LIEN

NYSI
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NEUROSURGERY
ORTHOPEDICS
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DIAGNOSTICS

LIEN

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.

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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

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): _____

_____

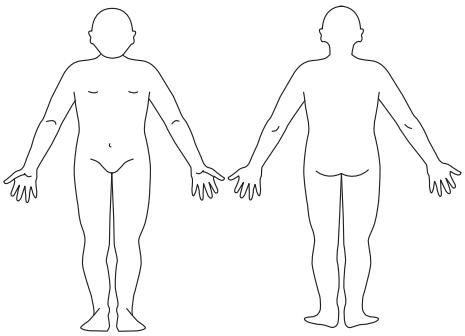
_____

Current Medications?: _____

_____

Any Radiology Testing?: _____

_____



Pain Drawing & Scale Review