

Alexandre B. deMoura, M.D., P.C.
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: _____

Marital Status: Single Married Divorced Widowed Separated Partner

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.



INSURANCE INFORMATION

Please fill out in entirety

PRIMARY INSURANCE/GUARANTOR

Insurance Carrier Name: _____

Member ID #: _____

Policy Holders Name: _____ Relationship to Patient: _____

Policy Holders Occupation: _____

Policy Holders Employer: _____

SECONDARY INSURANCE

Insurance Carrier Name: _____ Ins. Telephone #: _____

Member ID #: _____ Group #: _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____

Please provide the front desk with a copy of ALL your insurance cards



I understand that “**The NEW YORK SPINE INSTITUTE**” is participating only with the following insurance:

- MEDICARE**
- WORKERS COMPENSATION**
- NO FAULT**

All other **NEW YORK SPINE INSTITUTE** providers, including **MRI**, Pain Management, Physical Therapy, Chiropractic and X-ray DO NOT participate with any insurance companies other than **MEDICARE**.

I understand that if my insurance is not listed above, I will be utilizing my **OUT-OF-NETWORK** benefits for services rendered by the New York Spine Institute.

I understand it is the policy of the New York Spine Institute to accept my insurance payments as payment in full, and I will only be held responsible for my deductible, co- payment and co-insurance. **NEW YORK SPINE INSTITUTE** will accept the percentage paid by the insurance after the deductible met.

I understand that if my insurance does not provide **OUT-OF-NETWORK** benefits, I will be responsible for payment, in full unless other arrangements have been made with the billing department.

I, _____, understand that I may receive the payment(s) directly from my insurance carrier for services rendered to me at New York Spine Institute. In such event, I will immediately forward such payment(s) to New York Spine Institute. If I fail to do so, I will remain responsible for the payment(s) in full. Payments turned over in excess of thirty (30) days of receipt of payment(s) from the insurance carrier will be subject to monthly finance charges of 1.5%. I acknowledge that New York Spine Institute may seek remedies in recovering payment(s) for services rendered.

X _____
SIGNATURE

_____/_____/_____
DATE

Alexandre B. de Moura, MD, PC. / New York Spine Institute 761 Merrick Avenue, Westbury, NY 11590

MUST BE FILLED OUT IN ENTIRETY

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?: _____

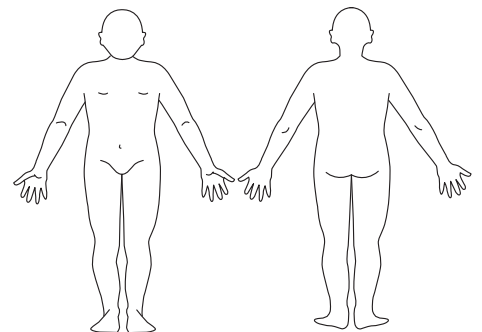
Social History:

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



PATIENT CONSENT FORM

Patient's Name: _____

I, the undersigned, do hereby authorize **New York Spine Institute** to provide me (or the patient-minor mentioned above) with medical and physical care and treatment that is considered necessary and proper in diagnosing and/or treating my (or the patient-minor's) physical condition including, but not limited to, diagnostic X-Rays or Magnetic Resonance Imaging, Physical Therapy or Chiropractic services, the administration and/or injection of medications and pharmaceutical products, including, but not limited to tripper point injections, and the drawing of blood (the "Procedure(s)"), as in the judgment of personnel and/or physicians of **New York Spine Institute** deems necessary.

I acknowledge that no guarantees or assurances have been given to me concerning the results or findings intended from the treatment or examination at **New York Spine Institute**. I understand that the Procedure(s) and any other treatment that I may receive appear indicated by the diagnostic and/or clinical observations performed by **New York Spine**. I attest that a medical staff member of **New York Spine** has explained to me the nature of the recommended Procedure(s), the purpose of and need for the recommended Procedure(s), the possible risks and complications of the recommended Procedure(s) and the alternatives, if any, to the recommended Procedure(s). I understand all explanations given to me and give this consent voluntarily. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction.

This consent with cover every visit made by me (or the patient-minor) as long as I (or patient-minor) remain an active patient of **New York Spine Institute**.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Date

I declare that I have personally explained the above information to the patient or the patient representative.

Provider's Signature Date

FOR FEMALE PATIENTS ONLY:

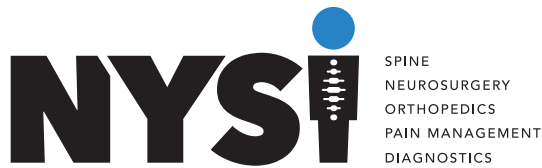
I understand that in the course of my treatment I may have x-rays or other diagnostic tests. I agree to inform the health care providers if I am or may be pregnant prior to administering any diagnostic tests.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Date



Alexandre B. Demoura, M.D., P.C d/b/a **New York Spine Institute**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

Dear Patient:

We are required to provide you with a copy of our Notice of Privacy Practices which describes your rights and the Provider's legal duties with respect to the use and/or disclosure of your protected health information. Please sign this form to acknowledge receipt of the Notice.

I acknowledge that I have received a copy of Alexandre B. De Moura, M.D., P.C. d/b/a New York Spine Institutes of Privacy Practices which discloses my rights and the Provider's legal duties with respect to the use and/or disclosure of my protected health information

Patient/Designated Representative Signature

Print Name

If designated representative, relationship to patient

Date

FOR PROVIDER USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices. We were unable to obtain such acknowledgment, however, because:

Treatment was rendered in an emergency treatment situation. Efforts will be made to obtain the acknowledgment as soon as reasonable practicable after the emergency.

We were unable to effectively communicate with the patient: Reason:

Patient refused to sign: Reason Given:

Other (please specify):
