience increased in pain and go through withdrawal, also known as abstinence syndrome. Withdrawal is a severe Flu-like syndrome caused by sudden cessation of opioids.

7. **Storage of medications;** I will make sure to store all prescribed controlled substances in a safe location away from the reach of children and pets, and under lock and key to avoid possible theft.

8. **Lost or stolen medication;** I am responsible for my controlled substances medications. If the prescriptions is lost, misplaced or stolen, I understand that it will **NOT** be replaced. We do not accept police reports or any other reports as proof.

9. **Sharing medication;** I understand that is strictly prohibited to share my medication with other individuals. Medications are to be taken only by the patient for which they were prescribed.

10. **"Street Drugs";** I will not take any "street" drugs. I understand that taking any non-prescription drugs may be grounds for expulsion from Dr. Mottahedeh, D.O and any other physician employed by New York Spine Institute.

11. **Drug Testing;** I will submit to urine and/or saliva drug testing on a random basis, as required by New York Spine Institute physicians, nurses and/or physician assistant. If illicit substances or evidence of mind-altering medications not prescribed by New York Spine Institute physicians are found in my urine or saliva or expected levels of prescribed drugs are not found, all controlled substance prescriptions will be discontinued at the discretion of the physicians at New York Spine Institute.

12. **Appointments;** I understand that refills of my controlled substances will be given only during a scheduled appointment. Patients must attend their appointments in order to be assessed for the need to continue taking the medication. Prescriptions will only be handed to the patient for whom they are intended. Prescriptions will not be mailed to patients of called in by phone to pharmacies.

13. **Discharge from New York Spine Institute;** I understand that violating the above conditions may result in discontinuation of my prescribed controlled substances and discharge from New York Spine Institute. In addition, this information may be disclosed to other individuals involved in my care, such as my primary care physician and local medical facilities.

14. **Authorization for information;** By signing this form, I am authorizing New York Spine Institute to call my other physicians, pharmacy and/or insurance company top verify compliance with these guidelines. I will tell my doctor about all other medicines and treatment that I am receiving.

15. **Pharmacy;** I shall only be using one dedicated pharmacy to fill all my prescriptions for all controlled substances prescribed to me and this information will be readily available to all physicians, nurses, physician assistant and other paramedical staff at New York Spine Institute.

My signature below indicates that I have read and understand the above guidelines.

Patient Name (PRINT): _____

Signature: _____

Pharmacy Name: _____

Address: _____

Telephone: _____ **Fax:** _____

NEW YORK SPINE INSTITUTE
Medical solutions for spine disorders

MUST BE FILLED OUT IN ENTIRETY

NO FAULT HISTORY

CHECK OFF IF POSITIVE:

PATIENT NAME:_____

DATE OF THE ACCIDENT: _____/_____/_____

CHIEF COMPLAINT_____

WHERE IS PAIN WORST? ( ) NECK ( ) BACK ( ) OTHER_____

1. YOU WERE THE: ( ) DRIVER ( ) PEDESTRIAN ( ) PASSENGER SITTING IN THE: (R) REAR or (L) REAR or (R) FRONT

2. ( ) WEARING A SEAT BELT ( ) LOST CONSCIOUSNESS

3. ( ) THE CAR WAS STOPPED ( ) THE CAR WAS MOVING

4. TYPE OF VEHICLE YOU WERE IN:
   ( ) CAR
   ( ) TRUCK
   ( ) VAN
   ( ) BUS
   ( ) MOTORCYCLE
   ( ) TAXI

5. TYPE OF VEHICLE YOU WERE STRUCK BY:
   ( ) CAR
   ( ) TRUCK
   ( ) VAN
   ( ) BUS
   ( ) MOTORCYCLE
   ( ) TAXI

6. ANY PRIOR MOTOR VEHICLE ACCIDENTS?
   ( ) YES
   ( ) NO

7. PRIOR HISTORY OF NECK OR BACK PAIN?
   ( ) YES
   ( ) NO

8. TREATMENTS YOU HAVE RECEIVED TO DATE:
   ( ) PHYSICAL THERAPY
   ( ) CHIROPRACTIC CARE
   ( ) ACCUPUNCTURE
   ( ) EPIDURAL INJECTIONS
   ( ) TRIGGER POINT INJECTION
   ( ) DIAGNOSTIC IMAGING

9. ARE YOU CURRENTLY WORKING? ( ) YES ( ) NO

10. ARE YOU DOING
    ( ) BETTER
    ( ) WORSE
    ( ) SAME

ANY OTHER MEDICAL PROBLEMS? _____

_____

OCCUPATION & EMPLOYER NAME: _____

_____

List ALL Attorneys Representing You for ALL claims (Third Party/NF/WC etc....) _____

_____

SOCIAL HISTORY: SMOKE? ☐ NO ☐ YES, HOW MUCH? _____

DRINK? ☐ NO ☐ YES, HOW MUCH? _____

LIST ANY OPERATIONS AND/OR HOSPITALIZATIONS (WITH DATES) _____

_____

_____

CURRENT MEDICATIONS? _____

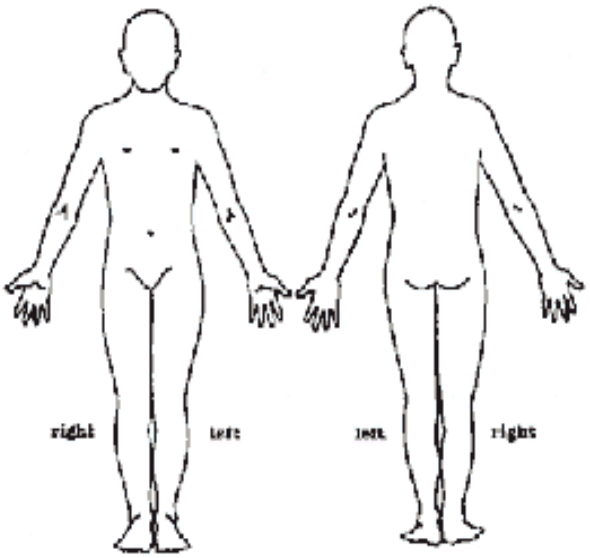
_____

ANY RADIOLOGY TESTING? _____

_____

ANY KNOWN ALLERGIES? _____

PAIN DRAWING & SCALE REVIEW



Signature: _____ Date: _____