NYSI
SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

NF

Patient Demographic

Name: ______________________________ Date: ______________

Address: ______________________ City: ____________________ State: _____ Zip: ________

Please Provide Your Email Address: ______________________________

Tel.#: (Home) ______________________ (Cell) ______________________

S.S.#: ____________________ Sex: ☐ Male ☐ Female D.O.B: ______________ Age: ______

Height: __________ Weight: __________ Race: ____________ Ethnicity: ______________

Preferred Language: ______________________________

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner

Do You Have An Attorney? ☐ Yes ☐ No Attorney: ______________________

Attorney Tel.#: ______________________________

Emergency Contact Name: ______________________ Tel.#: ______________________

Primary Care Physician's Name: ______________________ Tel.#: ______________________

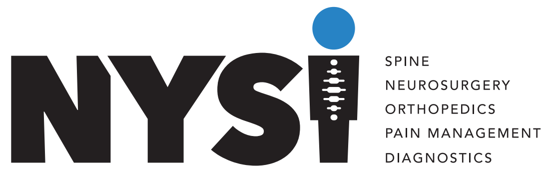
Address: ______________________ City: ____________________ State: _____ Zip: ________

Pharmacy Name: ______________________ Tel.#: ______________________

Address: ______________________ City: ____________________ State: _____ Zip: ________

Please Indicate Below How You Were Referred To Our Office:

☐ Doctor ☐ Attorney ☐ By Patient ☐ Internet/Magazine Ad/Etc.



NO FAULT INSURANCE INFORMATION

Please fill out in entirety

Insurance Carrier Name: ____

Carrier Address: ____

Carrier Telephone: ____

NF Claim #: ______________________ Policy #: ______________________

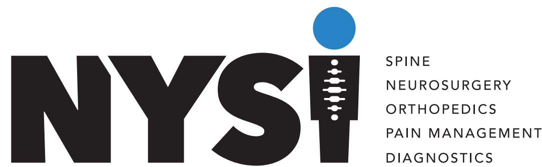
Date of Accident: ______________________ Auto Accident State: ______________________

Adjusters Name: ______________________ Adjusters Phone: ______________________

Adjusters Fax: ______________________

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

____



NEW YORK MOTOR VECHILE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURING IN AND AFTER 3/1/02)

I, ____ **("Assignor")** hereby assign Dr. Alexandre B. de Moura, Dr. Timothy Roberts, Dr. Peter G. Passias, Dr. Angel Macagno, Dr. Nicholas Post, Dr. John Ventrudo, Dr. Adam Landskowsky and Dr. Alan Greenfield **("Assignor")**

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, not-with-standing any other agreement to the contrary.

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.

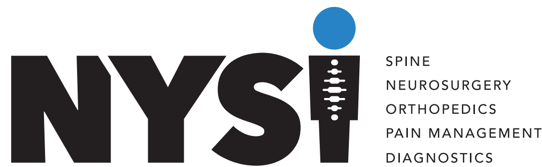
______________________________	______________________________
(Print name of Patient)	**(Signature of Patient)**
______________________________	______________________________
(Address of Patient)	**(Date of Signature)**
______________________________	
(Address of Patient)	

NYSI - NEW YORK SPINE INSTITUTE

Dr. Alexandre B. de Moura, Dr. Peter G. Passias, Dr. Angel E. Macagno, Dr. Timothy Roberts, Dr. Alan Greenfield, Dr. Adam Landskowsky, Dr. Nicholas Post and Dr. John Ventrudo

______________________________	______________________________
(Print name of Patient)	**(Signature of Patient)**
761 MERRICK AVENUE WESTBURY, NEW YORK 11590	______________________________
(Address of Provider)	**(Date of Signature)**

NYS FORM NF-AOB (Rev10/2017



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 acknowledgment 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 Signature: ____ **Date:** ________________

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MUST BE FILLED OUT IN ENTIRETY

History

Patient Name: ______________________________

Date Of The Accident: ________ / ________ / ________

Occupation And Employer: ______________________________

Chief Complaint: ______________________________

Where Is Pain? ☐ Neck ☐ Back ☐ Shoulder Rt/Lt ☐ Mid Back ☐ Knee Rt / Lt

How And Where Were You Injured?: ______________________________

Describe: ______________________________

Prior History Of Neck Or Back Pain? ☐ Yes ☐ No

Treatments You Have Received To Date: ______________________________

☐ Physical Therapy ☐ Chiropractic Care ☐ Acupuncture
☐ Diagnostic Imaging ☐ Epidural Injections ☐ Trigger Point Injection

Are You Currently Working? ☐ Yes ☐ No ☐ Limited Duty: ______________________________

Where Did Injury Occur: ______________________________

Work: ______________ Car Accident: ______________ Other: ______________

Are You Doing? ☐ Better ☐ Worse ☐ Same

Any Other Medical Problems?: ______________________________

Any Known Allergies?: ______________________________

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?: ______________________________

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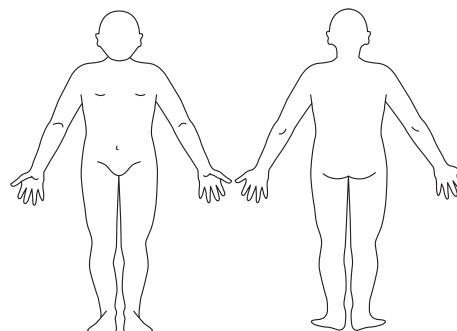

Pain Drawing & Scale Review