



New York  
Orthopaedic & Comprehensive  
Medical Services, P.C.

A **NYSI** Affiliate

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

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

Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Home: \_\_\_\_\_ Telephone Cell: \_\_\_\_\_

Telephone Work : \_\_\_\_\_ If Under 18, Parents Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex  Male  Female

Email Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Reason For Visit (Body Part):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**How Did It Happen (NF/WC):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Was This Work Related?  Yes  No    Were You In A Car Accident?  Yes  No

Date Symptoms Started: \_\_\_\_\_

Left  Right: \_\_\_\_\_

Were X-Rays Taken?  Yes  No \_\_\_\_\_

Where?: \_\_\_\_\_

Date Of X-Rays: \_\_\_\_\_

**How Did You Hear About Us**

Primary Care Physician     Social Media     Advertising     Family/Friend     Other (Please List)

\_\_\_\_\_



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Referring Doctor: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

### INSURANCE INFORMATION

Name Of Primary Insurance

Name Of Secondary Insurance

Address Of Insurance Company

Address Of Insurance Company

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Name Of Insured's Employer

Name Of Insured's Employer

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_

### Insurance Payment Order

I Authorize The Release Of Any Medical Information Necessary To Process An Insurance Claim And Authorize Direct Payment To New York Orthopaedic & Comprehensive Medical Services, P.C. I Understand That I Am Financially Responsible For Treatment Rendered. **(If Insurance Is A Minor, Parent Or Guardian Must Sign).**

Legal Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **AUTHORIZATION/SIGNATURE ON FILE**

I authorize the use of this form for all my insurance submissions, release of information to all insurance companies or adjustor involved in this case. I authorize payment directly to **New York Orthopaedic & Comprehensive Medical Services, P.C.** at the address designated by the practice. I permit a copy of this authorization to be used in place of an ORIGINAL. I authorize **New York Orthopaedic & Comprehensive Medical Services, P.C.** to initiate a complaint to the insurance commissioner for any reason on my behalf. I authorize **New York Orthopaedic & Comprehensive Medical Services, P.C.** to act as my agent in helping me obtain payment from all my insurance companies. This is a direct assignment of my rights and benefits under the insurance policy information I have provided the practice.

### **YOUR INSURANCE**

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized Co-Payment at the time of service. It is the policy of our office to collect the Co-Payment when you arrive for your appointment. If you have insurance coverage with a plan which we DO NOT HAVE a prior agreement with, we will prepare and send the claim for you on an unassigned basis. Your insurer will send the payment directly to you, and you are responsible to sign over the check along with any Explanation of Benefit Form (EOB) that relates to services rendered. Patients will be responsible for deductible amounts and any balance from your insurance carrier. This includes, but is not limited to, braces, splints and any other durable medical products and supplies provide to you by our office. In the event your health plan determines a service to be "not covered", you will be responsible for the charges in full. Payments are due upon receipt of a statement from our billing office. It is the patient's responsibility to obtain the necessary referral or authorization needed by your insurance company in order to be seen. If this information is not on file with the insurance carrier prior to your time of visit you will be held responsible for all services rendered for that date of service.

### **PATIENT'S AUTHORIZATION SIGNATURE FORM**

"I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered, or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my insurance carrier. I also authorize my insurance carrier to disclose information to a hospital or heal are service plan, self-insurer or any medical information obtained, if such disclosure is necessary to allow the processing of the claim. If my coverage is under a Group contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit."

### **ACKNOWLEDGEMENT FORM**

I acknowledge that the Notice of Privacy Procedures is posted in plain sight for my view in this office, and if requested, I may have a copy of such notice for my records or an opportunity to review it.

### **PATIENT RECORD OF DISCLOSURES**

I wish to be contacted in the following manner (Check All That Apply)  Home  Work  Cell  Email

Signature Written Communications (Check All That Apply)  Mail To Home Address.  Mail To Business Address

I authorize you to contact or speak to the following individuals regarding my care:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**"I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I AUTHORIZE THE RELEASE OF THIS INFORMATION AS PROVIDED ON THIS FORM. I ALSO AUTHORIZE THE ASSIGNMENT OF BENEFITS DIRECTLY TO NEW YORK ORTHOPAEDIC & COMPREHENSIVE MEDICAL SERVICES, P.C. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE TREATMENT RENDERED. I HEREBY AUTHORIZE NEW YORK ORTHOPAEDIC & COMPREHENSIVE MEDICAL SERVICES, P.C. TO SUBMIT A LAIM TO THE INSURANCE CCARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENTS CHECK(S) DIRECTLY TO NEW YORK ORTHOPAEDIC COMPREHENSIVE MEDICAL SERVICES, P.C.**

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