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 Symptons 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: _____