Metro
Healthcare Partners

OFFICE USE ONLY
LIEN ___YES___NO PVT INS__YES___NO
EMPLOYEE INITIAL ____

Name_____**DOB**____/____/____**Age**_____**Social Security**_____

Address_____**City**_____**State**_____**Zip**_____

Telephone_____**Cell**_____**Work**_____**Email**_____

Marital Status circle M S D W **Sex** circle Male Female **Drivers License #**_____**State**_____

Occupation_____**Employer**_____**Telephone#**_____

Is your visit due to automobile accident or work related injury? circle YES NO

EmergencyConact:_____**Relationship**_____**Telephone**_____

Primary Care Physician_____**Tele#**_____

Advance Directive form ☐ **received** **Patient Rights form** ☐ **received**

Primary Insurance_____**Insured Name**_____**DOB**___/___/____
Policy/ID Number_____

Secondary Insurance_____**Insured Name**_____**DOB**___/___/____
Policy/ID Number_____

NO FAULT/PERSONAL INJURY **Date of Accident**_____
How did accident occur?_____
_____
Insurance Carrier_____**Policy**_____**Claim**_____
Insured Name:_____**Attorney**_____**Tel**_____

WORKERS COMPENSATION **Date of Accident**_____
How did accident occur?_____
_____
Insurance Carrier_____**Policy**_____**Claim**_____
Insured Name:_____**Attorney**_____**Tel**_____

REFERRAL SOURCE_____**Telephone**_____

There will be no charged services without your informed consent. I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement. Authorization for release information: I hereby authorize Metro Healthcare Partners to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment services at Metro Healthcare Partners. I hereby authorize payment directly to Metro Healthcare Partners for services rendered. I have reviewed this office's notice of privacy practices which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

Patient's Signature_____**Date**_____

Metro
Healthcare Partners

Main Complaint:

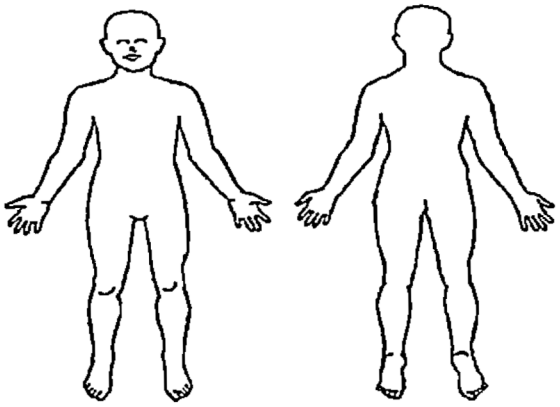
_____

How long have you had this condition_____

List any Doctors, Hospitals, or Therapist that you have seen for this condition:

1._____**2.**_____**3**_____

Ache Burning Numbness Pins & Needles Stabbing Other
^^^^^ ——— 00000000 ..... ////////// XXX



Duration of pain □Intermittent □Constant
Severity of pain □ Mild □ Moderate □ Severe
Describe pain □ Sharp □ Dull □Aching □ Burning □ Throbbing □ Tight □ Squeezing □ Pins and Needles
Pain travels □ Head □ Neck □ Upper back □ Lower back □ Arm □ Shoulder □ Elbow
Aggravated with □ Standing □ Sitting □ Lying □ Bending □ Walking □ Lifting □ Driving □ Other_____
Relieved with: □ Rest □ Heat □ Ice □ Pain Medication □ Other _____
Difficulty in □ Morning □ Night □ During the day □ With Activity
Other _____

No pain 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

List of any operations that you've had and approximate dates:
1._____Date_____Dr._____
2._____Date_____Dr._____
3._____Date_____Dr._____

List any prior accidents or injuries and approximate dates:
1._____**Date of Injury**_____2._____**Date of Injury**_____

Are you allergic to any medication:

_____

Are you taking any medications? Please list:_____
Are you pregnant? □ Yes □ No Due date:_____ **Do you smoke?** □ Yes □ No # of years_____
Do you drink alcohol? □ Yes □ No Amount □ light □ medium □ heavy

Medical History : (Please check as appropriate)

□ High or Low Pressure	□ Cholesterol	□ Diabetes	□ Heart Disease	□ Palpitations
□ Cardiac Disorder	□ Gastric Ulcer	□ GERD	□ Digestive Disorder	□ Insomnia
□ Liver Disorder	□ Lung Disorder	□ Anemia	□ Vascular Disorder	□ Depression
□ Prostate Problems	□ Bladder Problems	□ Female Problems	□ Kidney Problems	□ Loose Stool
□ Bowel Problems	□ Swollen Joints	□ Loose Stool	□ General Fatigue	□ Hot Flashes
□ Morning Fatigue	□ Poor Memory	□ other_____		

Patient Name:_____Date_____

Metro Healthcare Partners

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT,** except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Metro Healthcare Partners

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Metro Healthcare Partners to furnish medical care and treatment necessary in treating his/her physical condition.

→_____ _____

Signature of Patient/Guardian Date

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance, no fault insurance, workers compensation insurance and third party payers to Metro Healthcare Partners. A photo copy of this assignment is information necessary including medical records, to secure payment.

→_____ _____

Signature of Patient/Guardian Date

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Metro Healthcare Partners to obtain any and all medical records concerning my care from any physician, hospital, or health care professional that has provided medical care to me in the past.

I also authorize Metro Healthcare Partners to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself / and or child at any time.

→_____ _____

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restricts its users and disclosures of my health information for treatment, payment or health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. →_____ (Initial)

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have any effect on any actions the Practice has already taken in reliance of this consent.

→_____ _____

Signature of Patient/Guardian Date

Metro Healthcare Partners

THIS OFFICE IS IN COMPLIANCE WITH THE FEDERAL HIPAA GUIDELINES FOR PRIVACY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluation your health, diagnosing and providing treatment.

Your health information may be used as necessary to support day-to-day activities and management of **Metro Healthcare Partners (MHP).**

Your health information may be disclosed to law enforcement agencies and or public health agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting (such as public health reporting of communicable diseases).

Use or disclosure of your health information for any other purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

In addition, your health information may be used by our staff to send you appointment reminders, and/or information on the treatment and management of your medical condition.

You have certain rights under the federal privacy standards. These include: 1) The right to request restrictions on the use and disclosure of your protected health information. 2) The right to receive confidential communications concerning your medical condition. 3) The right to inspect and copy your protected health information. 4) The right to amend or submit corrections to your protected health information. 5) The right to receive an accounting of how and to whom your protected health information has been disclosed. 6) The right to receive a printed copy of this notice.

MHP is required by law to maintain the privacy of your information and to provide you with this notice. We reserve the right to amend or modify our privacy policies and practices as permitted by law. Any changes may be mandated by changes in federal law. If any changes occur, we will provide you with a revised notice upon your next visit. The revised notice will apply to all protected health information that we maintain.

You may generally inspect or copy the protected health information we maintain. As permitted by federal regulations, we require that all requests to inspect or copy protected health information be submitted in writing.

If you have any comments or complaints about our privacy practices, or if you feel like your privacy rights have been violated, please contact us in writing, or address the issue with our office manager in person. **Our contact address is**: 3500 Nostrand Avenue, Brooklyn, N.Y. 11229

This notice is effective as of December 1st, 2002.

Metro
Healthcare Partners

3500 Nostrand Avenue
Brooklyn, NY 11229

Please provide our office with your pharmacy information. Please give as much information as you have. You can provide us with up to two different pharmacies.

Patient Name: _____
Date of Birth: _____

Pharmacy Name: _____
Address: _____ Zip Code: _____
Phone Number: _____

Pharmacy Name: _____
Address: _____ Zip Code: _____
Phone Number: _____

Metro Healthcare Partners

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect__/__/__ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our practices or for additional copies of this notice please contact us using this information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment payment and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

PAYMENTS: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS: We may use and disclose you health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities. Reviewing the competence or qualifications of health care professionals, evaluating practitioners and provider performance conducting training programs accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment payment or health care operations you may give us written authorization to use you health information or to disclose it to anyone for any purpose if you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose you health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you as described in this patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify or assist in the notification of including identifying or locating a family member your personal representative or another person responsible for you care of you location you general condition or death. If you are present then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reason able inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x- rays or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIERED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you health or safety or the health or safety of others.

Metro Healthcare Partners

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I, (full name)_____, did receive a copy of

this office's Notice of Privacy Practices on (today's date)_____

_____ _____

Signature of Patient or Parent/Guardian Date

BELOW LINE FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining
( ) Other (please specify)

_____

_____

_____

Metro Healthcare Partners
3500 Nostrand Avenue
Brooklyn, New York 11229

Metro Healthcare Partners

Patients Bill of Rights for Diagnostic & Treatment Centers (Clinics)

As a patient in a Clinic in New York State, you have the right, consistent with law, to:

(1) Receive services(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, national origin or sponsor;

(2) Be treated with consideration, respect and dignity including privacy in treatment;

(3) Be informed of the services available at the center;

(4) Be informed of the provisions for off-hour emergency coverage;

(5) Be informed of the charges for services, eligibility for third-party reimbursements and, when applicable, the availability of free or reduced cost care;

(6) Receive an itemized copy of his/her account statement, upon request;

(7) Obtain from his/her health care practitioner, or the health care practitioner's delegate, complete and current information concerning his/her diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand;

(8) Receive from his/her physician information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. An informed consent shall include, as a minimum, the provision of information concerning the specific procedure or treatment or both, the reasonably foreseeable risks involved, and alternatives for care or treatment, if any, as a reasonable medical practitioner under similar circumstances would disclose in a manner permitting the patient to make a knowledgeable decision;

(9) Refuse treatment to the extent permitted by law and to be fully informed of the medical consequences of his/her action;

(10) Refuse to participate in experimental research;

(11) Voice grievances and recommend changes in policies and services to the center's staff, the operator and the New York State Department of Health without fear of reprisal;

(12) Express complaints about the care and services provided and to have the center investigate such complaints. The center is responsible for providing the patient or his/her designee with a written response within 30 days if requested by the patient indicating the findings of the investigation. The center is also responsible for notifying the patient or his/her designee that if the patient is not satisfied by the center response, the patient may complain to the New York State Department of Health's Office of Primary Health Systems Management;

(13) Privacy and confidentiality of all information and records pertaining to the patient's treatment;

(14) Approve or refuse the release or disclosure of the contents of his/her medical record to any health-care practitioner and/or health-care facility except as required by law or third-party payment contract;

(15) Access to his/her medical record per Section 18 of the Public Health Law, and Subpart 50-3. For additional information link to: http://www.health.ny.gov/publications/1449/section_1.htm#access

(16) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors; and

(17) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the center.

NEW YORK STATE | Department of Health

Patients' Rights, 10NYCRR, Section 751.9

Metro Healthcare Partners

ASSIGNMENT OF RIGHTS AND BENEFITS FORM

Please click each statement below to acknowledge.

○ I hereby authorize my insurance company (including private insurance and any other health/medical plan), my employer, my healthcare contractor, agents, assignees, and/or any other organization obligated to cover the cost of my healthcare benefits (collectively, the "Insurance Company") to direct any and all payments for any and all professional and medical services ("Medical Services") that I receive pursuant to my plan benefits directly to Provider(s) and/or Facility(s) providing said Medical Services, or their designated associates or assignee(s) (collectively "Provider"). I hereby authorize the Provider to obtain, including electronically or via email, on my behalf, the insurance plan, insurance and benefits policy booklet, and any and all other policy information from the Insurance Company. I also provide express consent and give full rights to the Provider to initiate and process any appeals on my behalf with my insurance for any reason.

○ I hereby fully assign the Provider any and all payments for Medical Services that are due to me and/or that I received pursuant to my benefits plan from any Insurance Company. I hereby authorize and direct my Insurance Company to issue payment check(s) directly to: Metro Healthcare Partners, 3500 Nostrand Avenue, Brooklyn NY 11229 for Medical Services which are otherwise payable to me under my current insurance policy, as payment toward the total charges for the services rendered by the Provider. I understand that as a courtesy to me, the Provider will file a claim with my insurance company on my behalf. I understand that my Insurance Company may consider certain diagnoses or services as medically uncovered, medically unnecessary, cosmetic, or excluded. I agree to be financially responsible for, and hereby do agree to pay, in a timely manner, charges for all services received and denied or otherwise not covered by my Insurance Company.

○ If my current policy prohibits direct payment to the Provider, I hereby also instruct and direct any payer to provide payment in my name and mail it to the above address of the Provider for the Medical Services expense benefits that are allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered.

○ Additionally, in the event payment(s) for services are mailed directly to me or to my partner by the Insurance Company, I hereby represent and warrant that I agree to either endorse the check and annotate "Pay to the Order of" : Metro Healthcare Partners, or immediately deposit the check and forward a personal or cashier's check for the full amount to the Provider at the above address.

○ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the Provider, Insurance Company or another medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original will be kept on file by the Provider.

○ I have been informed that the Provider is out- of-network with my Insurance Company and that this will lead to higher fees and increased financial responsibility on my behalf for the Medical Services rendered. I understand this responsibility and request to have my procedure performed at this Facility. I agree that I am responsible for annual deductibles, co-pays and charges not covered by my Insurance Company(s). Physician, Laboratory and Pathology services are billed separately from the Facility. I have been informed that in the event I am able to demonstrate financial hardship, a payment plan may be arranged for payment due for Medical Services which represent patient responsibility.

○ It is my responsibility to notify the Provider of any changes in my healthcare coverage. Exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my Insurance Company if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for Medical Services received.

○ I represent and warrant that I have read and understand the foregoing and agree to abide by and comply with all provisions contained herein.

Print your full name and sign: _____

Signature

X_____

Metro Healthcare Partners

Surprise Bill Notice

The "Emergency Medical Services and Surprise Bill Law", is a bill that is aimed to prevent you from receiving medical bills that you were not aware of. These types of bills are also called "surprise medical bills". This law went into effect on April 1, 2015. Under this law, providers must tell you if they accept your health plan. They must also provide you with any cost estimates for your care at your request.

• The "Surprise Medical Bill"

A "surprise medical bill" can happen in different ways:

1. You receive services at a hospital or ambulatory surgery center that does accept your health plan, but a provider that also accepts your health plan was not available. The provider that did care for you did not accept your health plan. OR
2. You receive services from a provider that does not accept your health plan and you were not told about that before the service. OR
3. Due to unforeseen medical circumstances that happen at the time you receive the services you did not get to choose to receive such services from a provider who did not participate with your health plan; OR
2. A provider who accepts your health plan refers you to a provider who does not accept your health plan and did not inform you of this. The provider also did not obtain your consent that you knew the services would be out-of-network and would result in costs not covered by your health plan.

• Patients' Rights

You have the right to know if the provider taking care of you for non- emergency medical services accepts your health plan. You also have the right to request an estimate of the costs for that care. For emergency medical services, you will continue to be responsible for your usual in- network copay's, coinsurance, and deductibles regardless of whether your provider accepts your health plan or not.

• Information Disclosure and Consent

Metro Healthcare Partners will provide you with the health plans that your provider(s) accepts. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

• Surprise Bill Received

If you do receive a surprise bill, you will be able to submit the bill to your health plan requesting it to be processed as if your provider participated with your health plan. Be sure to ask your provider about this.

Metro Healthcare Partners
3500 Nostrand Avenue
Brooklyn, New York 11229

Metro Healthcare Partners

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in- network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician; OR

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:
I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____
Patient Address: _____
Insurer Name: _____
Patient Insurance ID No.: _____
Provider Name: _____ **Provider Telephone Number:** _____
Provider Address: _____

Date of Service: _____
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, 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 stated value of the claim for each such violation.

_____ _____

(Signature of patient) (Date of signature)

NYS FORM OON-AOB (5/26/15)

Metro Healthcare Partners
3500 Nostrand Avenue
Brooklyn, New York 11229

Metro
Healthcare Partners

Name:_____ Employee ID#:_____ Date:_____ Age:____

Please answer the following questions.

1. **Do you have nutritional concerns?** ○ Yes (check all that apply) ○ No
   - ☐ healthy eating
   - ☐ sports nutrition
   - ☐ digestion problems
   - ☐ high blood pressure
   - ☐ weight gain
   - ☐ weight reduction
   - ☐ diabetic
   - ☐ other (describe): _____
   - ☐ high cholesterol
   - ☐ hypoglycemic
   - ☐ salt intake
2. **Food allergies or intolerances?** _____
3. **Describe type and amount of usual physical activity and/or exercise for you:** _____
4. **Do you take any medications on a regular basis?** ○ Yes (list below) ○ No

   Medication name(s) and amount: _____
5. **Do you take vitamins, mineral supplements or herbs?** ○ Yes (list below) ○ No

   Describe product, amount, and how often taken: _____
6. **Rate your appetite (check one):** ○ excellent ○ good ○ fair ○ poor
7. **Have you noticed any change in your appetite for certain foods?** ○ Yes (explain below) ○ No

   If yes, please explain: _____
8. **With whom do you usually eat your meals?** ☐ friends ☐ alone ☐ family ☐ other
9. **Where do you usually eat your meals (please check all that apply)?**
   - ☐ at work (_____ times per day)
   - ☐ at home (_____ times per day)
   - ☐ in a restaurant (_____ times per day or _____ times per week)
   - ☐ "take out" or "on the go" (_____ times per day or _____ times per week)
   - ☐ at IUN cafeteria (_____ times per week)
   - ☐ vending machines (_____ times per week)

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10. Who prepares your meals? ☐ self ☐ spouse/partner ☐ restaurant ☐ other (please list)

_____

11. In each line, please mark <u>one</u> box for frequency (more than once daily, daily, a few times a week, or rarely/never) and list specific foods you usually choose from each category.

Food	Frequency				Foods or types of foods I usually eat in this category are:
	More Than Once Daily	Daily	A Few Times A Week	Rarely Or Never	
Milk, Yogurt, or Soymilk	○	○	○	○	
Cheese	○	○	○	○	
Vegetables	○	○	○	○	
Fruit	○	○	○	○	
100% Fruit Juice	○	○	○	○	
Grains/Breads/Cereal/ Noodles/Rice/Pasta	○	○	○	○	
Meat/Poultry/Fish/Beans/ Eggs/Tofu/Soy Products/ Nuts/Seeds	○	○	○	○	

12. Which beverages do you drink (check all that apply)?

☐ water ☐ sports drink ☐ coffee ☐ tea ☐ juice

☐ milk (☐ skim ☐ ½% ☐ 1% ☐ 2% ☐ whole)

☐ soda/pop (○ diet OR ○ regular)

☐ soy or rice milk (○ fortified OR ○ unfortified)

☐ alcohol (☐ beer ☐ wine ☐ liquor)

☐ other: _____

13. Food dislikes: _____

_____

14. Describe what you ate and drank, yesterday, below. Please use yesterday, even if it is not a typical day. Be as specific as you can when listing food names and amounts.

Meals	Specific Food Item and Approximate Amount
Woke up at _____ a.m. to start the day. **Breakfast** What time did you eat breakfast? _____ How many times per week do you eat this meal? _____	
Mid-Morning Snack	
Lunch What time did you eat lunch? _____ How many times per week do you eat this meal? _____	
Mid-Afternoon Snack	
Dinner What time did you eat dinner? _____ How many times per week do you eat this meal? _____	
Evening Snack Bedtime for evening at _____ p.m.	

15. Is there anything not on this form that you would like to discuss with the dietitian? _____

_____

_____

_____

_____

_____

_____

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Instructions:

The questionnaire has been designed to give us information as to how your NECK PAIN has affected your ability to manage in everyday life. Please answer every question and mark in each section ONLY THE ONE BOX which applies to you. We realize you may consider that two of the statements in any one section relates to you but PLEASE JUST MARK THE BOX WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM.

Parameter	Status	Points
neck pain intensity	I have no pain at the moment.	0
	The pain is mild at the moment.	1
	The pain is moderate at the moment.	2
	The pain is severe at the moment.	3
	The pain is the worst imaginable at the moment.	4
neck pain and sleeping	My sleep is never disturbed by pain.	0
	My sleep is occasionally disturbed by pain.	1
	My sleep is regularly disturbed by pain.	2
	Because of pain I have less than 5 hours sleep in total.	3
	Because of pain I have less than 2 hours of sleep in total.	4
pins and needles or numbness in the arms at night	I have no pins and needles or numbness at night.	0
	I have occasional pins and needles or numbness at night.	1
	My sleep is regularly disturbed by pins and needles or numbness.	2
	Because of pins and needles I have less than 5 hours sleep in total.	3
	Because of pins and needles or numbness I have less than 2 hours of sleep in total.	4

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duration of symptoms	My neck and arms feel normal all day.	0
	I hae symptoms in my neck or arms on waking which last less than 1 hour.	1
	Symptoms are present on and off for a total period of 1-4 hours.	2
	Symptoms are present on and off for a total of more than 4 hours.	3
	Symptoms are present continuously all day.	4
carrying	I can carry heavy objects without extra pain.	0
	I can carry heavy objects but they give me extra pain.	1
	Pain prevents me from carrying heavy objects but I can manage medium weight objects.	2
	I can only lift light weight objects.	3
	I cannot lift anything at all.	4
reading and watching TV	I can do this as long as I wish with no problems.	0
	I can do this as long as I wish if I'm in a suitable position.	1
	I can do this as long as I wish but it causes extra pain.	2
	Pain causes me to stop doing this sooner than I would like.	3
	Pain prevents me from doing this at all.	4
working/housework	I can do my usual work without extra pain.	0
	I can do my usual work but it gives me extra pain.	1
	Pain prevents me from doing my usual work for more than half the usual time.	2
	Pain prevents me from doing my usual work for more than a quarter of the usual time.	3
	Pain prevents me from working at all.	4

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social activities	My social life is normal and causes me no extra pain.	0
	My social life is normal but increases the degree of pain.	1
	Pain has restricted my social life but I am still able to go out.	2
	Pain has resticted my social life to the home.	3
	I have no social life because of pain.	4
driving (see below)	I can drive whenever necessary without discomfort.	0
	I can drive whenever necessary but with discomfort	1
	Neck pain or stiffness limits my driving occasionally.	2
	Neck pain or stiffness limits my driving frequently.	3
	I cannot drive at all due to neck symptoms.	4

Status	**Response**
compared with the last time you answered this questionnaire is your neck pain	much better
	slightly better
	the same
	slightly worse
	much worse

where:

- The question on driving is omitted if the patient did not drive a car when in good health.

neck pain score = SUM(points for the first 9 questions)

If the all 9 questions are answered then

NPQ percentage = (neck pain score) / 36 * 100%

If only the first 8 questions are answered then

NPQ percentage = (neck pain score) / 32 * 100%

Interpretatation:

- minimum score: 0
- maximum score: 36 if all 9 questions answered 32 if only the first 8
- The percentages range from 0 to 100%.
- The higher the percentage the greater the disability.

Performance:

- The questionnaire has good short term repeatability and internal consistency.

References:

Leak AM Cooper J et al. The Northwick Park Neck Pain Questionnaire devised to measure neck pain and disability. Br J Rheumatol. 1994; 33: 469-474.

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Name:_____ Date:_____/_____/_____
mm dd yy

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage in every day life. Please answer every question by placing a mark in the **one** box that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but **please mark only the box which most closely describes your current condition**.

Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain medication.
- ☐ The pain is bad but I can manage without having to take pain medication.
- ☐ Pain medication provides me complete relief from pain.
- ☐ Pain medication provides me with moderate relief from pain.
- ☐ Pain medication provides me with little relief from pain.
- ☐ Pain medication has no affect on my pain.

Personal Care (Washing, Dressing etc.)
- ☐ I can take care of myself normally without causing increased pain.
- ☐ I can take care of myself normally but it increases my pain.
- ☐ It is painful to take care of myself and I am slow and careful.
- ☐ I need help but I am able to manage most of my personal care
- ☐ I need help every day in most aspects of my care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Lifting
- ☐ I can lift heavy weights without increased pain.
- ☐ I can lift heavy weights but it causes increased pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (ex. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I can not lift or carry anything at all.

Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk with crutches or a cane.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Standing
- ☐ I can stand as long as I want without increased pain.
- ☐ I can stand as long as I want but increases my pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than ½ hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using pain medication.
- ☐ Even when I take pain medication, I sleep less than 6 hours.
- ☐ Even when I take pain medication, I sleep less than 4 hours.
- ☐ Evens when I take pain medication, I sleep less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Social Life
- ☐ My social life is normal and does not increase my pain.
- ☐ My social life is normal, but it increases my level of pain.
- ☐ Pain prevents me from participating in more energetic activities (ex. sports, dancing etc.)
- ☐ Pain prevents me from going out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of my pain.

Traveling
- ☐ I can travel anywhere without increased pain.
- ☐ I can travel anywhere but it increases my pain.
- ☐ My pain restricts travel over 2 hours.
- ☐ My pain restricts my travel over 1 hour.
- ☐ My pain restricts my travel to short necessary journeys under ½ hour.
- ☐ My pain prevents all travel except for visits to the doctor/therapist or hospital.

Employment/Homemaking
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (ex. lifting, vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pan prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

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