NF

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.

NYSI
SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

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 VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)
New York Spine Institute

I, _____ **, ("Assignor") hereby assign to** **Dr. Alexandre B. de Moura, Dr. Adam Landskowsky,**
(Print patient's name)
Dr. Timothy Roberts Dr. Peter G. Passias, Dr. Angel Macagno, Dr. John Ventrudo, Dr. Nicholas Post & Dr. Alan Greenfield
, ("Assignee") (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 (the 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 pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

This 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 conduct 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 COMMERCIAL 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 A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF 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. Nicholas Post, Dr. Timothy Roberts

_____
(Signature of Provider)

_____ _____
(Print name of Provider) (Date of signature)

761 MERRICK AVENUE, WESTBURY, NEW YORK 11590
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

NYSI
SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

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:** _____

NYSI
SPINE
NEUROSURGERY
ORTHOPEDICS
PAIN MANAGEMENT
DIAGNOSTICS

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): _____

_____

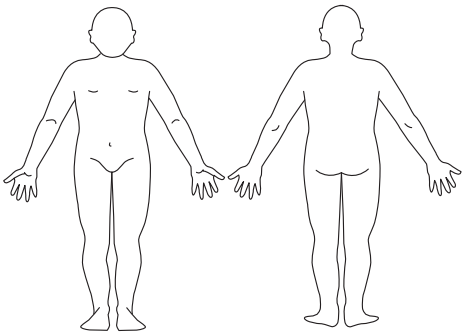
_____

Current Medications?: _____

_____

Any Radiology Testing?: _____

_____



Pain Drawing & Scale Review